School of Medicine and Public Health
UNIVERSITY OF WISCONSIN–MADISON

2019 Physician Benefit Checklist

UW Health

School of Medicine & Public Health – Complete and return to:

- Online: https://www.wisconsin.edu/ohrwd/benefits/how-to-enroll/
- Benefits Fax: 608-265-1456
- Payroll Fax: 608-265-6547

UW Medical Foundation – Complete and return to:

- Fax: 608-263-5778
- Scan/email: hrservicecenter@uwhealth.org
- Oracle Cloud HR Help Desk (scan/attach; use EPIC login)

UWSMPH

Complete Within 3 Days from Appointment Date

- ◯ **PAYROLL:** W-4 / WT-4 (Fed & State Withholding) Paper Form
- ◯ **PAYROLL:** Direct Deposit Paper Form
- ◯ **I-9:** I-9 section 1 online (US Department of Justice Employment Eligibility Verification) https://members.compli-9.com/Login.aspx (see separate email for username/passphrase)

Complete No Later than 30 Days from Appointment Date – Can be completed as early as 7 days prior to start date

Online Enrollment: https://www.wisconsin.edu/ohrwd/benefits/how-to-enroll/

Step 1: Log in to your MyUW portal
Step 2: Go to the Benefit Information module
Step 3: Click the Benefits Enrollment link to access Self Service
Step 4: Click 'Select' to begin
Step 5: Choose plans and add dependents; Finalize election and submit

- ◯ **HEALTH:** Group Health Insuance – Option to include Uniform Dental coverage (preventive/diagnostic) – *REQUIRED election to either enroll, waive or opt-out* (If electing Opt-Out Incentive, paper form must be completed)
- ◯ **DENTAL:** Supplemental Delta Dental - *OPTIONAL Enrollment*
- ◯ **VISION:** VSP Vision Coverage - *OPTIONAL Enrollment*
- ◯ **FLEX:** Health Care Flexible Spending Account – *OPTIONAL Enrollment*
- ◯ **FLEX:** Dependent Daycare Flexible Spending Account - *OPTIONAL Enrollment*
- ◯ **LIFE:** University Insurance Association **Mandatory coverage
- ◯ **LIFE:** State Group Life Insurance – *REQUIRED election enroll for Employee, Spouse, Dependent Coverage, or waive*
- ◯ **LIFE:** UW Employee's Inc Life Insurance - *OPTIONAL Enrollment for Employee*
- ◯ **LIFE:** Individual and Family Life Insurance - *OPTIONAL Enrollment for Employee or Family Coveage*
- ◯ **LIFE:** Accidental Death & Dismemberment Insurance - *OPTIONAL Enrollment for Employee or Family Coveage*
- ◯ **DISABILITY:** Income Continuation Insurance (ICI) – *REQUIRED election to enroll or waive*
- ◯ **RETIREMENT:** Wisconsin Retirement System (WRS) **Mandatory Coverage

Paper Enrollment Form:

- ◯ **RETIREMENT:** Tax Sheltered Annuity (TSA) 403(b): Salary Reduction Agreement- *OPTIONAL Enrollment*
- ◯ **RETIREMENT:** WDC 457(b): Salary Reduction Agreement- *OPTIONAL Enrollment*

UWMF

Complete and Return at Employee Health Appointment – Must Be Completed No Later Than Start Date (paper form)

- ◯ **HR:** I-9 Section 1 (US Department of Justice Employment Eligibility Verification).
  Documentation must be provided no later than 3 days following start date

Complete Within 3 Days following Appointment Date

- ◯ **PAYROLL**: Physician Setup Form
- ◯ **PAYROLL**: W-4 / WT-4 (Fed & State Withholding) Paper Form
  Online Oracle Cloud > Me > Pay > Tax Withholding
- ◯ **PAYROLL:** Direct Deposit
  Online Oracle Cloud > Me > Pay > Payment Methods

Return No Later than 7 Days From Deadline Stated on PRP Form – Can be completed prior (paper forms)

- ◯ **RETIREMENT:** UWMF Physicians Retirement Plan (PRP) Contribution Category Assignment Request Form ***Due to plan requirements, must be returned within 7-day deadline definition or will default to 10% for current 5-year Contribution Cycle Period (1/1/2017 to 12/31/2021) with no ability to change
- ◯ **RETIREMENT:** UWMF Physicians Retirement Plan Investment Elections Form ***Due to plan requirements, if form not returned or returned blank, will be defaulted to the age appropriate Target Date Fund
- ◯ **RETIREMENT:** Designation of Beneficiary Form

Return No Later than 30 Days from Appointment Date – Can be completed prior (paper forms)

- ◯ **DENTAL:** Dental Insurance Enrollment Form or Waiver – *OPTIONAL*
- ◯ **FLEX:** Health Care Flexible Spending Account Enrollment Form or Waiver – *OPTIONAL*
- ◯ **LIFE:** VEBA Election Form – *REQUIRED to complete and return indicating election*
- ◯ **LIFE:** Life & LTD Enrollment Form – *REQUIRED for life insurance*
- ◯ **LIFE:** Spouse Life Insurance – *OPTIONAL Enrollment – Yes or No on Life & LTD Enrollment Form*
- ◯ **LIFE:** VEBA Beneficiary Form – *REQUIRED for life insurance beneficiary if electing VEBA, as each Life & VEBA has a separate beneficiary designation*
- ◯ **LIFE:** Dependent Life Insurance Enrollment Form – *OPTIONAL*
- ◯ **DISABILITY:** Benefit Election Form – Class I – *REQUIRED to complete and return. Election of Spouse Coverage, and amount, on this form*
- ◯ **VOLUNTARY:** LifeLock Election Form – *OPTIONAL*
- ◯ **VOLUNTARY:** Long Term Care – *OPTIONAL*

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UW Health

PHYSICIAN

Physician Set-Up Form

Physician Information

Physician Name _____
Last *First* *Middle Initial*

Address _____
Street *City* *State* *Zip*

Home Phone # _____ Birth Date _____ Social Security Number _____

Office Phone # _____ Cell Phone # _____ Pager # _____

Email Address _____

Gender: Male_____ Female_____

Ethnic Category: _____White _____Hispanic or Latino _____Two or more races (not Hispanic or Latino) _____American Indian or Alaskan Native _____Asian _____African American _____Native Hawaiian or Pacific Islander

A disabled individual is defined as an individual who has a mental or physical impairment which substantially limits one or more major life activities, has a record of such impairment, or who is perceived as having such impairment.

Do you consider yourself disabled? Yes_____ No_____

If so, please explain _____

Emergency Contact

Name _____

Address _____

City _____ State _____ Zip _____

Emergency Telephone _____ Relationship _____

Veterans Status – Please Check All that Apply

Government contractors/subcontractors subject to the Vietnam Era Veterans Readjustment Act of 1974 and the Rehabilitation Act of 1973 are required to taken affirmative action to employ and advance in employment qualified disabled veterans, veterans of the Vietnam era and qualified disabled individuals. Submission of this information is *voluntary*; refusal to provide it will not subject you to any adverse treatment.

□ Yes □ No **Disabled Veteran** means (i) a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs, or (ii) a person who was discharged or released from active duty because of a service-connected disability.

□ Yes □ No **Special Disabled Veteran** means (i) a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Department of Veterans Affairs for a disability (A) rated at 30% or more, or (B) rated at 10 or 20% in the case of a veteran who has been determined under Section 38 U.S.C. 3106 to have a serious employment handicap or (ii) a person who was discharged or released from active duty because of a service-connected disability.

□ Yes □ No **Armed Forces Service Medal Veteran** means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985 (61 Fed. Reg. 1209)

□ Yes □ No **Veteran of the Vietnam-Era** means a person who: (i) served on active duty in the U.S. military, ground, naval or air service for a period of more than 180 days, and who was discharged or released there from with other than a dishonorable discharge, if any part of such active duty was performed: (A) in the Republic of Vietnam between February 28, 1961 and May 7, 1975; or (B) between August 5, 1964 and May 7, 1975, in all other cases; or (ii) was discharged or released from active duty in the U.S. military, ground, naval, or air service for a service-connected disability if any part of such active duty was performed (A) in the Republic of Vietnam between February 28, 1961 and May 7, 1975; of (B) between August 5, 1964 and May 7, 1975, in any other location;

□ Yes □ No **Recently Separated Veteran (36 months)** means a veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval or air service.

□ Yes □ No **Recently Separated Veteran (12 months)** means any veteran who served on active duty in the U.S. military, ground, naval or air service during the one-year period beginning on the date of such discharge or release from active duty.

□ Yes □ No **Other Protected Veteran** means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war or in a campaign or expedition for which a campaign badge has been authorized. For those with internet access, the information required to make this determination is available at http://www.opm.gov/veterans/html/vgmedal2.htm A copy of the list also may be obtained by sending an e-mail to helpdesk@vets100.com

For Human Resources Use Only

Physician Emp ID _____ Practice Location _____ Department/Specialty _____ FTE / % _____

Position Title _____ Supervisor _____

DOH _____ PVL# _____ Account # ___ / ___ ___ ___ / ___ ___ / ___ ___ ___ / ___ ___ ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___ ___

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Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		UW Medical Foundation

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
301 S. Westfield Road, Suite 200	*Madison*	*WI*	*53717*

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

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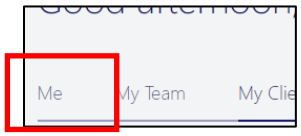
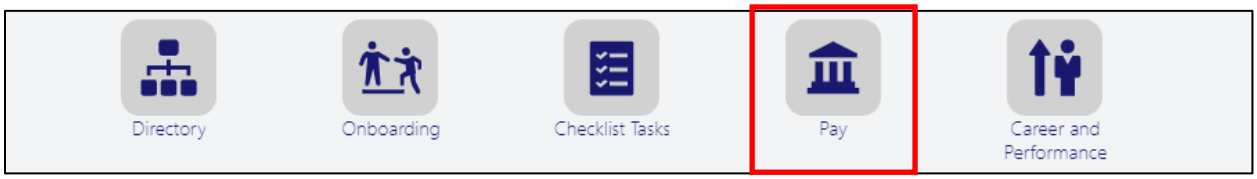
UW Health
Oracle Cloud Basics – Online Tax and Direct Deposit

1. Log into Oracle Cloud https://eimy.fa.us6.oraclecloud.com
   a. Click on '**Company Single Sign-On'** (do not enter username/password on this main screen; you will get locked out)
   b. If prompted on a separate screen, you may enter UWHealth username/password (same as your EPIC logon)
      a. Note: You will not have access until your start date (not able to enter prior to start date)
   c. If logging in from U-Connect (uwhealth.wisc.edu), then select 'Quick Links', and then 'Oracle Cloud'

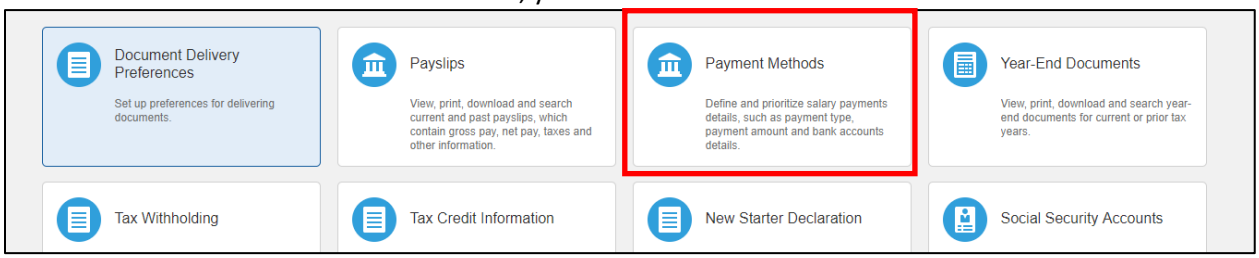
2. From the 'train stops' along the top, on the far-left side select "Me"

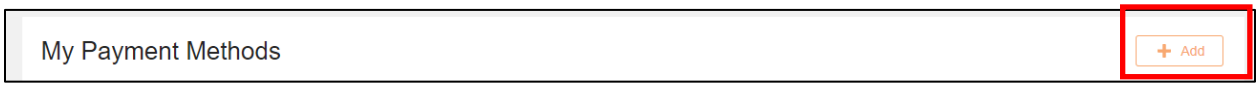


3. From the dashboard, select 'Pay'

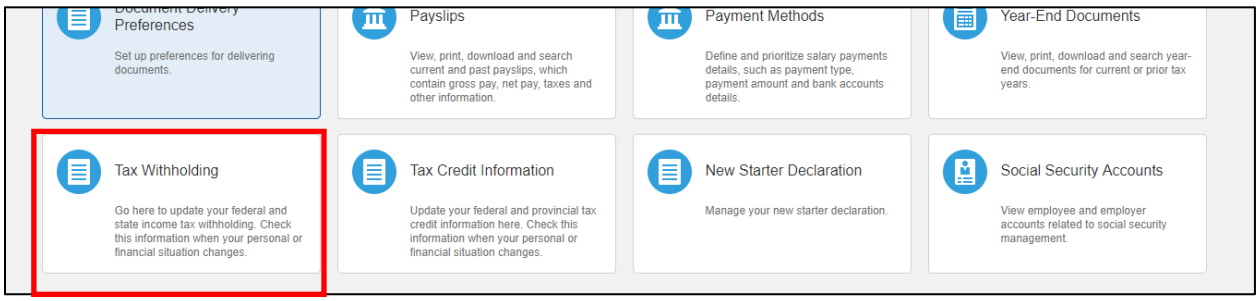


4. To update your direct deposit, select 'Payment Methods', and then "+ADD", to add in your information and click save.
   IMPORTANT In the 'Bank' field, you must select "Banks Located in the US"





5. To update your tax withholding, select 'Tax Withholding', and then "+ADD" to add in your information and click save.



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University of Wisconsin Medical Foundation
Physicians Retirement Plan

CONTRIBUTION-CATEGORY ASSIGNMENT REQUEST FORM
FOR THE 2017 TO 2021 CONTRIBUTION-CYCLE PERIOD

As a participant in the University of Wisconsin Medical Foundation Physicians Retirement Plan, I hereby request that UW Health assign me to the following contribution category from January 1, 2017 through December 31, 2021:

Contribution Category (Check One Box Only)

☐ 0%	☐ 15%
☐ 5%	☐ 20%
☐ 10%	☐ 25%

I understand that:

(a) My request is not legally binding, because UW Health (through its Retirement Plan Committee or otherwise) must make the final decision;

(b) My request applies for the entire upcoming 5-year contribution cycle period;

(c) If I fail to properly complete this form and return it within the first seven days of employment or within the first seven days after the first of the month in which I receive my first paycheck from UWMF (whichever comes first), with that date being, _____ UWMF will assign me to the 10% Contribution Category without the benefit of my input;

(d) UW Health will inform me of the contribution category to which I have been assigned;

(e) If I continue to be employed by UW Health for any part of a 5-year contribution-cycle period that begins on January 1, 2022, or on a 5-year anniversary of that date, UW Health will give me an opportunity to request assignment to a different contribution category for that period;

(f) The contributions to my Plan account for each year cannot exceed the dollar limit imposed by law for that year (e.g., $56,000 for 2019).

_____ _____
Participant Signature Date

_____ _____
Participant Printed Name UWMF Employee ID

_____ _____
UW Health Named Fiduciary Signature Date

Please return this form to:

UW Health Human Resources
Oracle Cloud HR Help Desk
hrservicecenter@uwhealth.org
Fax: 608.263.5778

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301 S. Westfield Road, Suite 200
Madison, WI 53717
Phone: 608.263.6500
Oracle Cloud HR Help Desk
hrservicecenter@uwhealth.org
Fax: 608.263.5778

Investment Elections Form

University of Wisconsin Medical Foundation Physicians Retirement Plan

Participant Information

Name (please print)	**UWMF Employee ID**

Investment Elections

I hereby elect to have all **future contributions** invested in the manner indicated below. (Elections must be in 1% increments and must total 100%.)

Target Date Funds:

_____% Vanguard Target Date Retirement Income Trust II
_____% Vanguard Target Date Retirement 2015 Trust II
_____% Vanguard Target Date Retirement 2020 Trust II
_____% Vanguard Target Date Retirement 2025 Trust II
_____% Vanguard Target Date Retirement 2030 Trust II
_____% Vanguard Target Date Retirement 2035 Trust II
_____% Vanguard Target Date Retirement 2040 Trust II
_____% Vanguard Target Date Retirement 2045 Trust II
_____% Vanguard Target Date Retirement 2050 Trust II
_____% Vanguard Target Date Retirement 2055 Trust II
_____% Vanguard Target Date Retirement 2060 Trust II
_____% Vanguard Target Date Retirement 2065 Trust II

Single-Style Funds:

_____% Dodge & Cox Balanced Fund
_____% Dodge & Cox International Stock Fund
_____% DoubleLine Core Fixed Income Fund Class I
_____% Dreyfus Treasury Securities Cash Management Inst Shares
_____% Fidelity Contrafund Commingled Pool
_____% Fidelity Emerging Markets Index Fund - Inst. Premium Class
_____% Fidelity 500 Index Fund - Institutional Premium Class
_____% Fidelity International Index Fund - Institutional Premium Class
_____% Fidelity Inflation-Protected Bond Index Fund - Inst. Prem. Class
_____% Fidelity Mid Cap Index Fund - Institutional Premium Class
_____% Fidelity Small Cap Index Fund - Institutional Premium Class
_____% Fidelity U.S. Bond Index Fund - Institutional Premium Class
_____% PIMCO Inflation Response Multi-Asset Fund Institutional
_____% PIMCO Stable Income Fund Class IV

This form must be completed and returned to UWMF Human Resources within the first seven days of employment with UWMF. If not received at that time, any contributions will be invested, by default, into the Vanguard Target Date Retirement Trust II fund that most closely matches your retirement date. This election can be changed at any time through Fidelity NetBenefits® – www.netbenefits.com/uwmfprp.

Signature

_____

Participant Signature / Date

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PHYSICIAN

Designation of Beneficiary
The UWMF, Inc. Employee & Physician Retirement Plans

To the Trustee of: **The UWMF, Inc. Employee and Physician Retirement Plans**

Participant Name:_____

Social Security #:_____ **Employee #**: _____

Pursuant to the provisions of the plan permitting the designation of a beneficiary or beneficiaries by a participant, I hereby designate the following person or persons as primary and secondary beneficiaries of my accrued benefit under the plan payable by reason of my death:

PRIMARY BENEFICIARY(IES): *Please attach another sheet of paper if necessary.*

Name	Relationship	Address
Social Security Number	Birthdate	City, State, Zip Code
Name	Relationship	Address
Social Security Number	Birthdate	City, State, Zip Code

SECONDARY BENEFICIARY(IES): *Please attach another sheet of paper if necessary.*

Name	Relationship	Address
Social Security Number	Birthdate	City, State, Zip Code
Name	Relationship	Address
Social Security Number	Birthdate	City, State, Zip Code

I RESERVE THE RIGHT TO REVOKE OR CHANGE ANY BENEFICIARY DESIGNATION. I HEREBY REVOKE ALL PRIOR DESIGNATIONS (IF ANY) OF PRIMARY AND SECONDARY BENEFICIARIES.

The trustee will pay all sums payable under the plan by reason of my death to the primary beneficiary. If he or she survives me, and if no primary beneficiary survives me, then to the secondary beneficiary, and if no named beneficiary survives me, then the trustee will pay all amounts in accordance with the plan's death beneficiary provisions.

_____ _____

Date of this Designation Signature of Participant

☐ **I am married** ☐ **I am not married**

NOTE: IF YOU ARE MARRIED AND YOU DO NOT NAME YOUR SPOUSE AS YOUR ONLY PRIMARY BENEFICIARY, YOUR SPOUSE'S SIGNATURE MUST BE NOTARIZED ON THE UWMF, Inc. Employee & Physician Retirement Plans Spousal Consent Form.

Return completed form to Human Resources:
Upload to a service request in HR Help Desk or
Email to hrservicecenter@uwhealth.org

COMPLETE THIS FORM ONLY IF YOU DO NOT LIST YOUR SPOUSE AS YOUR PRIMARY BENEFICIARY.

The UWMF, Inc. Employee & Physician Retirement Plans

Spousal Consent Form

I, the undersigned spouse of _____named in the foregoing
(Participant/Employee Name – please print)
"Designation of Beneficiary", hereby certify that I have read the Designation of Beneficiary and fully understand the property subject to the designation is my spouse's benefit under the Plan, in which I possess a beneficial interest, provided I survive my spouse. Being fully satisfied with the provisions of the designation, I hereby consent to and accept the beneficiary designation, without regard to whether I survive or predecease my spouse. This consent is irrevocable unless my spouse changes the designation. If my spouse changes the designated (choose either a or b)

_____ (a) I understand I must sign a similar consent to agree with any changes in the designation, or my consent is no longer effective; or

_____ (b) I waive my right to withhold my consent to a change in designation. I understand that I do have the right to limit my consent to the specific beneficiary designated on the life insurance or request for change form by checking line (a).

I have executed this consent this _____ day of _____, 20_____.

_____
Signature of spouse of participant

Witness by Plan Representative

Signature of spouse for consent witnessed this _____ day of _____, 20_____.

_____
Plan Representative

OR

Witness by Notary

STATE OF _____

COUNTY OF _____

Before me, as the undersigned Notary Public, personally appeared _____ who executed the above Spousal Consent as a free and voluntary act.

In witness whereof, I have signed my name and affixed by official notarial seal this _____ day of _____, 20_____.

(SEAL)

_____
Notary Public

My commission expires:_____

Note: If you are married and you do not name your spouse as your only primary beneficiary, your spouse's signature must be notarized on this page.

Return completed form to Human Resources:
Upload to a service request in HR Help Desk or
Email to hrservicecenter@uwhealth.org

DELTA DENTAL®

PHYSICIAN

Delta Dental of Wisconsin

Enrollment/Change/Waiver Form - Dental

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

EMPLOYER USE ONLY

GROUP NUMBER 91805-002 EFFECTIVE DATE

COMPLETE THIS SECTION IF YOU ARE ACCEPTING, CHANGING, OR TERMINATING COVERAGE

EMPLOYEE LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID	DATE OF BIRTH (M/D/Y)	SEX F ☐ M ☐
				/ /	

HOME ADDRESS - STREET	CITY	STATE	ZIP

EMPLOYER NAME	EMPLOYER LOCATION CITY STATE	DATE OF HIRE (M/D/Y)
UW Medical Foundation	301 S. Westfield Road, Madison WI 53717	/ /

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

SPOUSE LAST NAME (IF DIFFERENT)	FIRST	M.I.	F ☐	M ☐	DATE OF BIRTH (M/D/Y)
CHILDREN / DEPENDENT LAST NAME (IF DIFFERENT)			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

REASON FOR SUBMITTING THIS FORM

☐ **NEW ENROLLEE** ☐ **REHIRE** (Date: _____)

IF THIS IS FOR CHANGE, WHAT IS THE REASON?

	Date Occurred
☐ ~~Birth/Adoption (Name: _____)~~	
☐ ~~Marriage/~~ ☐ ~~Divorce~~	
☐ ~~Add/~~ ☐ ~~Drop Dependent (Name: _____)~~	
☐ ~~Termination of Benefits (Reason: _____)~~	
☐ ~~Loss of Dental Benefits~~	
☐ ~~Name Change (Former Name: _____)~~	
☐ ~~Address Change (_____)~~	
☐ ~~Group Transfer (From _____ To _____)~~	
☐ ~~COBRA Application~~	

COVERAGE TYPE

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

☐ Employee Only ☐ ~~Employee & Spouse / Domestic Partner~~

☐ ~~Employee & Child(ren)~~ ☐ Entire Family

YOUR MARITAL STATUS ☐ Single ☐ Married

If you are not accepting coverage for your spouse or dependents, are they covered by another dental plan? ☐ Yes ☐ No

☐ **ACCEPT COVERAGE**

X _____ _____

Signature is Required Date

COMPLETE THIS SECTION **ONLY** IF YOU ARE **WAIVING** COVERAGE

EMPLOYEE LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID	**PLEASE CHECK ONE:**
				☐ I have coverage through my spouse ☐ I have other dental coverage ☐ I do not have other dental coverage

EMPLOYER NAME	EMPLOYER LOCATION CITY STATE
UW Medical Foundation	301 S. Westfield Road, Madison WI 53717

☐ **WAIVE COVERAGE**

X _____ _____

Signature is Required Date

Acceptance of Coverage

I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance. (This authorization applies only if employee contributions are required.) I understand that by accepting insurance, I am required to remain enrolled as a covered employee and cannot make an elective change in the coverage selected until the next open enrollment period, if there is one provided for in the Master Agreement to Provide Dental Benefits.

Waiver of Coverage

I understand that if I decide not to apply for coverage, or if I apply only for single coverage even though I am eligible for family coverage, any subsequent application will be subject to the applicable terms and conditions of the Master Agreement to Provide Dental Benefits, which may require additional limitations and waiting periods. I also understand that Delta Dental of Wisconsin, Inc. reserves the right to reject such an application.

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Discovery Benefits®
www.DiscoveryBenefits.com

PHYSICIAN

www.DiscoveryBenefits.com · 866-451-3399

Flexible Spending Account (FSA) Data Collection Worksheet

Please complete and submit this worksheet to your employer. **This is an internal document used by your employer for data collection purposes. Worksheets returned to Discovery Benefits cannot be processed.**

*=Required Fields

Step 1: Participant Information

UW Medical Foundation

*Employer Name (Do not abbreviate)

Employee ID Number

*Participant Name (First, MI, Last)

*Social Security Number

*Participant Mailing Address

*City

*State

*Zip

Email Address

Day Telephone

*Date of Birth (mm/dd/yyyy)

*Hire Date (mm/dd/yyyy)

*Gender (M/F)

*Marital Status (Married/Single)

Step 2: Employee Premiums

If you have a payroll deduction for insurance premiums, eligible premiums will be deducted before taxes are calculated. You will automatically be enrolled in this portion of your Section 125 Plan. However, if you wish, you may opt out of the Employee Premium Conversion part of the Plan by contacting your HR Department and filling out the waiver form. **Note:** Insurance premiums are not eligible for reimbursement with your Medical or Limited Medical Spending Account.

Step 3: Enrollment and Election Information

*Plan Type (If enrolled in an HSA, you are not eligible to enroll in the Medical FSA. However, you are eligible for both the Limited Medical FSA and Dependent Care FSA if offered through your employer.)	**Medical FSA** Limit set by employer	**Dependent Care Account** Limit set by employer up to IRS maximum	**Combination FSA** Must be enrolled in HDHP to enroll
***Annual Election** (if employer funded, note "ER" next to amount):	$	$ X	$
***Number of Pay Periods** (if enrolling mid-year, please enter the number of remaining pay periods within the plan year):	÷	÷	÷
***Per Pay Period Amount** (to be deducted each pay period):	=	=	=
***Date of First Payroll** (mm/dd/yyyy):			
***Participant Effective Date** (mm/dd/yyyy):			

*Pay Frequency (please check one):

Monthly | Semi-Monthly | Bi-Weekly 24 | Bi-Weekly 26 | Weekly | Other

Step 4: Authorization

I authorize my employer to reduce my pay on a per-pay-period basis as indicated above. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account.

*Participant Signature

*Date

Step 5: Refusal (**Note:** Only complete this step if you are NOT electing to enroll in a Flexible Spending Account)

Participant Signature

Date

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PHYSICIAN

Human Resources
301 S. Westfield Road Suite 200
Madison, WI 53717
Phone: 608-263-6500
Oracle Cloud HR Help Desk
Email: hrservicecenter@uwhealth.org
Fax: 608-263-5778

2019 UWMF Physician VEBA Life Insurance Election Form

Name: (printed) _____ **Employee ID #:** _____

Department: _____ **Date of Hire:** _____

With my signature, I hereby voluntarily elect to participate or not to participate in the University of Wisconsin Medical Foundation (UWMF) VEBA life insurance option for the purpose of purchasing additional term life insurance coverage.

If electing VEBA coverage, I understand that $50,000 of the mandatory $500,000* in life insurance coverage will be under the UWMF basic group life insurance program. The remaining $450,000 will be under the VEBA option. The 2019 VEBA rates per $1,000 in coverage are listed below.

Age Band	VEBA Rate per $1,000
30-39	$0.035
40-44	$0.044
45-49	$0.079
50-54	$0.132
55-59	$0.236
60-64	$0.324
65-69*	$0.420
70 -74*	$0.534
75 -80*	$0.534

*Coverage will be reduced on January 1 after the attainment of age 65 and every five (5) years thereafter.

VEBA rates are reviewed and may change as of January 1 each year.

If declining VEBA coverage, I understand that my $500,000* life insurance coverage will be provided under the UWMF basic group life insurance program for the amount for which I am entitled.

Physician Election and Authorization

☐ **I ELECT participation in VEBA** ☐ **I DECLINE participation in VEBA**

I authorize UW Medical Foundation to follow the election instructions above and make any required payroll deductions based on the VEBA rate table.

Signature: _____ **Date:** _____

Return completed form to Human Resources:
Upload to a service request in HR Help Desk or
Email to hrservicecenter@uwhealth.org

For HR Use Only		
Date Received	**Coverage Effective Date**	**Processor Initials**

Human Resources
301 S. Westfield Road Suite 200
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UWMF Physician 2019 VEBA Life Insurance Rates

Eligible UWMF Physicians are automatically enrolled in a $500,000 life insurance benefit through The Hartford. This automatic enrollment occurs at the time of new employment or if you experience a change in status from non-benefit eligible to benefit eligible.

The Internal Revenue Service (IRS) requires individuals to pay income tax on the value of any life insurance coverage in excess of $50,000. This means UWMF Physicians are required to pay taxes on the imputed cost of $450,000 in life insurance. The IRS published tax rates(1) can create a significant tax liability for Physicians.

To reduce the Physician tax liability, UWMF offers the option to separate the life insurance into a base of $50,000 through UWMF and an additional $450,000 through a Voluntary Employee Benefit Association (VEBA). By electing the VEBA option, the tax liability can be reduced as shown in the chart below. Please note the amounts in the chart are *estimates* based on a 30% tax rate.

Age	IRS Taxable Benefit Option			2019 VEBA Option			
Age Band	Rate per $1,000	W-2 Income(2) UWMF Annual Premium	W-2 Tax(3) Estimated Physician Annual Tax	Rate per $1,000	W-2 Income(2) UWMF Annual Premium	W-2 Tax(3) Estimated Physician Annual Tax	Monthly Deduction(4)
30-34	$0.08	$ 432	**$ 130**	$0.035	$ 189	**$ 57**	$ 15.75
35-39	$0.09	$ 486	**$ 146**	$0.035	$ 189	**$ 57**	$ 15.75
40-44	$0.10	$ 540	**$ 162**	$0.044	$ 238	**$ 71**	$ 19.80
45-49	$0.15	$ 810	**$ 243**	$0.079	$ 427	**$128**	$ 35.55
50-54	$0.23	$1,242	**$ 373**	$0.132	$ 713	**$214**	$ 59.40
55-59	$0.43	$2,322	**$ 697**	$0.236	$1,274	**$382**	$106.20
60-64	$0.66	$3,564	**$1,069**	$0.324	$1,750	**$525**	$145.80
65-69(5)	$1.27	$4,458	**$1,337**	$0.420	$1,474	**$442**	$122.85
70 -74(6)	$2.06	$5,006	**$1,502**	$0.534	$1,298	**$389**	$108.14
75 -80(7)	$2.06	$3,337	**$1,001**	$0.534	$865	**$260**	$ 72.09

(1) IRS published tax rates: https://www.irs.gov/pub/irs-pdf/p15b.pdf
(2) Rate per $1,000 X 450 X 12 months
(3) Rate per $1,000 X 450 X 12 months X applicable tax rate (***estimate*** *based on 30% tax rate*)
(4) Rate per $1,000 x 450
(5) The 1st of the year following the attainment of age 65, insurance coverage reduces to 65% of $450,000, or $292,500
(6) The 1st of the year following the attainment of age 70, insurance coverage reduces to 45% of $450,000, or $202,500
(7) The 1st of the year following the attainment of age 75, insurance coverage reduces to 30% of $450,000, or $135,000

Revised 12/05/2018

UW Health

PHYSICIAN

Human Resources
301 S. Westfield Road Suite 200
Madison, WI 53717
Phone: 608-263-6500
Oracle Cloud HR Help Desk
Email: hrservicecenter@uwhealth.org
Fax: 608-263-5778

UWMF GROUP LIFE AND LTD ENROLLMENT/CHANGE FORM

EMPLOYER INFORMATION

EMPLOYER'S FULL LEGAL NAME	GROUP POLICY#	BILL UNIT	LOSS UNIT
UNIVERSITY OF WISCONSIN MEDICAL FOUNDATION	036143		

ENROLLMENT INFORMATION

PLEASE CHECK ONE OF THE FOLLOWING:

☐ INITIAL ENROLLMENT ☐ BENEFICIARY CHANGE

☐ CHANGE TO EXISTING ENROLLMENT

☐ NAME / ADDRESS CHANGE FORMER NAME:

☐ COVERAGE CHANGE ☐ ADD ☐ DELETE/CANCEL EFFECTIVE DATE: _____

☐ FAMILY STATUS CHANGE EVENT TYPE: _____ DATE OF EVENT: _____

EMPLOYEE INFORMATION

EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)		DATE OF BIRTH	GENDER	MARITAL STATUS	SOCIAL SECURITY NUMBER
EMPLOYEE'S HOME ADDRESS		CITY / STATE		MARRIAGE DATE	ZIP
SPECIALTY/OCCUPATION	ANNUAL EARNINGS (AS DEFINED BY THE POLICY)	# HOURS WORKED PER WEEK		DATE OF HIRE	

BENEFICIARY INFORMATION

PRIMARY LIFE BENEFICIARY NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURTIY NUMBER	% OF BENEFIT
PRIMARY LIFE BENEFICIARY NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURTIY NUMBER	% OF BENEFIT
CONTINGENT LIFE BENEFICIARY NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURTIY NUMBER	% OF BENEFIT
CONTINGENT LIFE BENEFICIARY NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURTIY NUMBER	% OF BENEFIT

Note: If additional space is needed, use back of form. Your beneficiary designation can be changed at any time. If you are married and/or divorced and reside in a community property state, you should consult with your legal counsel prior to changing your beneficiary. The designation takes effect as of the date the completed form is received and accepted by The Hartford.

APPLICABLE BENEFIT ELECTIONS

Please make your benefit elections by checking the appropriate box.

LONG TERM DISABILITY	☒ YES		
LIFE AND AD&D	☒ YES		
SPOUSE LIFE	☐ YES	☐ NO	If yes, ☐ **$50,000** guarantee issue or ☐ **$100,000** (must apply for additional $50,000 via medical underwriting)
DEPENDENT LIFE	☐ YES	☐ NO	Includes $10,000 coverage on Spouse/Domestic Partner and $5,000 on each eligible dependent for $0.93 per month. If yes, must complete separate Dependent Life Application.

SPOUSE INFORMATION

SPOUSE'S NAME	SPOUSE'S GENDER	SPOUSE'S SOCIAL SECURITY NUMBER	SPOUSE'S DATE OF BIRTH

APPLICATION FOR COVERAGE

I apply for the group insurance coverage checked above provided under my employer plan. I authorize deductions from my wages to cover my contribution, if required. If I have declined any contributory coverages for which I am eligible above, I understand that to later enroll for these coverages satisfactory medical evidence of insurability will be required and the insurance carrier will have the right to refuse my request. Any person who knowingly, and with the intent to defraud or deceive any insurance company, submits an insurance application containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

EMPLOYEE SIGNATURE DATE

For HR Use Only

Date Received	Coverage Effective Date	Processor Initials

(COMPLETE IF YOU DO NOT DESIGNATE YOUR SPOUSE AS 100% PRIMARY BENEFICIARY)

Human Resources
301 S. Westfield Road Suite 200
Madison, WI 53717
Phone: 608-263-6500
Oracle Cloud HR Help Desk
Email: hrservicecenter@uwhealth.org
Fax: 608-263-5778

UWMF Physician Life Spousal Consent Form

I, the undersigned spouse of _____***(Participant/Physician Name – please print)*** named in the foregoing "Designation of Beneficiary", hereby certify that I have read the Designation of Beneficiary and fully understand the property subject to the designation is my spouse's benefit under the Plan, in which I possess a beneficial interest, provided I survive my spouse. Being fully satisfied with the provisions of the designation, I hereby consent to and accept the beneficiary designation, without regard to whether I survive or predecease my spouse. This consent is irrevocable unless my spouse changes the designation. If my spouse changes the designated
(choose either a or b)

☐ (a) I understand I must sign a similar consent to agree with any changes in the designation, or my consent is no longer effective; or

☐ (b) I waive my right to withhold my consent to a change in designation. I understand that I do have the right to limit my consent to the specific beneficiary designated on the life insurance or request for change form by checking line (a).

I have executed this consent this _____ day of _____, 20_____.

_____
Signature of spouse of participant

Witness by Plan Representative

Signature of spouse for consent witnessed on this date: _____

_____
Plan Representative signature

OR

Witness by Notary State of County of

Before me, as the undersigned Notary Public, _____ ***(spouse's name),*** personally appeared who executed the above Spousal Consent as a free and voluntary act.

In witness whereof, I have signed my name and affixed by official notarial seal this _____ day of _____, 20_____.

_____
Notary Public

My commission expires: _____

Return completed form to Human Resources:
Upload to a service request in HR Help Desk or
Email to hrservicecenter@uwhealth.org

Human Resources
301 S. Westfield Road Suite 200
Madison, WI 53717
Phone: 608-263-6500
Oracle Cloud HR Help Desk
Email: hrservicecenter@uwhealth.org
Fax: 608-263-5778

UWMF Physician VEBA Life Insurance Beneficiary Form

Your beneficiary designation can be changed at any time. If you are married and/or divorced and reside in a community property state, you should consult with your legal counsel prior to changing your beneficiary. The designation takes effect as of the date the completed form is received and accepted by UWMF.

EMPLOYER INFORMATION

EMPLOYER'S FULL LEGAL NAME	GROUP POLICY#	BILL UNIT	LOSS UNIT
UNIVERSITY OF WISCONSIN MEDICAL FOUNDATION	GL-036143		

PHYSICIAN INFORMATION

EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH	MARITAL STATUS	SOCIAL SECURITY NUMBER	EMPLOYEE ID #

EMPLOYEE'S HOME ADDRESS	CITY	STATE	ZIP

BENEFICIARY DESIGNATION

PRIMARY BENEFICIARY(IES)

In the event of my death, the VEBA life insurance death benefit shall be paid to the following primary beneficiaries who survive me.

NAME (FIRST, MI, LAST)	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURTIY NUMBER	% OF BENEFIT
NAME (FIRST, MI, LAST)	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURTIY NUMBER	% OF BENEFIT
NAME (FIRST, MI, LAST)	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURTIY NUMBER	% OF BENEFIT
NAME (FIRST, MI, LAST)	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURTIY NUMBER	% OF BENEFIT

SECONDARY BENEFICIARY(IES)

In the event all primary beneficiaries die before me, the VEBA life insurance death benefit shall be paid to the following secondary beneficiaries who survive me.

NAME (FIRST, MI, LAST)	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURTIY NUMBER	% OF BENEFIT
NAME (FIRST, MI, LAST)	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURTIY NUMBER	% OF BENEFIT
NAME (FIRST, MI, LAST)	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURTIY NUMBER	% OF BENEFIT
NAME (FIRST, MI, LAST)	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURTIY NUMBER	% OF BENEFIT

If more space is needed, please attach an additional, signed page.

PHYSICIAN SIGNATURE

I reserve the right to revoke of change any beneficiary at any time. I hereby revoke all prior designations (if any) of primary and secondary beneficiaries. If you are married and do not designate your spouse as 100% primary beneficiary, your spouse's signature must be notarized on the attached VEBA Life Insurance Plan Spousal Consent Form.

SIGNATURE: **DATE:**

Note: The date the form is signed is not the date it becomes effective. A Beneficiary Designation form does not become effective until received and approved by UWMF Human Resources. The person filing the designation must still be alive when UWMF receives the form.

Return completed form to Human Resources:
Upload to a service request in HR Help Desk or
Email to hrservicecenter@uwhealth.org

(COMPLETE IF YOU DO NOT DESIGNATE YOUR SPOUSE AS 100% PRIMARY BENEFICIARY)

Human Resources
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Fax: 608-263-5778

UWMF Physician VEBA Life Spousal Consent Form

I, the undersigned spouse of _____***(Participant/Physician Name – please print)*** named in the foregoing "Designation of Beneficiary", hereby certify that I have read the Designation of Beneficiary and fully understand the property subject to the designation is my spouse's benefit under the Plan, in which I possess a beneficial interest, provided I survive my spouse. Being fully satisfied with the provisions of the designation, I hereby consent to and accept the beneficiary designation, without regard to whether I survive or predecease my spouse. This consent is irrevocable unless my spouse changes the designation. If my spouse changes the designated
(choose either a or b)

☐ (a) I understand I must sign a similar consent to agree with any changes in the designation, or my consent is no longer effective; or

☐ (b) I waive my right to withhold my consent to a change in designation. I understand that I do have the right to limit my consent to the specific beneficiary designated on the life insurance or request for change form by checking line (a).

I have executed this consent this _____ day of _____, 20_____.

_____
Signature of spouse of participant

Witness by Plan Representative

Signature of spouse for consent witnessed on this date: _____

_____
Plan Representative signature

OR

Witness by Notary State of County of

Before me, as the undersigned Notary Public, _____ ***(spouse's name),*** personally appeared who executed the above Spousal Consent as a free and voluntary act.

In witness whereof, I have signed my name and affixed by official notarial seal this _____ day of _____, 20_____.

_____
Notary Public

My commission expires: _____

Return completed form to Human Resources:
Upload to a service request in HR Help Desk or
Email to hrservicecenter@uwhealth.org

PHYSICIAN

This form only needs to be completed if you are newly enrolling or cancelling coverage.

Human Resources
301 S. Westfield Road Suite 200
Madison, WI 53717
Phone: 608-263-6500
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Email: hrservicecenter@uwhealth.org
Fax: 608-263-5778

UWMF Dependent Life Insurance

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Name		**Employee ID #**	
Title		**Date of Birth**	
Date of Hire		**SSN**	

Basic Life Insurance – Spouse/Domestic Partner and Child(ren)

Plan Details

- Term life insurance covering your Spouse/Domestic Partner at $10,000 and all eligible child(ren) at $5,000.
- Eligible Child(ren) are defined as: Your children, stepchildren, legally adopted children; or any other children related to you by blood or marriage or domestic partnership provided such children are:
  1) from live birth but not yet 26 years;
  2) age 26 or older and disabled. Such children must have become disabled before attaining age 26. You must submit proof, satisfactory to us, of such children's disability.
- The monthly premium is $0.93.
- You, the employee, are the designated beneficiary for this insurance coverage.
- **Note:** If your spouse or child(ren) are no longer eligible for this benefit it is your responsibility to notify HR and they will assist you in making this change.

Election/Cancellation

☐ **I elect to enroll in this plan due to the following reason:**

- ☐ **New Hire**: Coverage will be effective the 1st of the month on or following one (1) full month of employment.
- ☐ **Qualifying Event**: Coverage will be effective the 1st of the month following receipt of application in Human Resources.
- ☐ **Open Enrollment**: Coverage will be effective January 1st following the open enrollment period.

☐ **I elect to cancel coverage in this plan**
Coverage will be cancelled the 1st of the month following receipt of application in Human Resources.

Employee Authorization

I authorize UW Medical Foundation to follow the election/cancellation instructions above and deduct any required monthly premiums from my pay.

_____ _____
Signature **Date**

Return completed form to Human Resources:
Upload to a service request in HR Help Desk or
Email to hrservicecenter@uwhealth.org

For HR Use Only		
Date Received	**Coverage Effective Date**	**Processor Initials**

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Benefit Election Form – Class I

(Please print)

PHYSICIAN

Physician Completes

Last Name		**First & M.I.**	
Department		**Start Date**	
Office Phone		**Pager**	
Assistant		**Phone**	
Email Address		**Location**	

Physician Enrollment Summary

Disability Insurance	
Basic Disability (eligibility is 50% appointment)	Required - processed as payroll deduction
Basic Wrap Disability (eligibility is 75% appointment)	Required - processed as payroll deduction
Supplemental Wrap Disability (eligibility is 75% appointment)	Optional - processed as payroll deduction
Life Insurance	
□ $500,000 □ Voluntary Employee Benefit Association Option □ Yes □ No	Required – UWMF benefit, guaranteed issue See the attached VEBA enrollment form.
□ Yes □ No Spousal Life ($50,000 Basic)	Optional – processed as payroll deduction
□ Yes □ No Spousal Life ($50,000 Additional)	Optional – processed as payroll deduction
Long Term Care Insurance	
□ Yes □ No Long Term Care *	Optional – processed as payroll deduction

Physicians will be eligible for benefits **ONLY** if they have a **50%** or greater appointment to the University of Wisconsin School of Medicine and Public Health (UWSMPH).

To be completed by Human Resources Department Administration

FTE Percentage to UWSMPH (has to be 50% or greater) _____%

UWMF Annual Compensation $_____

VA Annual Compensation $_____

Total Income for initial 18 months of coverage $_____

UWSMPH Annual Compensation $_____

_____ _____

UWMF Human Resources / Administrator Signature Date

To be completed by Insurance Representative

1st 18 Months

Insurance _____

System _____

Bill _____

Certificate _____

After 18 Months

Insurance _____

System _____

Bill _____

Certificate _____

1st Call_____ 2nd Call_____

Office Location_____ Appt Date_____ Appt Time_____

Other In-force Coverage_____

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LifeLock Membership Election Form

EMPLOYER NAME
UW Medical Foundation

PHYSICIAN

Benefit Effective Date: ____

MONTHLY RATES SHOWN BELOW	LifeLock™ Benefit Elite
○ Employee Only [18 and over]	$7.49
○ Employee + Family**	$14.99

MONTHLY RATES SHOWN BELOW	LifeLock Ultimate Plus™
○ Employee Only [18 and over]	$22.49
○ Employee + Family**	$44.98

○ I wish to decline LifeLock identity theft protection.

BIWEEKLY (24) RATES SHOWN BELOW	LifeLock™ Benefit Elite
○ Employee Only [18 and over]	$3.75
○ Employee + Family**	$7.50

BIWEEKLY (24) RATES SHOWN BELOW	LifeLock Ultimate Plus™
○ Employee Only [18 and over]	$11.25
○ Employee + Family**	$22.49

○ I wish to decline LifeLock identity theft protection.

ALL LIFELOCK ENROLLEES WHO SIGN BELOW ACKNOWLEDGE AND AGREE AS FOLLOWS:

I accept the LifeLock Terms and Conditions and Privacy found at https://www.lifelock.com/legal and I am providing my "written instructions" under the Fair Credit Reporting Act authorizing LifeLock, its successors and assigns, to obtain my credit data from any consumer reporting agency on a recurring basis in order to: confirm my identity, disclose my credit data to me, and monitor my credit data in order to create and deliver certain services and features to me as available in the plan I have selected. I understand that the LifeLock credit services may require an additional validation process and until it is complete, I will be enrolled in a LifeLock subscription without credit features.

PRIMARY ACCOUNT HOLDER: Complete and accurate information is required to enroll for LifeLock. **All fields are required.**

Employee ID: ____

Printed Name: ____

DOB: ______/________/_______ SSN: __________ -__________ - __________

Email: ____ Home Work Other

Phone: (__________) __________ – ____________ Home Work Other

Street Address: ____

City: ________________ State: _____ Zip: ________________________

Signature: ______________________________ Date: ____________________

By signing this form, you represent that you have the authority, on behalf of yourself and any other members of your family, to enroll those dependents indicated below in LifeLock services and you further agree to LifeLock's Terms and Conditions. To review a copy of LifeLock terms and conditions visit https://www.lifelock.com/legal, which terms may be updated from time to time.

SECONDARY AND ADDITIONAL ENROLLEES

Printed Name: ____

DOB: ______/________/_______ Adult Minor SSN: __________ -__________ - __________

Email: ____ Home Work Other

Phone: (__________) __________ – ____________ Home Work Other

Secondary Signature: ____ Date: ______/_____/_______

Secondary if signing on behalf of a minor: ______________________________ Date: ______/_____/_______

Printed Name: ____

DOB: ______/________/_______ Adult Minor SSN: __________ -__________ - __________

Email: ____ Home Work Other

Phone: (__________) __________ – ____________ Home Work Other

Secondary Signature: ____ Date: ______/_____/_______

Secondary if signing on behalf of a minor: ______________________________ Date: ______/_____/_______

Printed Name: ____

DOB: ______/________/_______ Adult Minor SSN: __________ -__________ - __________

Email: ____ Home Work Other

Phone: (__________) __________ – ____________ Home Work Other

Secondary Signature: ____ Date: ______/_____/_______

Secondary if signing on behalf of a minor: ______________________________ Date: ______/_____/_______

1 If your LifeLock plan includes credit reports, scores, and/or credit monitoring features ("Credit Features"), two requirements must be met to receive said features: (i) your identity must be successfully verified with Equifax; and (ii) Equifax must be able to locate your credit file and it must contain sufficient credit history information. IF EITHER OF THE FOREGOING REQUIREMENTS ARE NOT MET YOU WILL NOT RECEIVE CREDIT FEATURES FROM ANY BUREAU. If your plan also includes Credit Features from Experian and/or TransUnion, the above verification process must also be successfully completed with Experian and/or TransUnion, as applicable. If verification is successfully completed with Equifax, but not with Experian and/or TransUnion, as applicable, you will not receive Credit Features from such bureau(s) until the verification process is successfully completed and until then you will only receive Credit Features from Equifax. Any credit monitoring from Experian and TransUnion will take several days to begin after your successful LifeLock plan enrollment.

No one can prevent all identity theft.

† LifeLock does not monitor all transactions at all businesses.

** The LifeLock Junior plan is for minors under the age of 18. LifeLock enrollment is limited to employees and their eligible dependents. Membership is available only as an added membership to an adult LifeLock plan. LifeLock services will only be provided after receipt and applicable verification of certain information about you and each family member. Please refer to employer group for the required information under your plan. In the event you do not complete the enrollment process for any family member, those individuals will not receive LifeLock services, but you will continue to be charged the full amount of the monthly membership selected until you cancel or modify your plan at your employer's next open enrollment period, which may be annually. Please note that we will NOT refund or credit you for any period of time during which we are unable to provide LifeLock services to any family member on your plan after your benefit effective date due to your failure to submit the information necessary to complete enrollment. If you do not complete the enrollment process for each family member, you may continue to pay more for LifeLock services than you otherwise would if you had selected a lower tier plan.

LifeLock

Identity Theft Protection: An Essential Employee Benefit

CHOOSE THE LIFELOCK SERVICE THAT'S RIGHT FOR YOU.

LIFELOCK™ BENEFIT ELITE identity theft protection is designed to help protect against identity theft plus monitor for threats to your identity and financial assets—your 401(k), investment, checking and savings accounts.† LifeLock Benefit Elite membership is only available as an employee payroll-deducted benefit.

LIFELOCK ULTIMATE PLUS™ provides peace of mind knowing you have LifeLock's most comprehensive identity theft protection. Enhanced services include bank account application and takeover alerts, online annual three-bureau credit reports and credit scores plus monthly one-bureau credit score tracking[1].†

LIFELOCK JUNIOR™ (Membership is available only as an added membership to an adult LifeLock plan) protection helps safeguard your child's Social Security number and good name with proactive identity theft protection designed specifically for children. To learn more about LifeLock Junior™ membership, and the specific features available with this plan, please visit LifeLock.com/products/lifelock-junior.

Special employee benefit rate starting as low as

$7.49 MONTHLY

Based on monthly deductions for LifeLock Benefit Elite service, employee only.

FEATURES	LifeLock Benefit Elite	LifeLock Ultimate Plus
LifeLock Identity Alert™ System†	✓	✓
Lost Wallet Protection	✓	✓
USPS Address Change Verification	✓	✓
Dark Web Monitoring	✓	✓
LifeLock Privacy Monitor™	✓	✓
Reduced Pre-Approved Credit Card Offers	✓	✓
Fictitious Identity Monitoring	✓	✓
Court Records Scanning	✓	✓
Data Breach Notifications	✓	✓
Credit, Checking & Savings Account Activity Alerts†	✓	✓
Investment Account Activity Alerts†	✓	✓
24/7 Live Member Support	✓	✓
U.S.-Based Identity Restoration Specialists	✓	✓
Stolen Funds Reimbursement°	up to $1 Million	up to $1 Million
Coverage for Lawyers and Experts°	up to $1 Million	up to $1 Million
Personal Expense Compensation°	up to $1 Million	up to $1 Million
Checking and Savings Account Application Alerts†		✓
Bank Account Takeover Alerts†		✓
Three-Bureau Credit Monitoring[1]		✓
Three-Bureau Annual Credit Reports and Credit Scores[1] The credit scores provided are VantageScore 3.0 credit scores based on data from Equifax, Experian and TransUnion respectively. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.		✓
One-Bureau Monthly Credit Score Tracking[1] The credit score provided is a VantageScore 3.0 credit score based on Equifax data. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.		✓
File-Sharing Network Searches		✓
Sex Offender Registry Reports		✓
Priority 24/7 Live Member Support		✓

°Indicates features included within the Million Dollar Protection™ Package°††

[1]If your LifeLock plan includes credit reports, scores, and/or credit monitoring features ("Credit Features"), two requirements must be met to receive said features: (i) your identity must be successfully verified with Equifax; and (ii) Equifax must be able to locate your credit file and it must contain sufficient credit history information. **IF EITHER OF THE FOREGOING REQUIREMENTS ARE NOT MET YOU WILL NOT RECEIVE CREDIT FEATURES FROM ANY BUREAU.** If your plan also includes Credit Features from Experian and/or TransUnion, the above verification process must also be successfully completed with Experian and/or TransUnion, as applicable. If verification is successfully completed with Equifax, but not with Experian and/or TransUnion, as applicable, you will not receive Credit Features from such bureau(s) until the verification process is successfully completed and until then you will only receive Credit Features from Equifax. Any credit monitoring from Experian and TransUnion will take several days to begin after your successful LifeLock plan enrollment.

No one can prevent all identity theft. † LifeLock does not monitor all transactions at all businesses.

*LifeLock defers to the employer's benefit eligibility rules regarding the number and age of the eligible dependents.

°††Reimbursement and Expense Compensation, each with limits of up to $1 million for Benefit Elite and Ultimate Plus and up to $25,000 for Junior. And up to $1 million for coverage for lawyers and experts if needed, for all plans. Benefits provided by Master Policy issued by United Specialty Insurance Company (State National Insurance Company, Inc. for NY State members). Policy terms, conditions and exclusions at: LifeLock.com/legal.