Health Insurance Application/Change

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

There are certain times throughout the year when you may enroll in health insurance or change your coverage. Visit etf.wi.gov/benefits-by-employer to learn more about choices available to you and see how to enroll. **Return this completed form to your employer. Print clearly.** Please read the terms and conditions on page 6. Sign on page 4.

Your health insurance deductions will be taken pre-tax unless you request they be taken post-tax. Contact your employer to make this change or submit the *Automatic Premium Conversion Waiver/Revocation of Waiver* (ET-2340) to your employer.

1. Applicant Information *Only the subscriber applying for coverage/making a change should complete this form.*

Check here if your name, phone, address, email, or marital status has changed: ☐ *List updated information below*

Name First	M.I.	Last	Former/Maiden (if applicable)

ETF ID	SSN or ITIN	Telephone, including area code	Email

Mailing address (Street) City State ZIP code Country

Birth date (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Primary care physician or clinic *Health plan may also ask*

Check your marital status:

☐ Single *(no change date required)*

☐ Married Date: _____ (MM/DD/YYYY)

☐ Divorced Date: _____ (MM/DD/YYYY)

☐ Widowed Date: _____ (MM/DD/YYYY)

Please check which applies to you (this determines your eligibility)

☐ Employee ☐ Graduate assistant ☐ COBRA recipient ☐ Surviving dependent

2. Spouse Information (Only complete if you are on a family plan; not required for single coverage)

Name First	M.I.	Last	Former/Maiden	SSN or ITIN

Birth date (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Primary care physician or clinic *Health plan may also ask*

Check here if your spouse's information has changed: ☐

3. Dependent Information (Only complete if you are on a family plan; this does not include spouse)

Name *You may attach additional pages if more space is needed*			SSN or ITIN	Birth date	Sex (M/F)	Relationship (child, stepchild, legal ward, child of minor dependent)	Disabled (Y/N)	Primary care physician or clinic *Health plan may also ask*
First	*M.I.*	*Last*						

Is any dependent listed here your or your spouse's grandchild? ☐ Yes ☐ No

If yes, name of parent: _____

Name: _____ ETF ID: _____

4. Are you eligible to enroll or make a change?

You can modify your benefits during the annual open enrollment period, your initial hire period, and in response to an eligible life event change. Eligible life changes are listed below.

Reason for Application: Select a reason for enrolling or changing your coverage or health plan:

- ☐ Annual open enrollment (coverage effect January 1).
- ☐ New hire (Choose date your coverage will be effective, see below).
- ☐ Rehired annuitant.
- ☐ Eligible life event change (select change below). Life event change date: _____
- ☐ Eligible move to a new service area *(may only change health plan)*. Move date: _____

New hires or employees returning from leave (lapsed coverage) *only*: Choose your coverage to be effective:

- ☐ When my employer contributes to my premium.
- ☐ As soon as possible (you will pay the entire monthly premium until you are eligible for your employer contribution).
- ☐ I choose to decline/waive coverage *(to decline health insurance and elect the opt-out incentive, go to section 12).*
- ☐ I choose to decline/waive coverage *because I have other health insurance coverage (go to section 13 and sign).*

Eligible life event changes, which allow you to make a change outside of the annual open enrollment period (or your initial hire period), include birth/adoption, marriage and divorce. Visit etf.wi.gov/insurance/life-events-guide for more.

Select one reason to add coverage/dependent or remove dependent(s):

Add coverage/dependent(s) *(complete section 3)*

- ☐ Marriage*
- ☐ Transfer to a new state agency (state only)
  Former agency name: _____
- ☐ Birth or adoption*
- ☐ LTE new hire (state only)
- ☐ Enroll in COBRA (*Continuation-Conversion Notice* (ET-2311) required)
- ☐ National Medical Support Notice*
- ☐ Spouse-to-spouse transfer at retirement
- ☐ Loss of employer contributions or loss of other coverage*
- ☐ Paternity acknowledgment*
- ☐ Legal ward/guardianship*
- ☐ Disabled dependent, age 26+*
- ☐ Dependent not on initial enrollment (excludes adult dependents)
- ☐ Other: _____

Remove dependent(s) *(complete section 8)*

- ☐ Divorce*
- ☐ Death of dependent
- ☐ Legal ward/guardianship end*
- ☐ Disabled dependent disability end or support/maintenance less than 50%
- ☐ Grandchild's parent age 18
- ☐ Adult dependent eligible for other coverage*
- ☐ Other: _____

**You may be required to provide supporting documentation.*
See etf.wi.gov/life-change-event-documentation

5. Enroll in a Plan Design

Compare factors like monthly payments, coverage levels, out-of-network benefits, and provider availability. See your insurance benefits materials or your employer for specific options available to you, and descriptions of each plan design. If you are not changing the options below, you do not need to complete this section.

Make your plan (chosen on next page) a High Deductible Health Plan (HDHP)? ☐ Yes ☐ No

Individual or family coverage? ☐ Individual ☐ Family

With or without Uniform Dental? ☐ With dental ☐ Without dental

If you choose with dental, your dental plan will be Delta Dental.

State employees: If you elect HDHP, you must also enroll in the state-sponsored health savings account (HSA). You are not eligible for an HDHP if you have other coverage. You may enroll in an HDHP if your dependents have other coverage.

Local Wisconsin Public Employer (WPE) employees: You can only enroll in the plan designs your employer offers, including dental. Check with your employer.

6. Select Your Health Plan

All health plans provide the same in-network benefits. When choosing a plan, consider where you live or work, health plan quality ratings and the monthly premium. See your insurance benefits materials for your options. Health plan provider directories are available online.

- ☐ Access Plan by Dean Health Plan
- ☐ Aspirus Health Plan
- ☐ Common Ground Healthcare Cooperative
- ☐ Dean Health Plan
- ☐ Dean Health Plan - Medica West and Mayo Clinic Health System
- ☐ Dean Health Plan - Prevea360 East
- ☐ GHC of Eau Claire Greater Wisconsin
- ☐ GHC of Eau Claire River Region
- ☐ GHC of South Central Wisconsin Dane Choice
- ☐ GHC of South Central Wisconsin Neighbors
- ☐ HealthPartners Health Plan Southeast
- ☐ HealthPartners Health Plan West
- ☐ Medical Associates Health Plans
- ☐ MercyCare Health Plans
- ☐ Network Health
- ☐ Quartz Central
- ☐ Quartz UW Health
- ☐ Quartz West
- ☐ Robin with HealthPartners
- ☐ Security Health Plan
- ☐ State Maintenance Plan (SMP) by Dean Health Plan

7. Complete if you or any of your Dependents are Covered by Medicare

Required for all persons covered by Medicare, including yourself. Eligibility reasons include age, disability or end-stage renal disease (ESRD).

Name (*First, M.I., Last*)	Medicare number (see your Medicare ID card)	Part A effective date	Part B effective date	Why eligible?
				☐ Age ☐ Disability ☐ ESRD
				☐ Age ☐ Disability ☐ ESRD
				☐ Age ☐ Disability ☐ ESRD

8. Remove a Spouse or Dependent(s)

Name of person(s) you are removing *(First, M.I., Last)*	Birth date	Address (if different than your address on page 1)

9. Complete if you are Changing from Family to Individual Coverage

If your employee monthly premium share is pre-tax, IRC Section 125 restricts midyear changes to your coverage. For more information on IRC Section 125 limitations, visit www.irs.gov.

My employee-required monthly premium contribution is deducted (*check one*):

- ☐ Pre-tax and my employee premium contribution has increased significantly
- ☐ Pre-tax eligible life event change

  What was the event? _____
- ☐ Pre-tax change to individual during annual open enrollment period (January 1)
- ☐ Post-tax (midyear changes to coverage level can be made at any time)

  Event date: _____

Name: _____ ETF ID: _____

10. Cancel Health Insurance Coverage

Only complete this section to cancel coverage entirely. Do not complete if you are changing health coverage.

My premiums are deducted: ☐ Pre-tax (select a life change event below)
☐ Post-tax (no event required to cancel coverage)

Choose one reason for canceling coverage:

☐ Open enrollment; cancel all coverage for next year

☐ I am terminating employment

☐ My employee premium share has increased significantly

☐ I and all eligible dependents are now eligible for, and enrolled in, other coverage

Event date: _____ *(you must provide proof)*

☐ Spouse-to-spouse transfer at retirement

Event date: _____

☐ I am going on an unpaid leave of absence *(you may want to let your coverage lapse instead; see your employer)*

Your cancellation is effective on the first of the month after ETF receives your written request to cancel, unless you specify a later date, above.

11. Do you Have Other Health Insurance Coverage

Do you or any of your dependents also have other medical coverage or health care flexible spending account coverage that has a balance available as of the effective date of this coverage (excludes dental or vision)? (Coordination of benefits will apply.)

☐ No

☐ Yes (complete other health insurance information below)

Name of health insurance company:_____

Policy number: _____ Group number: _____

Name(s) of insured: _____

12. *State Employees Only*: Decline Health Insurance & Elect the Opt-Out Incentive

Are you electing to receive the opt-out incentive for 2025? ☐ Yes ☐ No

If yes, you certify you are eligible for the opt-out stipend and are not currently, nor will be this program year, a covered dependent under the State of Wisconsin Group Health Insurance Program, and that you did not decline or waive coverage in 2015.

13. Subscriber Signature *Required* If not signed, ETF cannot accept your application

By signing this application, I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and I have read and agreed to the *Terms and Conditions* (see page 6). A copy of this application is considered as valid as the original. In addition, to the best of my knowledge, all statements and answers in this application are complete and true. Providing false information is punishable under Wis. Stat. § 943.395. Additional documentation may be required by ETF at any time to verify eligibility.

Subscriber signature	Date (MM/DD/YYYY)

Return this completed form to your employer.

If you are enrolling in COBRA, return this completed form to ETF.

Employer must review the completed application before completing the employer section on the next page.

Name: _____ ETF ID: _____

Employer Completes – complete entire section, including the signature

Employer must review the completed employee application before completing and signing this section.
Coding instructions are in the *Employer Health Insurance Administration Manual*.

EIN	Employer name		Payroll representative email
Group number	Employee type	Coverage type ☐ Individual ☐ Family	Health plan name/suffix
Business Unit *(if applicable)*	Employment status of applicant ☐ Full time ☐ Part time ☐ LTE		Employee deductions ☐ Pre-tax ☐ Post-tax
Hire date or date WRS-eligible employment or graduate appointment began	Employer received date	Event date	Prospective coverage date

Are you a WRS-participating employer? ☐ Yes ☐ No

Previous service check completed? ☐ Yes ☐ No

Source of previous service check? ☐ WRS System ☐ ETF

Did employee participate in the WRS prior to being hired by you? ☐ Yes ☐ No

Payroll representative signature	Telephone, including area code	Date signed (MM/DD/YYYY)

Terms and Conditions

To the best of my knowledge, all statements and answers in this application are complete and true. I understand that if I provide false or fraudulent information, misrepresentation or fail to provide complete or timely information on this application, I may face action, including, but not limited to, loss of coverage, employment action, and/or criminal charges/sanctions under Wis. Stat. § 943.395.

I authorize the Department of Employee Trust Funds to obtain any information from any source necessary to administer this insurance.

I agree to pay in advance the current premium for this insurance, and I authorize my employer (the remitting agent) to deduct from my wages or salary an amount sufficient to provide for regular premium payments that are not otherwise contributed. The remitting agent shall send the premium on my behalf to ETF.

I understand that eligibility for benefits may be conditioned upon my willingness to provide written authorization permitting my health plan and/or ETF to obtain medical records from health care providers who have treated me or any dependent(s). If medical records are needed, my health plan and/or ETF will provide me with an authorization form. I agree to respond to questions from health plans and ETF, including, but not limited to, audits, in a timely manner.

I have reviewed and understand the eligibility criteria for dependents under this coverage and affirm that all listed dependents are eligible. I understand that children may be covered through the end of the month they turn 26. Children may also be covered beyond age 26 if they: have a disability of long standing duration, are dependent on me or the other parent for at least 50% of support and maintenance, and are incapable of self-support; or are full-time students and were called to federal active duty when they were under the age of 27 years and while they were attending, on a full-time basis, an institution of higher education.

I understand that it is my responsibility to notify the employer, or if I am a retiree or continuant to notify ETF, if there is a change affecting my coverage, including but not limited to, a change in eligibility due to divorce, marriage or an address change due to a residential move. Furthermore, failure to provide timely notice may result in loss of coverage, delay in payment of claims, loss of continuation rights and/or liability for claims paid in error. Upon request, I agree to provide any documentation that ETF deems necessary to substantiate my eligibility or that of my dependent(s).

I understand that if there is a qualifying event in which a qualified beneficiary (me or any dependent(s)) ceases to be covered under this program, the beneficiary(ies) may elect to continue group coverage as permitted by state or federal law for a maximum of 18, 29, or 36 months, depending on the type of qualifying event, from the date of the qualifying event or the date of the notice, whichever is later. I also understand that if continuation coverage is elected by the affected qualified beneficiary(ies) and there is a second qualifying event (i.e, loss of eligibility for coverage due to death, divorce, marriage but not including non-payment of premium) or a change in disability status as determined by the Social Security Administration, continuation coverage, if elected subsequent to the second qualifying event, will not extend beyond the maximum of the initial months of continuation coverage. I understand that timely notification of these qualifying events must be made to ETF.

I understand that if I am declining enrollment for myself or my dependent(s) (including spouse) because of other health insurance coverage, I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for that other coverage (or if the employer stops contributing toward that other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if I have (a) new dependent(s) as a result of marriage, birth, acknowledgement of paternity, adoption, or placement for adoption, I may be able to enroll myself and my dependent(s) if I request enrollment within 30 days after the marriage or within 60 days after the birth, acknowledgement of paternity, adoption, or placement for adoption. To request special enrollment or obtain more information, I should contact my employer (or ETF if I am a retiree or continuant).

I understand that I am responsible for enrolling in Medicare Parts A and B when I am first eligible and required by this coverage, and that as the subscriber I am responsible for ensuring my spouse and any other eligible dependents also enroll in Medicare Parts A and B when they are first eligible, to ensure proper coordination of benefits with Medicare. In the event I or any eligible dependent does not enroll in Medicare Parts A and B when first eligible and required by this group health insurance program, I understand that I will be financially liable for the portion of claims Medicare would have paid had proper Medicare enrollment been attained.

I understand that if I enrolled in IYC Medicare Advantage with an individual or family contract and subsequently I or my dependents cancel Medicare coverage, I and all covered dependents on the contract will be unenrolled from the IYC Medicare Advantage plan and enrolled in the Medicare Plus plan effective the date of loss of Medicare coverage. I understand that I will be financially liable for the portion of claims Medicare would have paid had proper Medicare enrollment been attained.

I agree to abide by the terms of my benefit plan, as explained in any written materials I receive from ETF or my health plan, including, without limitation, the insurance materials.

Nondiscrimination and Language Access

42 U.S. Code § 18116

ETF complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ETF provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats and others). ETF provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact ETF at 1-877-533-5020; TTY: 711.If you believe that ETF has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

ETF Office of Policy, Privacy & Compliance
P.O. Box 7931
Madison, WI 53707-7931

1-877-533-5020; TTY: 711
Fax: 608-267-4549
Email: ETFSMBPrivacyOfficer@etf.wi.gov

If you need help filing a grievance, ETF's Office of Policy, Privacy & Compliance is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal at ocrportal.hhs.gov/ocr/smartscreen/main.jsf or by mail or phone:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019; 1-800-537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/complaints/index.html.

The Wisconsin Department of Employee Trust Funds is a state agency that administers the Wisconsin Retirement System pension, health insurance and other benefits offered to eligible government employees, former employees and retirees.

Spanish – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-533-5020 (TTY: 711).

Hmong – LUS CEEV: Yog tias koj xav tau kev pab txhais lus. Peb pab koj tau, peb pab koj dawb xwb, thov hu rau 1-877-533-5020 (TTY: 711)

Chinese– 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-533-5020（TTY：711）

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-533-5020 (TTY: 711).

ملاحظة: إذا كنت تتحدث اللغة العربية، فهناك خ
متاحة بلغتك دون أي مصاريف: اتصل بالرقم
1-877-533-5020 (خدمة الصم والبكم: 711)

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-533-5020 (телетайп: 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-533-5020 (TTY: 711)번으로 전화해 주십시오.

Vietnamese – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-533-5020 (TTY: 711).

Pennsylvania Dutch – Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-533-5020 (TTY: 711).

Laotian/Lao – ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-533-5020 (TTY: 711).

French – ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-877-533-5020 (ATS : 711).

Polish – UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwońpod numer 1-877-533-5020 (TTY: 711).

Hindi – ध्यान दें: यदि आप ि दी बोलते ै तो आपके लिए मुफ्त में भाषा स ायता सेवाएं उपलब्ध ै। 1-877-533-5020 (TTY: 711) पर कॉल करें।

Albanian – KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, papagesë. Telefononi në 1-877-533-5020 (TTY: 711).

Tagalog – PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-533-5020 (TTY: 711).

Health Plan Contact Information

Aspirus Health Plan
3000 Westhill Dr., Suite 303
Wausau, WI 54401
Telephone: 1-866-631-8583
Fax: 715-843-1246
1-833-811-4176
Website: p1.aspirushealthplan.com/etf

Common Ground Healthcare Cooperative
Offered in partnership with GHC of Eau Claire
2503 N. Hillcrest Parkway
Altoona, WI 54720
Telephone: 1-833-742-0952
Fax: 715-552-3500
Website: group-health.com/members/state-of-wi-ghcec-cghc

Dean Health Plan
1277 Deming Way
Madison, WI 53717
Telephone: 1-800-279-1301
Fax: 608-827-4212
Dean On Call: 1-800-576-8773
Website: deancare.com/wi-employees

Dean Health Plan - Prevea360
2710 Executive Drive
Green Bay, WI 54304
Telephone: 1-877-230-7555
Fax: 1-608-827-4212
Prevea Care After Hours: 1-888-277-3832
Website: prevea360.com/wi-employees

Group Health Cooperative of Eau Claire (GHC-EC)
P.O. Box 3217
Eau Claire, WI 54702
Telephone: 1-888-203-7770, 715-552-4300
Fax: 715-552-3500
Website: group-health.com

Group Health Cooperative of South Central Wisconsin (GHC-SCW)
1265 John Q. Hammons Drive
P.O. Box 44971
Madison, WI 53717-4971
Telephone: 1-800-605-4327, 608-828-4853
Fax: 608-662-4186
Website: ghcscw.com

HealthPartners Health Plan
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 1-855-542-6922, 952-883-5000
Fax: 952-883-5666
Website: healthpartners.com/stateofwis

Medical Associates Health Plans
1605 Associates Drive, Suite 101
Dubuque, IA 52002
Telephone: 1-866-421-3992
Fax: 563-584-4760
Website: mahealthcare.com

MercyCare Health Plans
580 N. Washington Street
P.O. Box 550
Janesville, WI 53547-0550
Telephone: 1-800-895-2421 option 5
Fax: 608-752-3751
Website: mercycarehealthplans.com

Navitus Health Solutions
P.O. Box 999
Appleton, WI 54912-0999
Telephone: 1-844-268-9789
Website: navitus.com

Navitus MedicareRx (PDP)
(Prescription drug coverage for Medicare-eligible retirees)
P.O. Box 1039
Appleton, WI 54912-1039
Telephone: 1-866-270-3877
Website: medicarerx.navitus.com

Network Health
1570 Midway Place
P.O. Box 120
Menasha, WI 54952
Telephone: 1-844-625-2208, 920-720-1811
Fax: 920-720-1909
Website: networkhealth.com/employer/state

Quartz
2650 Novation Parkway
Fitchburg, WI 53713
Telephone: 1-844-644-3455
Fax: 608-643-2564
Website: ChooseQuartz.com

Robin with HealthPartners
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 1-855-542-6922, 952-883-5000
Fax: 952-883-5666
Website: healthpartners.com/etfrobin

Security Health Plan
1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
Telephone: 1-844-813-7286, 715-221-9555
Fax: 715-221-9500
Website: securityhealth.org/state

UnitedHealthcare
P.O. Box 29675
Hot Springs, AR 71903-9675
Telephone: 1-844-876-6175
Website: UHCRetiree.com/etf

Life Insurance Application/Cancellation/Refusal

Wis. Stat. §40.70

EMPLOYEE: You have an enrollment opportunity for life insurance coverage through the Wisconsin Public Employers Group Life Insurance Program if you meet the qualifications on the reverse side of this page. Please review the reverse side and the brochure *The Wisconsin Public Employers Group Life Insurance Program* (ET-2101) very carefully for more program information.

INSTRUCTIONS FOR COMPLETING LIFE INSURANCE APPLICATION/CANCELLATION/REFUSAL FORM
NOTE : If you choose not to enroll, complete Sections 1, 2 and 4, then return this form to your employer.

Section 1 - Applicant Information

Print all requested information legibly in the space provided. Missing information may delay enrollment processing.

Section 2 - Reason for Application

Indicate the reason for completing the form:

Enrollment: Select this option to enroll if you are newly hired or newly eligible for life insurance. Check the box(es) next to all coverage for which you wish to enroll in Section 3, Coverage Selection.

Decline Coverage: Select this option if you choose not to enroll.

Cancellation: Check the box(es) next to all coverage you wish to cancel in Section 3, Coverage Selection. You may cancel all or part of your life insurance coverage. If Basic coverage is canceled, all other life insurance coverage is automatically canceled. Coverage will end at the end of the month in which your employer receives the cancellation application. If you wish to re-enroll at a later date, you must apply through evidence of insurability, unless you experience a qualifying family status change event.

Note: When you retire and reach age 65, your Basic life insurance will continue at no cost to you. If you are actively working, your Basic life insurance will continue at no cost to you beginning at age 70. Please consult your employer or ETF for more information about this benefit.

Transfer: (Employees of State agencies as designated in Wis. Stat. 40.02 (54) and the UW only) Indicate the agency you are transferring from and the agency you are transferring to, as well as the effective date of transfer. Only coverage that is in force at the time of your transfer will be maintained.

Reinstate Coverage: Use this option to reinstate coverage that lapsed while on an unpaid leave of absence (LOA). Be sure to provide your LOA start and end dates. Only coverage that was in force at the time you began your unpaid leave will be reinstated.

Enrollment or Coverage Increase Due to Family Status Change: Select this option if you are enrolling in Basic coverage or increasing coverage for yourself or if you are adding Spouse & Dependent coverage due to a qualifying family status change. Enrollment must be within 30 days of the qualifying event, and coverage can be increased by one level (1x earnings) of employee coverage or one or two units of Spouse & Dependent coverage. Check the box next to the coverage level that you wish to add in Section 3, Coverage Selection.

Section 3 - Coverage Selection

Select the coverage options that you wish to enroll in or cancel.

Section 4 - Signature

Sign and date the application.
Submit this form to your employer. Your employer will complete Section 5 and provide you with a copy.

EMPLOYER: Please complete the processing of this form by doing the following:

Section 5 - Employer Completes

Please collect this form from all employees when they become eligible for enrollment, **even if they choose not to enroll.**

It is important to provide all the information requested in Section 5. The “Date received from employee” must be completed. Omissions may delay enrollment.

NOTE: If the form is late due to employer error, a letter of explanation **must be** attached to the application or the application will be returned to you.

Employer must forward a copy of the completed form to ETF at P.O. Box 7931, Madison, WI 53707-7931. Keep a copy for yourself; give the employee a copy.

The employee’s coverage amount will be based on the estimated earnings that the employer provides on the application. The employer should provide estimated earnings for a full calendar year period.

Wisconsin Public Employers Group Life Insurance Program

You have an enrollment opportunity for life insurance coverage through the Wisconsin Public Employers Group Life Insurance Program if you:

- Are under age 70;
- Are enrolled in the WRS with your current employer; and
- Apply within 30 days of eligibility.

You have an opportunity to enroll in Basic coverage or to increase employee coverage by one level (1x earnings) or add one or two units of Spouse & Dependent coverage if you apply within 30 days of one of the following family status changes:

- Marriage;
- Birth, adoption, placement for adoption, or award of legal guardianship of a dependent child.

If you do not enroll for all available coverage when you are eligible, you may apply for future coverage through *Evidence of Insurability* (ET -2305).

Plan Summary

The Wisconsin Public Employers (WPE) Group Life Insurance program offers employee coverage of up to five times your annual earnings. All five levels of insurance are available to state employees. The amount of coverage available to local government employees depends on which plans are offered by your employer. The following is a summary of the life insurance coverage that is available.

Coverage Options

The **Basic Plan** provides coverage equal to your earnings for the previous year, rounded up to the next $1,000.

The **Supplemental Plan** provides coverage equal to your earnings for the previous year, rounded up to the next $1,000.

The **Additional Plan** provides up to three units of coverage. Each unit of coverage equals your earnings for the previous year, rounded up to the next $1,000. Depending on how many levels of coverage are offered by your employer, you may choose 1, 2, or 3 units of Additional coverage.

The **Spouse & Dependent Plan** provides coverage for your spouse and all dependent(s). If you elect one unit of coverage, your spouse will have $10,000 in coverage and each dependent (regardless of the number) will have $5,000 in coverage. If you elect two units, your spouse will have $20,000 in coverage and each dependent will have $10,000 in coverage.

Amount of Coverage

The following is an example of how the amount of employee coverage is determined for an employee who chooses Basic, Supplemental and 3 Units of Additional coverage. The employee's previous year earnings are $53,200. The earnings rounded up to the next thousand equals $54,000 of coverage. The employee has coverage as follows:

Basic: (1x earnings) = $54,000

Supplemental: (1x earnings) = $54,000

Additional (3 units): (3x earnings) = $162,000

Total Amount of Insurance Coverage: (5x earnings) = $270,000

Coverage for Active Employees Age 70 and Over

If you are actively employed when you turn age 70, your Basic coverage will reduce to the final post-retirement coverage amount and continue for life with no premiums due. Your Supplemental and Spouse & Dependent coverage will cease on your 70th birthday. Your Additional coverage will continue until you cancel coverage or terminate employment.

Effective Date of Coverage

If you file an application within 30 days after becoming eligible, the effective date will be the first day of the month following 30 days from the date of hire or the first day of the month following 30 days from the date of the qualifying family status change event. For claims purposes, an employee's election date will be the point of reference for providing coverage and paying claims. Election date is the "Date received by employer" (or the date received by ETF if left incomplete) but not earlier than the date of hire or the date of the qualifying family status change event.

Life Insurance Application/Cancellation/Refusal

Wis. Stat. §40.70

1. Applicant Information

Applicant— name (last, first, middle, previous)			ETF Member ID
Social Security number	Date of birth	Telephone number	Gender ☐ Male ☐ Female

2. Reason for Application - (check all that apply)

☐ **Enrollment:** I want to enroll for the life insurance coverage indicated in section 3 and I hereby authorize deductions from my earnings for premium.

☐ **Decline Coverage:** I do not wish to enroll at this time. I understand that if I wish to enroll at a later date I must apply and submit evidence of insurability.

☐ **Cancellation:** I wish to voluntarily cancel the life insurance coverage indicated in section 3. I understand that if I wish to re-enroll at a later date, I must apply and submit evidence of insurability, or enroll due to a qualifying family status change event. Coverage will end at the end of the month in which your employer receives the cancellation application.
Reason_____ Date_____

☐ **Transfer:** (State agency and UW employees only) From (agency)_____ To (agency)_____
Date of transfer_____
I understand that I am entitled to have only the coverage that is in force at the time of the transfer.

☐ **Reinstate Coverage:** I am reapplying for the coverage that lapsed while on an unpaid Leave of Absence (LOA). I understand I am entitled to have only the coverage that was in force at the time my unpaid leave began.
LOA Began_____ (mm/dd/ccyy) LOA Ended_____ (mm/dd/ccyy)

☐ **Enrollment or Coverage Increase Due to Family Status Change:** I want to enroll for the life insurance coverage indicated in section 3 and I hereby authorize deductions from my earnings for premium. Coverage increase is limited to one level of employee coverage (1x earnings). You may elect 1 or 2 units of Spouse & Dependent coverage.

Qualifying event_____

Date of marriage, birth, adoption, placement for adoption, or award of legal guardianship of a dependent child.

_____

3. Coverage Selection

☐ **Basic Coverage (1x earnings)** ☐ **Supplemental Coverage (1x earnings)**

Spouse & Dependent Coverage (check one)
☐ 1 Unit (Spouse = $10,000; Dependent = $5,000)
☐ 2 Units (Spouse = $20,000; Dependent = $10,000)

Additional Coverage (check one)
☐ 1 Unit (1x earnings)
☐ 2 Units (2x earnings)
☐ 3 Units (3x earnings)

4. Signature - (Sign and return to employer)

I understand that Wis. Stat. §943.395 provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the information is true and correct.

Applicant signature	Date signed (mm/dd/ccyy)
X	

5. Employer Completes

ETF Employer number	Name of employer	Employer billing unit number
69-036-		

Employer agent signature	Prepared by	Telephone number
X		
Date WRS employment began with current employer (mm/dd/ccyy)	Date provided to employee (mm/dd/ccyy)	Date received from employee (mm/dd/ccyy)
Coverage effective date (mm/dd/ccyy)	Full calendar year earnings (12 month earnings)	Earnings are ☐ Estimate ☐ Actual

Income Continuation Insurance Application

State Employee
Wis. Stat. § 40.61

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

☐ This form is being submitted due to an employer error.

Refer to the *Income Continuation Insurance Administration Manual — State* (ET-1119) for instructions.

Employee Information Type or print in ink. Sign and return to *employer*. Employer: Complete page 2.

Name (first, middle, last, former/maiden)		
Birth date (MM/DD/YYYY)	Member ID	Social Security number
Address (street)		
City State ZIP code Country and Mail Code (if not USA)		Sex ☐ Male ☐ Female

1. Income Continuation Insurance (ICI) coverage. *Check one:*

☐ I elect ICI coverage and authorize payroll deductions for premiums.

☐ I do not elect ICI coverage. *Sign below.*

☐ I wish to cancel my ICI coverage. Cancellation is effective the first day of the month which occurs on or after the date the application is received. *Sign below.*

2. I was most recently employed by the following state agency: _____

From *(MM/DD/YYYY)* _____ to *(MM/DD/YYYY)* _____

University of Wisconsin faculty/academic staff only, complete this section
(excludes employees of the University of Wisconsin Hospitals and Clinics)

Elect calendar day elimination period for ICI coverage:
☐ 30-day ☐ 90-day ☐ 125-day ☐ 180-day

I want my coverage to be effective: ☐ As soon as possible
☐ When the UW contributes toward premium *(defer coverage for up to 12 months)*

Sign and Return to Employer

I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the above information is true and correct. I authorize the monthly employee share premium deduction (indicated below) from my earnings to provide ICI coverage. I understand that if premiums are not deducted, I do not have ICI coverage.

Employee signature	Date	Telephone, including area code

Submit this completed form to your employer. Your employer will complete the next page and then submit to ETF.

This page is for the employer to complete.
Refer to the *Income Continuation Insurance Administration Manual — State* (ET-1119) for instructions.

Application Information (To be completed by Employer)

Date application provided to employee: _____

Date received from employee: _____

Reason to submit application—check one box and list date event occurred:

- ☐ Began WRS participation with current employer on: _____
- ☐ Reinstating coverage upon return from temporary layoff or leave of absence.
  Date temporary layoff or leave of absence began: _____ Date employee returned: _____
- ☐ Transferred from another state agency on: _____
- ☐ Eligible through deferred coverage on: _____
- ☐ Enrollment through employer error provision
  Note: More information available in chapter 10 of the ICI administration manual (ET-1119).
- ☐ Other (specify): _____

UW Faculty/Academic Staff only (*not* applicable to UWHC Employees):

- ☐ Changed to a longer elimination period effective on: _____
  (Evidence of insurability is required to change to a shorter elimination period.)

UW Faculty/Academic Staff only (*not* applicable to UWHC Employees):

1. Did employee participate under WRS prior to being hired by you? ☐ Yes ☐ No
2. Previous service check, completed? ☐ Yes ☐ No
3. Source of previous service? ☐ ONE Site ☐ ETF

Annual Earnings *(Rounded up to the next higher thousand.)*

$

**Refer to Chapter 3 of the ICI Administration Manual (ET-1119) for instructions on determining annual earnings amount to use.*

Basis of employment

- ☐ Full time
- ☐ Part-time: _____%
- ☐ Seasonal
- ☐ Academic
- ☐ Project
- ☐ LTE

Sick Leave Information for Deferred Coverage or Reinstated or Rehired Employees

Total accumulation of sick leave credits for the preceding two calendar years:

Year	Beginning balance	Sick leave earned	Sick leave used	Ending balance

Employer Information

Employer name	EIN 69-036-	
Employer agent signature	Telephone, including area code	Effective date

Copy and distribute: ☐ ETF ☐ Employee ☐ Employer

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Employee Reimbursement Accounts Enrollment Form

Form instructions: Please complete all entries on this form. Please print, sign and date this form, and submit to your Employer Benefits Specialist or Payroll Benefits Staff.

Personal Information			
First Name	Last Name	Change Effective Date	
Employer Name	Employee ID		
Permanent Address	City	State	Zip Code
Day Time Phone Number	Email Address		
Social Security Number	Date of Birth (Month/Day/Year) / /		
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Enrollment Status ☐ New enrollment ☐ Re-enrollment		

STEP 2: Health Care FSA Elections (Select Limited Purpose FSA coverage, which is limited to dental, vision, and post-deductible medical expenses, if you also elect the HDHP/Health Savings Account (HSA) plan.)

☐ Select Health Care FSA ☐ Decline Health Care FSA

☐ Select Limited Purpose Health Care FSA ☐ Decline Limited Purpose Health Care FSA

I. Annual Employee Contribution (Not to Exceed Contribution Maximums*)	II. Number of regular pay periods:	III. Contribution per pay period (I divided by II)

*The 2025 IRS limit has not been announced yet. State of Wisconsin is electing $3,200 as the limit for 2025. 2024 contributions were $3,050 annually. This limit is per person; a married couple may contribute up to a specified limit.

STEP 3: Dependent Day Account Elections

☐ Select Dependent Day Care Account ☐ Decline Dependent Day Care Account

I. Annual Employee Contribution (Not to Exceed Contribution Maximums**)	II. Number of regular pay periods:	III. Contribution per pay period (I divided by II)

**Couples who are married and file a joint return, as well as single parents, can contribute up to $5,000 in a Dependent Care FSA. Couples who are married and file separately can put a maximum of $2,500 each into a Dependent Care FSA.

STEP 4: Commuter Elections

Transit Account ☐ Select Transit Account ☐ Decline Transit Account

I. Annual Employee Contribution***	II. Contribution per month(I divided by 12)

Parking Account ☐ Select Parking Account ☐ Decline Parking Account

I. Annual Employee Contribution***	II. Contribution per month(I divided by 12)

***For 2025, commuter contributions are $315 per month for transit expenses, and $315 per month for parking expenses. 2024 contributions were $300 per month for parking and $300 per month for transit.
Note: UW Hospital & Clinics employees are not eligible to elect the above Commuter Fringe Benefits.

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STEP 5: Authorization and Certification

Health Care FSA and Dependent Day Care Account

I understand that:

- I am authorizing my employer to reduce my compensation by the amount specified. This election will expire at the end of the plan year, and I must make a new election each year.
- I am not permitted to change my elections during the plan year unless the change is due to and in accordance with certain recognized IRS regulations for change in status events.
- I must report any administrative errors to my payroll administrator or human resources department within 10 days of my first payroll deduction of the plan year.
- Funds left in my Dependent Day Care Account at the close of the plan year will be forfeited. Funds left in my Health Flexible Spending Account may be forfeited, per plan rules. See plan documents for more details.
- I will receive an Optum Financial payment card to access Health Care FSA funds in my account. I certify that:
  - The card will only be used for eligible medical and/or dependent care expenses.
  - Claims I pay with the card have not been reimbursed and I will not seek reimbursement from any other plan covering health or dependent care benefits.

Commuter Account

I understand that:

- I am authorizing my employer to reduce my compensation by the amount specified.
- My monthly election is recurring for entirety of the plan year unless the I make an election change.
- I may change my election any month of the plan year, as long as my request is received before the last pay period of the month prior to the new benefit month.
- I must report any administrative errors to my payroll administrator or human resources department within 10 days of my first payroll deduction of the plan year.

Account Holder Signature	Date:

Please also sign and date the signature section on page 5 of this document.

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Enrollment terms and conditions

I elect to participate in Employee Reimbursement Accounts and agree to be bound by the terms of the Plan.

I understand that:

- The Employee Reimbursement Accounts Program (ERA) is an optional benefit established for eligible state employees sponsored by the State of Wisconsin and administered by the Department of Employee Trust Funds (Plan Administrator). The ERA is also referred to as Flexible Spending Accounts or FSAs. The ERA has five pre-tax benefit program options: Health Care FSA, Limited Purpose FSA (LPFSA), Dependent Day Care Account, Transit Account, and Parking Account. The ERA is authorized under Internal Revenue Service (IRS) Code Sections §125, §105, §129, and §132 and Wisconsin Statutes §40.85-§40.875.
- The Plan Administrator reserves the right to amend at any time, any or all of the provisions of the Plan. The Plan Administrator reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Such decision to terminate the Plan shall be approved by the Group Insurance Board (Board) in accordance with its normal procedures for transacting business. Upon Board approval, affiliated employers may withdraw from participation in the Plan.
- A new enrollment must be completed each plan year. If I do not complete enrollment during open enrollment, I forfeit the opportunity to participate in the Health Care FSA, LPFSA, or Dependent Day Care Account benefit options.
- Contribution(s) are deducted on a pre-tax basis. If I do not wish to have my ERA contributions deducted pre-tax and prefer to be taxed on these dollars, I am to contact my human resource or benefit office.
- Pre-tax contribution deductions reduce my compensation for Social Security benefit purposes.
- According to Wisconsin Statutes §40.87, participation in an ERA will not reduce my wages for calculating state retirement benefits. Also, my contributions in an ERA will not reduce my gross income for the purpose of calculating any other state benefits such as sick leave conversion credits, income continuation insurance, life insurance, deferred compensation, unemployment, or worker's compensation.
- Contributions made into one account cannot be transferred and used for expenses in any other account.
- Participating in an ERA is completely voluntary, and payments from my ERA are independently reviewed for compliance with IRS regulations.
- The IRS requires me to reimburse the Plan for any improper, erroneous, or excess reimbursement amount that I do not resolve within the time frame provided by the Plan. In accordance with Wisconsin Statute §40.08(4), by enrolling in an ERA, I specifically authorize the Plan Administrator, Department of Employee Trust Funds and/or my employer to withhold from my wages on a post-tax basis such amounts as are necessary to replenish my ERA for any improper, erroneous or excess reimbursement.
- If my employment terminates, only expenses incurred through my period of coverage as defined by the Plan can be considered for reimbursement.
- Health Care FSA, LPFSA, and Dependent Day Care Account elections can only be changed or revoked during the plan year if I experience a qualified life change event or am no longer eligible to participate, as defined by the Plan. The new election must be consistent with my change in status, must be applied for within 30 days of the qualified life change event, and is subject to final approval by the Plan Administrator. I cannot lower my election to an amount that is less than what I have already been reimbursed from my account. Whether I increase or decrease my election, my new election will be spread out evenly over my remaining pay periods.

- Parking Account and Transit Account elections can be changed or revoked prior to the first day of the next monthly coverage period. Elections can only be changed for future months. Upon termination or cessation of eligibility, my elections will be immediately revoked.
- If I am enrolled in a Health Care FSA or an LPFSA, my eligible expenses must qualify as a health care deduction under IRS Publication 502 and 969.
- If I am enrolled in a Dependent Day Care Account, my eligible expenses must qualify as a dependent care deduction under IRS Publication 503. The expenses are for a qualified dependent (child under age 13, spouse, or adult dependent unable to care for themselves), for care by a qualified dependent care provider such as a day care center or by an individual including a non-dependent family member over age 19, inside or outside the home.
- The maximum election under a Dependent Day Care Account for married individuals filing a joint return is $5,000 per calendar year. Married individuals filing separately will get a lower election ($2,500 per calendar year). IRS Form 2441 must be filed with my personal income tax return.
- If I am enrolled in a Parking Account or Transit Account, my eligible expenses must qualify as a commuter benefit deduction under IRS Publication 5137.
- At the close of the plan year, any amounts remaining in the Health Care FSA or LPFSA in excess of $640, and any amounts remaining in a Dependent Day Care Account, will be forfeited in accordance with current Plan provisions and tax laws.
- Under IRS and Treasury regulations, payments from the ERA require third-party substantiation unless the transaction is auto-substantiated or substantiated by other appropriate means approved by the Plan. I am obliged to satisfy any documentation requirements and to retain those documents for tax purposes or in the event of an IRS audit. When I am unable to substantiate my claims with a Payment Card transaction, I am to substantiate those claims manually with supporting documentation, if applicable. When I make a mid-year ERA contribution election or enrollment change, I am re-certifying to the terms and conditions.
- In circumstances where my Payment Card is lost/stolen or I become aware of fraudulent charges, I am to notify Optum Financial immediately. Optum Financial will deactivate the Payment Card and reissue a new Payment Card.
- If I am found to have used my ERA or Payment Card fraudulently, my participation in the ERA may be terminated and I may lose the ability to participate in the ERA in the future.
- If I use the City of Madison Transportation Office (located at the City of Madison Parking Utility, 215 Martin Luther King Jr. Blvd,Madison, WI 53703), I may be asked by Optum Financial to provide information, as Optum Financial may require from time to time to permit auto-substantiation. I will retain all documentation for commuter expenses as this location for this purpose.
- Any ERA claims paid out in error and/or do not have proper documentation to validate the expense can be subject to employer payroll withholding during the runout period, request for repayment, or a business debt collection with the Plan Administrator.
- If I enroll in an FSA or commuter benefit account, I am required to have a minimum annual election amount of $50 per year. To automatically receive the balance carryover for FSAs, Parking Account, and Transit Account, you must have a balance of $50+ in your account on December 31, 2024 (or by the end of the run-out period), and no enrollment is required for 2025. Any balance less than $50 by the end of the run-out period requires a new election for the funds to be carried over. If there is not a new election made for remaining funds less than $50, the funds will be subject to forfeiture.

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I certify that:

- The information that I provided is complete and accurate to the best of my knowledge.
- I agree to have my compensation reduced by the contribution amount(s) I elected on a pre-tax basis. If I do not wish to have my ERA contributions deducted pre-tax and prefer to be taxed on these dollars, I will contact my human resource or benefit office.
- I have reviewed and understand the benefits program eligibility and enrollment information and I agree to abide by all participation requirements.
- All dependents I list in my ERA will meet the eligibility requirements of the program.
- I will not claim a federal income tax deduction or credit for any expenses that were reimbursed through my ERA.
- My use of the Payment Card will comply with the terms and conditions of the Cardholder Agreement received with the Payment Card.
- All expenses charged on the Payment Card will qualify as reimbursable per IRS rules, will be incurred only for me or my eligible dependents, and will not be reimbursed and not reimbursable through any other means, including my or my dependent's insurance plans.
- I will keep all receipts and other documentation related to expenses charged on the Payment Card for account management and tax purposes. Upon request, within eighty-five (85) days, I will fax, mail, or upload the required documentation of expenses to the Third-Party Administrator.
- I understand additional Payment Cards issued to my spouse or dependent(s) will provide the named individual with access to my ERA. I accept responsibility for all Payment Card transactions incurred by the named individual and will submit documentation, as requested, for those transactions.
- I acknowledge and agree that use of the Payment Card in violation of this enrollment agreement or the Cardholder Agreement may result in the invalidation and forfeiture of the Payment Card. If the Third-Party Administrator determines that an expense charged on the Payment Card was not a qualified expense under the Plan or according to IRS rules, I shall immediately reimburse the Plan for the entire amount of the unqualified expense. If I fail to reimburse the Plan in a timely manner, I understand the amounts may be withheld post-tax from my wages or from an otherwise valid expense in order to reimburse the unqualified expense.
- If I use the City of Madison Transportation Office (located at the City of Madison Parking Utility, 215 Martin Luther King Jr. Blvd, Madison, WI 53703), I will only use the Payment Card for commuter expenses under Section 132 of the Internal Revenue Code. If requested, I will provide Optum Financial with appropriate documentation at the time and point of sale supporting that the auto-substantiated claims were for Section 132 eligible expenses and sufficient to permit auto substantiation of such expenses under all IRS requirements relating to real-time substantiation.

Signature _____ **Date** _____

Return this form to your Employer Benefits Specialist or Payroll Benefits Staff.

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Health Savings Account (HSA) Enrollment Form

Form Instructions: Please complete all entries on this form. Please print, sign and date this form, and submit to your Employer Benefits Specialist or Payroll Benefits Staff.

STEP 1: HSA Enrollee Personal Information Section 326 of the USA PATRIOT Act requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account through the Customer Identification Program (CIP).			
Employee Name	Last Name		
Employer Name	Employee ID		
Permanent Address*	City	State	Zip Code
Day Time Phone Number	Email Address		
Social Security Number	Date of Birth (Month/Day/Year)		
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Enrollment Status ☐ New enrollment ☐ Re-enrollment	Health Plan Coverage ☐ Single ☐ Family	
*Must be a valid U.S. street address. P.O. Box may not be used.			

STEP 2: HSA Qualifications

Your HSA is your financial asset even if you change employers or health plans. You must meet the requirements under Internal Revenue Code Section 223 to be eligible to open and contribute to an HSA. This means that:

1. You must be covered by a qualified high-deductible plan.
2. You cannot be covered by another health plan, including Medicare or Flexible Spending Account. (You may be covered by a Limited Use Flexible Spending Account or Limited Use Health Reimbursement Arrangement.)
3. You cannot be claimed as a dependent on another individual's tax return.

Consult IRS Publication 969 for more information about HSA eligibility requirements.

STEP 3: HSA Elections		
☐ Select HSA ☐ Decline HSA	Annual Employer Contribution	
I. Annual Employee Contribution (Not to Exceed Contribution Maximums**)	II. Number of regular pay periods	III. Contribution per pay period (I divided by II)

**The total combined amount of both employer and employee contributions cannot exceed IRS maximum contribution limits. For 2025, that limit is $8,550 for employees with family HDHP coverage, $4,300 for self-only coverage, and $1,000 additional catch-up contribution allowed for employees aged 55 or older. 2024 contributions were $8,300 for family and $4,150 for self-only. Please note that your employer contributes $828 for an individual HSA plan and $1,650 for a family HSA plan toward the contribution limit. This is only applicable if you are receiving the employer share of the health premiums. IRS regulations are indexed annually for inflation. If you want to contribute the total annual amount for a tax year in which you were only HSA eligible for a portion of that year, you must remain HSA eligible through the end of the next tax year or face tax penalties.

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STEP 4: Account Holder Authorization	
The HSA Enrollee named above hereby certifies that the information set forth in this HSA Enrollment Form is correct, and that the HSA Enrollee is applying to open a Health Savings Account at Optum Financial. Once the HSA is opened, Optum Financial will serve as the custodian of your HSA, which consists of all the funds in your HSA deposit account, as well as any other investments you make with your HSA funds. HSA Enrollee acknowledges receipt of the Custodial Agreement and agrees to be bound by the terms and conditions as set forth in the Custodial Agreement. HSA Enrollee will be sent a debit card that will access this HSA, once the HSA has been opened. The debit card will be governed by the Cardholder Agreement that will be sent with the card. The HSA Enrollee understands that they must return this Enrollment Form to their employer, or the employer's designated benefit administrator, and authorizes and directs Optum Financial and its affiliates to provide any information about your HSA, including your account number, or any other non-public personal information to your employer, or your employer's designated benefit administrator, in connection with the establishment and maintenance of your HSA. HSA Enrollee acknowledges that he or she has not relied on Optum Financial or its affiliates for personal tax or insurance advice and that Optum Financial and its affiliates are not responsible for determining whether HSA enrollee is qualified to open or contribute to an HSA in accordance with Section 223(c) of the Internal Revenue Code.	
Account Holder Signature	Date

Enrollment terms and conditions

I elect to participate in the Health Savings Program and agree to be bound by the terms of the Plan.

I understand that:

- The Health Savings Account (HSA) program is a benefit established for eligible state employees enrolled in one of the It's Your Choice (IYC) High Deductible Health Plans (HDHP). The HSA program is authorized under Internal Revenue Service (IRS) Code Sections §125, §105, and §223 and Wisconsin Statutes §40.515.
- A new enrollment must be completed each plan year. If I do not complete enrollment during open enrollment, I forfeit the opportunity to participate in the HSA benefit option.

  The annual HSA contribution amount I elect will be deducted from my paycheck a on pre-tax basis. If I do not wish to have my HSA contributions deducted pre-tax and prefer to be taxed on these dollars, I will contact my human resource or benefit office.

  Pre-tax HSA contribution deductions reduce my compensation for Social Security benefit purposes.

  According to Wisconsin Statutes §40.87, participation in an HSA will not reduce my wages for calculating state retirement benefits. Also, my contributions in an HSA will not reduce my gross income for the purpose of calculating any other state benefits such as sick leave conversion credits, income continuation insurance, life insurance, deferred compensation, unemployment, or worker's compensation.
- Contributions made into one account cannot be transferred and used for expenses in any other account.

  Contributing to an HSA is completely voluntary, and I am solely responsible for determining whether any distribution from my HSA is in compliance with IRS regulations.

  Generally, contributions to an HSA are made on a month-to-month rule basis depending on what coverage I am enrolled in under the IYC HDHP on the first day of the month.

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- There is a limited exception to the month-to-month rule described above. This exception allows me to make the maximum annual contribution for the plan year based on my enrollment in the IYC HDHP and HSA on December 1st. Assume I change from individual to family coverage during the second half of the year, I am limited to a maximum contribution under the month-to-month rule. Since I was enrolled in family coverage on December 1st, I can use the limited exception and can contribute the full family HSA contribution amount.
- IMPORTANT NOTE: In order to use this limited exception, I have to stay enrolled in the IYC HDHP and HSA at the same or higher level of coverage for the entire next plan year, called the 'testing period'. If I do not maintain this coverage, for instance I terminate employment or switch to a non-HDHP the next plan year, then the excess funds contributed will be subject to a 6% excise tax.
- Eligible expenses must qualify as a health care deduction under the IRS.
- When I make a mid-year HSA contribution election or enrollment change, I am re-certifying to the terms and conditions.
- In circumstances where my Payment Card is lost/stolen or I become aware of fraudulent charges, I will notify Optum Financial immediately. Optum Financial will deactivate the Payment Card and reissue a new Payment Card.
- If I am found to have used my HSA or Payment Card fraudulently, my participation in the state sponsored HSA may be terminated and I may lose the ability to participate in the state-sponsored HSA benefit program in the future.

I certify that:

- The information I have provided is complete and accurate to the best of my knowledge.
- If the Bank Custodian is unable to verify my identity, the Bank Custodian may contact me for additional information, such as a copy of the driver's license, W-2, Social Security Card, or other identifying documents. If I fail to pass Customer Identification Program (CIP) within 90 days of the request, my HDHP will be reverted back to a non-HDHP and the HSA will be canceled.
- I am covered by one of the qualified IYC HDHP, and that I am not covered by any non-permitted coverage.
- I have available to me a copy of the application and Custodial Agreement and Disclosure Statement and amendments thereto.
- I release and agree to hold the HSA custodian harmless against any and all claims or losses arising from my actions.
- I agree to have my compensation reduced by the contribution amount(s) I elected on a pre-tax basis. If I do not wish to have my HSA contributions deducted pre-tax and prefer to be taxed on these dollars, I will contact my human resource or benefit office.
- I have reviewed and understand the benefits program eligibility and enrollment information and I agree to abide by all participation requirements.
- All dependents listed meet the eligibility requirements of the program.
- I shall not claim a federal income tax deduction or credit for any expenses that were reimbursed through my HSA.

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- I will inform my human resources benefit office as soon as reasonably possible when I am no longer eligible to contribute to the HSA, for instance if I obtain other non-permitted coverage such as coverage under my spouse's plan or Medicare, and I understand any contributions made for any month in which I am not an eligible individual will be subject to an excise tax, and that my employer will deduct any contributions it made for such an ineligible month from my HSA.
- Use of the Payment Card will comply with the terms and conditions of the Cardholder Agreement received with the Payment Card.
- That all expenses charged on the Payment Card will qualify as reimbursable per IRS rules, will be incurred only for me or my eligible dependents, and will not be reimbursed through any other means, including my or my dependent's insurance plans.
- I will keep all receipts and other documentation related to expenses charged on the Payment Card for account management and tax purposes.
- I understand additional Payment Cards issued to my spouse or dependent(s) will provide the named individual with access to my HSA. I accept responsibility for all card transactions incurred by the named individual and will submit documentation, as requested, for those transactions.
- I acknowledge and agree that use of the Payment Card in violation of this enrollment agreement or the Cardholder Agreement may result in the invalidation and forfeiture of the Payment Card.

_____ _____

Account Holder Signature Date

Return this form to your Employer Benefits Specialist or Payroll Benefits Staff.

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Health Savings Account (HSA)

Custodial Agreement and Notices

Custodial Agreement, Terms and Conditions, Fee Schedule, and Privacy Policy are subject to change. Current documents may be accessed through your online account or by calling 1-833-881-8158.

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Health Savings Account Custodial Agreement

The named account owner ("Participant") is establishing this Health Savings Account ("HSA") in accordance with the Internal Revenue Code of 1986 ("IRC") and the regulations promulgated thereunder with ConnectYourCare, LLC ("Custodian"), a subsidiary of Optum Financial, Inc. for the purpose of paying or reimbursing qualified medical expenses of the Participant, his or her spouse, and/or dependents.

ConnectYourCare, LLC is an Internal Revenue Service authorized, passive non-bank trustee ("NBT") serving as the custodian of HSAs. The letter authorizing ConnectYourCare, LLC to act as an NBT may be found at my.optum.com/etf.

This Custodial Agreement ("Agreement") sets forth the terms and conditions that govern your HSA with ConnectYourCare, LLC, and its affiliates. Throughout this Agreement, the words "Custodian", "we", "us", or "our" means ConnectYourCare, LLC, and its successors and assigns and "you", "your", or "yours" means the Participant, and any spouse or non-spouse beneficiary, or any third party authorized or appointed by you to access and use the HSA ("Authorized Users").

The Participant represents that, unless this account is used solely to make rollover contributions, the Participant is eligible to contribute to this HSA in accordance with Section 223(c) of the IRC; specifically, that he or she: (1) is covered under a high-deductible health plan ("HDHP"); (2) is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and permitted coverage); (3) is not enrolled in Medicare; and (4) cannot be claimed as a dependent on another person's tax return.

Nothing in this Agreement is intended to serve as legal, tax, financial or investment advice. Please consult your own tax advisor or attorney with respect to your specific situation.

The Participant and the Custodian make the following agreement:

Article I

1.01

The Custodian will accept additional cash contributions for the tax year made by the Participant or on behalf of the Participant (by an employer, family member, or any other person). No contributions will be accepted by the Custodian for any Participant that exceeds the maximum amount for family coverage plus the catch-up contribution.

1.02

Contributions for any tax year may be made at any time before the deadline for filing the Participant's federal income tax return for that year (without extensions).

1.03

Rollover contributions from an HSA or an Archer Medical Savings Account ("Archer MSA") (unless prohibited under this Agreement) need not be in cash and are not subject to the maximum annual contribution limit set forth in Article II.

1.04

Qualified HSA distributions from a health flexible spending arrangement or health reimbursement arrangement must be completed in a trustee-to-trustee transfer and are not subject to the maximum annual contribution limit set forth in Article II.

1.05

Qualified HSA funding distributions from an individual retirement account must be completed in a trustee-to-trustee transfer and are subject to the maximum annual contribution limit set forth in Article II.

Article II

2.01

To view the current HSA annual contribution limits, please visit the IRS at irs.gov.

2.02

Contributions to Archer MSAs or other HSAs count toward the maximum annual contribution limit to this HSA.

2.03

An additional $1,000.00 catch-up contribution may be made for a Participant who is at least age 55 or older and not enrolled in Medicare.

2.04

Contributions in excess of the maximum annual contribution limit are subject to an excise tax. However, the catch-up contributions are not subject to an excise tax.

Article III

It is the responsibility of the Participant to determine whether contributions to this HSA have exceeded the maximum annual contribution limit described in Article II. If contributions to this HSA exceed the maximum annual contribution limit, the Participant shall notify the Custodian that there exist excess contributions to the HSA. It is the responsibility of the Participant to request the withdrawal of the excess contribution and any net income attributable to such excess contribution. The Participant is responsible to pay any applicable taxes resulting from the excess contribution.

Article IV

The Participant's interest in the balance in this HSA is nonforfeitable.

Article V

5.01

No part of the custodial funds in this HSA may be invested in life insurance contracts or in collectibles as defined in Section 408(m) of the IRC.

5.02

The assets of this HSA may not be commingled with other property except in a common trust fund or common investment fund.

5.03

Neither the Participant nor the Custodian will engage in any prohibited transaction with respect to this HSA (such as borrowing or pledging the account or engaging in any other "prohibited transaction" as defined in Section 4975 of the IRC).

Article VI

6.01

Distributions of funds from this HSA may be made upon the direction of the Participant.

6.02

Distributions from this HSA that are used exclusively to pay or reimburse "Qualified Medical Expenses," as defined in Section 213(d) of the IRC, of the Participant, his or her spouse, or dependents are tax-free.

However, distributions that are not used for Qualified Medical Expenses are included in the Participant's gross income and are subject to an additional 20% tax on that amount. The additional 20% tax does not apply if the distribution is made after the Participant's death, disability, or reaching age 65. The Participant is solely responsible for determining whether the distribution from the HSA is for payment of or reimbursement of a Qualified Medical Expense.

6.03

The Custodian is not required to determine whether the distribution is for the payment or reimbursement of Qualified Medical Expenses. Only the Participant is responsible for substantiating that the distribution is for Qualified Medical Expenses and must maintain records sufficient to show, if required, that the distribution is tax-free.

Article VII

If the Participant dies before the entire interest in the HSA is distributed, the entire account will be disposed of as follows:

(1) If the beneficiary is the Participant's spouse, the HSA will become the spouse's HSA as of the date of death.

(2) If the beneficiary is not the Participant's spouse, the HSA will cease to be an HSA as of the date of death. If the beneficiary is the Participant's estate, the fair market value of the HSA as of the date of death is taxable on the Participant's final return. For other beneficiaries, the fair market value of the account is taxable to that person in the tax year that includes such date.

Article VIII

8.01

The Participant agrees to provide the Custodian with information necessary for the Custodian to prepare any report or return required by the Internal Revenue Service IRS.

8.02

The Custodian agrees to prepare and submit any report or return as prescribed by the IRS.

Article IX

Notwithstanding any other article that may be added or incorporated in this Agreement, the provisions of Articles I through VIII and this sentence are controlling. Any additional article in this Agreement that is inconsistent with Section 223 of the IRC or IRS published guidance will be void.

Article X

This Agreement will be amended from time to time to comply with the provisions of the IRC or IRS published guidance. Other amendments to this Agreement may be made by the Custodian upon notice to the Participant in accordance with Section 11.12 of this Agreement.

Article XI

11.01

Account Establishment and Account Verification

(a) If you instruct us to open an HSA, or we are instructed to open an HSA on your behalf as part of a health benefit plan or other program in which you have enrolled or participate, any use of the HSA, including, but not limited to, activating any associated payment card(s), registering on our website to obtain online access to your HSA, making or receiving contributions, or otherwise using the HSA, is ratification of your desire to establish an HSA, and consent to be bound by the terms and conditions of this Agreement, our Notice of Privacy Practices, the HSA Fee and Interest Schedule, the HSA Cardholder Agreement, if applicable, and other disclosures and notices, as applicable (collectively the "HSA Documentation"), which may be provided to you from time to time and made available at my.optum.com/etf.

(b) If applicable, you authorize and direct us to provide any information about your HSA, including your account number, account balance, or any other non-public personal information to your HSA Plan Provider (as defined in Subsection (d) below) and those acting on behalf of your HSA Plan Provider in connection with the establishment and maintenance of your HSA. You also authorize and direct that the HSA Plan Provider and those acting on behalf of the HSA Plan Provider to take any actions with regard to your HSA as deemed necessary and appropriate, including, but not limited to, making contributions and correcting errors in accordance with applicable laws. The Custodian has policies and procedures in place, in accordance with applicable laws, regulations and standards, to maintain the confidentiality and privacy of your personal information. The Custodian collects, processes, discloses and safeguards your information in accordance with the Custodian's Notice of Privacy Practices provided to you in your account welcome kit and available online at my.optum.com/etf/ privacy-policy. You acknowledge and agree that we may need to disclose information about your HSA as required by law, when necessary to complete transfers or provide a service to you, or as otherwise permitted in this Agreement, the Custodian's Notice of Privacy Practices, and the HSA Cardholder Agreement.

(c) The HSA is self-administered by the Participant. You acknowledge and agree that we are the custodian of your HSA and nothing in this Agreement shall be construed to confer fiduciary status upon us for any purpose. For avoidance of doubt, Custodian acts in accordance with the terms of this Agreement and Participant's instructions, and does not exercise discretionary authority or control with respect to funds held in the HSA.

(d) To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you open an HSA, we will ask for your name, date of birth, taxpayer identification number, and physical United States address. We may also ask for a copy of your government-issued identification, such as a driver's license, or any other identifying documents. If a third party, including, but not limited to, your employer or health insurance carrier (collectively, the "HSA Plan Provider") is facilitating your enrollment, you authorize your employer or HSA Plan Provider to provide us with a copy of your identifying information, including, but not limited to your IRS Form I-9 Eligibility. Your account may not be opened until your identity has been verified. If your account is unable to be opened, any funds sent to the Custodian will be sent back to the funding source.

11.02

Account Administration

(a) Aggregate Account

Funds contained in your HSA are maintained in an aggregate account established for the benefit of Participants at one or more Federal Deposit Insurance Corporation (FDIC) insured financial institutions of our choosing (an "Aggregate Account"). Contact us to determine the financial institution(s) holding your funds.

(b) Interest Calculation

We will credit interest on the balance in your HSA above the required minimum balance for interest, if any, that applies to your HSA as set forth on the applicable HSA Fee and Interest Schedule. Interest begins to accrue no later than the business day that the funds are contributed to your HSA. Interest will be compounded on a monthly basis. Interest will be credited to your HSA as of the last day of the month. If your HSA is closed before interest is credited, you will not receive the accrued interest for that month. We use the daily balance method to calculate interest on your HSA. This method applies a daily periodic rate to the principal in the HSA each day. The interest rate and Annual Percentage Yield (APY) applicable to the balance in your HSA on any given day will depend on which of the specific balance ranges your daily account balance falls within on that day. We may, in our discretion, change interest rates and APYs at any time. For current interest rates, please visit my.optum.com/etf and sign in to your participant portal.

(c) Account Statements and Objections

We will provide you a statement of your HSA at least quarterly. Your account statement can be accessed and retrieved from the Custodian's website or other internet portal. You may choose to have your HSA statement, as well as certain other notices, mailed at an additional cost, as provided for on the written HSA Fee and Interest Schedule.

The Participant shall examine his or her account statement promptly and carefully. If you believe any statement contains an error or includes an unauthorized transaction, please notify us immediately. Written objections should be sent to ConnectYourCare, LLC, Attn: Legal, PO Box 85960, 6300 Wayne Road, Westland, MI 48185. Verbal objections may be made by calling us at 1-877-292-4040. If, within 60 days after receipt of the account statement, you have not given us written notice of any exception or objection thereto, the HSA statement shall be deemed to have been approved by you and will preclude you from making future objections, claims, or exceptions regarding the account statement.

(d) Unclaimed Property

Your HSA may become dormant if you do not initiate an account-related activity for a certain period of time as defined by state law. An account-related activity is determined by the laws governing your account. Examples of account-related activity may include contributions or distributions from your HSA, such as automatic transactions, including recurring and one-time transactions, and pre-authorized transfers/ payments and electronic contributions, including payroll direct deposits. We put safeguards in place to protect a dormant account. We may restrict distributions from your HSA if your account has been inactive or dormant for a certain period of time.

Monthly service and other fees may continue to apply, except where prohibited by law.

If you do not initiate an account-related activity on your HSA within the time period specified by state law, your HSA may be closed and the funds transferred to the appropriate state authority. To recover your HSA funds, you must file a claim with the state.

(e) Deposit Insurance

You, the Participant, "own" balances held in your HSA, and such balances are eligible for insurance coverage by the FDIC up to the standard maximum amount as determined under FDIC rules (together with any other deposits owned by Participant at the FDIC insured financial institution, including savings and checking accounts, money market deposit accounts, and CDs issued directly to Participant by the FDIC insured financial institution, and deposits from similar cash placement programs offered by other custodians, brokerages or other entities). Additional information regarding FDIC insurance coverage is available at fdic.gov or by calling the FDIC at 1-877-ASK-FDIC (1-877-275- 3342).

We are not responsible for monitoring the balance in your HSA, or any other deposits at a financial institution holding an Aggregate Account, to determine the FDIC insurance coverage. If you expect to have aggregate deposits that exceed FDIC insurance coverage limits at a financial institution that may hold an Aggregate Account, you may contact Custodian to request that the balance in your HSA is reassigned to another financial institution holding an Aggregate Account. Contributions to the HSA are eligible for FDIC insurance coverage only after they

become available to the Participant in the HSA or otherwise in accordance with applicable law.

Subject to the terms and conditions applicable to HSA Investments, as defined herein, securities and insurance product purchases directed by Participant and held as HSA Investments are not FDIC insured and are subject to risk of loss, including loss of principal.

11.03

Fees and Compensation

(a) Service Fees

We may charge administrative, maintenance, service and other designated fees as set forth in our HSA Fee and Interest Schedule. You are responsible for payment of the fees set forth in our HSA Fee and Interest Schedule. In some instances, the fees, or a portion thereof, may be paid by your employer, the HSA Plan Provider, or other third party. To the extent that the fees are not paid by a third party, or if a third party discontinues paying the fees, we will deduct the fees from your HSA.

We reserve the right to charge any additional fees or change any fees upon 30-days' notice to you. We may deduct all fees from the HSA, or at our discretion, charge you separately for such fees. If there are not enough funds in your HSA to cover the amounts you owe us, we may overdraw your HSA without being liable to you.

(b) Custodian's Compensation/Revenue

In addition to revenue earned from administrative, maintenance, and service fees, we may receive compensation equal to the difference between the interest received by us in connection with the Aggregate Accounts and the amount of interest we pay to you on your HSA, otherwise referred to as "spread". The spread may change depending on prevailing interest rates. We may, in our discretion, change your interest rate or APY at any time.

We may also earn revenue from interchange fees arising from the use of the payment card that may be issued for your HSA. Interchange fees are paid by the merchants and not you.

We perform certain clerical and ministerial services with respect to HSA Investments, as defined in Section 11.06, and we may receive a fee for those services from the Registered Investment Advisor, or any other service provider related to the HSA Investment program.

11.04

Account Contributions

(a) There is no minimum contribution required to open an HSA. You may make an unlimited number of contributions to your HSA, however, the terms of the Agreement and the IRC may limit the total dollar amount that may be contributed to your HSA in a calendar year. We may refuse to accept contributions to your HSA that we believe would cause your HSA to exceed the maximum annual contribution amount for account holders having family coverage plus the catch-up contribution as established by the IRS.

We are not responsible for determining whether contributions to your HSA exceed the maximum annual contribution limit.

(b) Contributions may be made by check, direct deposit, automated clearing house ("ACH"), wire transfers, or any other means we make available to you. All contributions must be made in United States Dollars.

(c) If you have arranged with your employer or any other third party to have payments directly deposited into your HSA, and your HSA is closed or otherwise unavailable to receive any contribution, we may elect, in our discretion, to return the contribution to the source.

(d) If a claim is made with respect to any item after final credit has been given to your HSA for the item on the grounds that it was altered, forged, had an unauthorized signature or endorsement, or was otherwise not properly payable, the amount of that item may be withheld from your HSA until the claim is resolved finally. If we are subject to any loss or damage as a result of relying on your representations or instructions related to the item, you will be held responsible for the costs and fees.

(e) We are not responsible for losses which happen during collection of a check or other item that are not caused by circumstances under our direct control.

(f) We are not responsible for monitoring your employer's contributions to your HSA. You are responsible for monitoring your employer's contributions to your HSA and notifying the employer of any changes, errors, or discrepancies regarding the employer's contributions to your HSA.

(g) Contributions for any given tax year may be made at any time before the deadline for filing your federal income tax return for that calendar year, without extensions.

(h) Contributions into your HSA will become available to you in accordance with our Funds Availability policy as set forth in Section 11.14 of this Agreement.

(i) If an item you contribute is returned for any reason, we may elect, in our sole discretion, to deduct the amount of the returned item from your HSA, return the item to you, and charge a fee, as applicable; or to redeposit the item and charge a fee, as applicable. If we elect to redeposit the item, you acknowledge that we have not waived or forfeited our right to deduct the amount of the item from your HSA if the item is subsequently returned.

11.05

Account Distributions

(a) Distribution of funds from your HSA may be made upon your direction. Only you or any other Authorized User may initiate a distribution from your HSA. You may request a distribution from the HSA through the online participant portal, at my.optum.com/etf, by completing the Custodian's HSA distribution request form, or by other means acceptable to us.

(b) You are solely responsible for determining whether the distribution from the HSA is for payment of or reimbursement of a Qualified Medical Expense. You are solely responsible for substantiating that the distribution is for a Qualified Medical Expense and for maintaining records sufficient to show, if applicable, that the distribution is for a Qualified Medical Expense. You are solely responsible for determining the federal or state tax consequences of a distribution from your HSA. Please consult a tax advisor regarding the tax treatment of any distribution from your HSA.

(c) We will report your HSA distributions to the IRS on an annual basis, as prescribed by the IRS.

(d) Upon your death, we may liquidate your HSA Investments and, if applicable, distribute any proceeds, along with the funds in your HSA, to your designated beneficiary(ies). If no beneficiary is designated, the distribution will be made to your estate.

(e) We may make a distribution from your HSA without your authorization if directed to do so pursuant to a court order, garnishment, or levy. We shall not incur any liability in making such a distribution in accordance with a court order, garnishment, or levy.

(f) If your HSA becomes overdrawn for any reason, you agree to immediately repay the amount of any overdraft. If we pay distributions by overdrawing your HSA, we are not obligated to continue paying overdrafts. We may charge overdraft fees. See the HSA Fee and Interest Schedule for more information.

(g) We reserve the right to process distributions, withdrawals, transfers or other related requests received by you on the same day in any order we determine appropriate.

(h) ACH credits and debits received to your HSA are subject to the rules of the National Automated Clearing House Association (NACHA) and any other applicable ACH rules. You agree to be bound by the ACH rules. You agree to indemnify and hold Custodian harmless from and against all claims, demands, liabilities and expenses (including reasonable attorneys' fees and costs) resulting from any error on your part, or any failure on your part to exercise reasonable care, in the provision, transmission, or processing of data provided to Custodian or any third party or in complying with any NACHA rules or other applicable law.

11.06

Self-Directed HSA Investments

Generally, HSA funds in excess of a threshold established by the Custodian may be invested in certain mutual funds and other securities ("HSA Investments"), as permitted by law.

Investment advice or investment recommendations are not part of the custodial services provided by the Custodian and are not covered by this Agreement.

HSA Investments are not FDIC insured, not bank issued or guaranteed, and are subject to investment risks, including fluctuations in value and the possible loss of principal amount invested.

The HSA Investments available to you are selected by the Registered Investment Advisors (each, an "Advisor") made available to the Participant by, and at the discretion of, the Custodian. The Advisor selects the HSA Investments in accordance with an investment policy provided by the Advisor. In certain situations, your employer may select the HSA Investments provided to you and the investment policy provided by the Advisor shall not apply. Please review the Advisor's disclosures for information about limitations and fees related to the HSA Investments.

You have the sole responsibility and authority to select investments and direct the purchase or sale of HSA Investments. Your determination to sell or purchase any HSA Investments presented to you through the online participant portal does not confer fiduciary status upon the Custodian. The Custodian does not provide investment advice or recommendations, or serve as an investment advisor to the Participant. To the extent applicable, the Custodian will settle any transactions related to HSA Investments only upon receipt of, and pursuant to, your instructions to us. If any of your instructions are unclear, or provided in a manner not acceptable to us, we may, in our sole discretion, continue to hold funds in your HSA or HSA Investments, as applicable, without liability for loss of income or appreciation.

The Custodian does not have a duty to disclose any risks associated with any HSA Investments and shall not be liable for any loss of principal or income, nor for any expenses incurred relating to HSA Investments.

Participation in the self-directed HSA Investments will be subject to any and all applicable additional terms and conditions provided by the Advisor or other third party providers, available in the online participant portal at my.optum.com/etf.

By your online registration and use of HSA Investments, you consent to and agree that all notices and documentation, including but not limited to, prospectuses, statements of information, the Advisor's terms and conditions, and reports to shareholders, will be made available to you through our website. Your consent permits the Advisor to use its discretion to vote proxies, consents, direction, approvals or similar matters on behalf of your HSA Investments.

If you close your HSA with us or transfer your HSA to another custodian, your HSA Investments will also be closed. HSA Investments must be liquidated to your HSA before your HSA can be closed or funds can be transferred or rolled over to another custodian. In the event of your death or court order, we may liquidate your HSA Investments without your authorization to comply with the death distribution or court order.

In the event that your HSA balance is insufficient to cover any distributions, fees, taxes, or other expenses, we have the right to liquidate your HSA Investments, if necessary, to pay any distributions, fees, taxes or other expenses properly chargeable against your HSA.

Subject to the Advisor's terms and conditions, the Advisor may change or modify the menu of HSA Investments made available to you and restrict your ability to purchase HSA Investments in accordance with the Advisor's instructions.

If you have selected an HSA Investment that is removed, terminated, modified, or otherwise unavailable, the Advisor may direct the transfer of your interest in the HSA Investment to a similar or comparable HSA Investment, unless you otherwise take action on your HSA Investment as set forth in the Advisor's terms and conditions. If a similar or comparable HSA Investment is not available, your HSA Investment may be liquidated and the resulting funds will be transferred to your HSA, unless you otherwise take action on your HSA Investment as set forth in and subject to the Advisor's terms and conditions.

11.07

Death or Divorce Transfers/Distributions

(a) Beneficiary Designation

You may designate one or more beneficiaries to receive the proceeds of your HSA and investment interests upon your death. Beneficiary designations must be made using the Beneficiary Designation Form provided by the Custodian. We reserve the right to require a signature on a Beneficiary Designation Form.

You may revoke a designated beneficiary by delivering written notice of the revocation to us at ConnectYourCare, LLC, Attn: Trust Operations, PO Box 85960, 6300 Wayne Road, Westland, MI 48185. A previously submitted Beneficiary Designation Form may be revoked or changed by subsequently submitting a valid Beneficiary Designation Form.

We reserve the right to require the written consent of your spouse prior to designating a non-spousal beneficiary to your HSA.

You represent and warrant that any beneficiary designation submitted to us is complete, accurate and satisfies all applicable legal requirements. We may presume that a beneficiary is legally competent until we receive written notice otherwise.

If there is no valid Beneficiary Designation Form on file with us at the time of your death, the HSA funds will be distributed to your estate. Please consult a tax professional regarding additional tax-related requirements, obligations, or consequences.

Upon notification of your death, we will freeze your HSA. We may require the presentment of certain documents before your HSA funds may be distributed to your designated beneficiary or your estate. Please review the Beneficiary Designation Form in the participant portal at my.optum.com/etf for more information.

(b) Divorce Distribution/Transfer

If a request for a transfer or distribution is made pursuant to the terms of a divorce or separation agreement, we must receive the request within 90 days of the effective date of the divorce or separation instrument or decree. Transferring your interest to someone other than your spouse may subject you to income tax and penalties on the transferred amount.

11.08

Rollovers and Transfers

(a) HSA Rollovers

Your HSA can accept rollover funds from another HSA or Archer MSA, if you provide us with advanced notice and you provide us with any other information we request, including a written or electronic rollover form. Rollover funds from an HSA or Archer MSA need not be in cash and are not subject to the maximum annual contribution limits set forth in Article II of this Agreement. Funds may not be available during the rollover period. Special rules apply to HSA rollovers.

Please see IRS Publication 969 for detailed HSA rollover rules and limitations.

(b) HSA Transfers

You may transfer all or a portion of funds from this HSA to another HSA or from another HSA to this HSA. Such a transfer is called a "Trustee-to-Trustee Transfer". The IRS does not limit the frequency of Trustee-to-Trustee Transfers. We may require you provide us with advanced notice of the transfer and with any other information we request, including a written or electronic Trustee-to-Trustee Transfer form.

(c) IRA Transfers

You may execute a one-time, tax-free trustee to-trustee transfer of funds from an Individual Retirement Account (IRA) to your HSA. Such transfers are subject to additional rules and limitations and may have tax consequences. You may request a transfer form from us, but please contact your IRA trustee or custodian to see whether a transfer is permitted and to initiate the transfer. Please consult a tax professional or financial advisor regarding additional tax and other related requirements, obligations, or consequences.

11.09

Custodian's Authorization and Empowerment

You authorize and empower the Custodian to administer the HSA, including the power to:

(a) Hold HSA funds received from time to time from the Participant or another source, including rollovers and transfers, as Custodian in an Aggregate Account at a financial institution of Custodian's choosing.

(b) Collect fees from the HSA in accordance with the terms of this Agreement and the HSA Fee and Interest Schedule, including as it relates to overdraft and return item fees.

(c) Make payments, distributions, and disbursements from the HSA as directed by the Participant or his or her Authorized User, in accordance with this Agreement and applicable law.

(d) Perform any and all other acts, which in Custodian's judgment may be necessary or appropriate for the proper administration of the HSA, including correcting errors made by either the Custodian or an employer, or employing attorneys, agents, and vendors as the Custodian feels appropriate, without notice to the Participant.

(e) Seek, at the expense of Participant, direction or approval from a court of competent jurisdiction whenever the Custodian shall, in its sole discretion, deem it appropriate.

(f) Request any documentation or certification as Custodian may, in it is sole discretion, deem appropriate to verify and establish the identity of the beneficiary or the estate upon death of the Participant, if the assets are to be distributed to the Participant's beneficiary or estate.

(g) Pay any estate, inheritance, income, or other tax or assessment attributable to any property or interest held in the HSA out of the balance held in the HSA or from any associated assets as the Custodian may, in its sole discretion, deem to be required.

(h) Require releases or other related documentation from the taxing authority, the Participant, each beneficiary or other payee, and require indemnification from each payee as may be necessary for the Custodian's protection against tax liability.

(i) Close, in the Custodian's sole discretion, the HSA (a) if the HSA does not have a sufficient balance to pay fees that are due or (b) for whatever reason, including if your account has been inactive or dormant for a certain period of time, and liquidate and distribute the funds in the HSA accordingly, including to the appropriate state authority in accordance with Section II.02(d) above.

(j) Not accept, in the Custodian's sole discretion, transfers to the HSA from a custodian or trustee of another HSA or certain other types of accounts.

(k) Contract with third-party service providers, including record-keepers, clearing firms and broker dealers, to provide certain services with respect to the HSA or HSA Investments.

(l) Substitute, in the Custodian's sole discretion, another trustee or custodian for any reason.

11.10

Termination, Resignation and Removal of Custodian

(a) Resignation or Termination by Trustee

We reserve the right to terminate or assign this Agreement, without your prior consent, provided that any assignee, if applicable, must be qualified to serve as an IRS designated HSA custodian or trustee. If applicable, upon notification by the IRS that the Custodian must appoint and transfer the HSA to a substitute custodian, we reserve the right to terminate and assign this Agreement, without your prior consent.

Upon such resignation of us as custodian, and in our sole discretion, we will either appoint a successor custodian or we will distribute the remaining assets in the HSA to you. If applicable, we will liquidate your interests in any HSA Investments and contribute the proceeds to the cash balance to your HSA prior to distributing the HSA funds to the successor trustee/custodian or to you.

You agree that an assignment of this Agreement to another qualified trustee or custodian may result in the loss of FDIC insurance coverage for any HSA funds for which such assignee becomes a custodian or trustee. We shall not be liable or any actions or failures to act on the part of any successor trustee or custodian, nor for any tax consequences that you may incur as a result of the assignment, liquidation, distribution, or termination of the HSA.

In the event that our organization is acquired by or merged with another entity, or otherwise changes its name, that other organization will become the trustee or custodian of your HSA, if the organization is qualified or designated in accordance with IRS regulations.

(b) Termination by Participant

You may terminate this Agreement at any time by giving us 30 days prior written notice. In such event, we shall deliver or transfer the assets of the HSA in accordance with your instructions. We may require you to submit your request in writing using our approved account closure form. If you hold HSA Investments, you must first liquidate those investments in accordance with their applicable terms and conditions. Proceeds of the liquidated HSA Investments will then be reallocated to your HSA. You may not transfer, assign, or pledge your HSA without our prior written approval.

(c) Other Considerations

We reserve the right to debit your HSA for any outstanding charges and other reasonable amounts we believe necessary, and as detailed on the HSA Fee and interest Schedule, to cover any costs, fees, expenses, or taxes associated with the closing of your HSA.

As soon as practical after receiving notice of termination from you or after providing you notice of our termination or resignation, and if applicable, we will distribute the HSA funds in accordance with your direction, the IRC, and this Agreement. After distribution of all funds, this Agreement will terminate and we will have no further duties, obligations, or liabilities to you, to your designated beneficiary(ies), or anyone else, except as required by law.

Any contributions received by us after your HSA has been closed will be returned to the contributing person/entity.

11.11

Representations, Warranties and Waiver of Liability

You hereby represent, warrant, and acknowledge that:

(a) You are eligible to establish and contribute to an HSA and we are not responsible for determining your eligibility to establish or contribute to your HSA;

(b) You agree that we are the custodian of your HSA and nothing in this Agreement shall be interpreted to confer fiduciary status on us, or any of our affiliates, for any purpose;

(c) You agree that we are not responsible for any duty, responsibility, or obligation not specifically assumed by us in this Agreement. We are not responsible for (i) determination of your eligibility to make a contribution to or establish your HSA; (ii) determination of whether contributions made to your HSA, alone or in combination with other contributions, exceed the maximum contribution limitations as detailed under Section 223(b) of the IRC; and (iii) any adverse tax or other consequences as a result of such contributions;

(d) You agree that you are responsible for reviewing all material provided by us and that we may rely on any electronic signature given by you for purposes of your authorization of withdrawals or third-party transfers, notices regarding change of name or address, or other instructions to us, or when required by law;

(e) You agree to provide us with all necessary information for us to prepare any report or return required by the IRS and we agree to prepare and submit any report or return required by the IRS;

(f) All notices and disclosures that are required to be provided to you via first class mail will be provided to you via first class mail unless you otherwise consent and agree to electronic delivery of such notices and disclosures in accordance with the E-SIGN Act. Regardless of whether you opt in and consent to receive electronic delivery of important documents, all notices, documentation, and other information related to your HSA will be made available to you through our website and/or delivered to you via the e-mail address you provide to us. You and we agree that the notice to you will be considered delivered when so made available or delivered, as applicable. Any notice given to us will be considered delivered when we actually receive the notice in writing at ConnectYourCare, LLC, Attn: Legal, PO Box 85960, 6300 Wayne Road, Westland, MI 48185. If you are enrolled to receive electronic delivery of notices, then upon request and for an additional fee, we will mail you any notice at the most current address provided by you;

(g) You agree to indemnify us and hold us harmless from and against, to the fullest extent permitted by applicable law, any loss, claim, liability, damage, cost or expense (including reasonable attorney's fees) that arises or may arise from this Agreement, from Custodian's good faith performance pursuant to this Agreement, except liability arising from gross negligence or willful misconduct of Custodian, or from any actions taken by you and any other Authorized User regarding the HSA and including, without limitation, any action that we do or do not take in reliance on you or any other Authorized User's instructions received with respect to the HSA; and

(h) WE ARE NOT LIABLE FOR ANY INDIRECT, CONSEQUENTIAL, EXEMPLARY, PUNITIVE OR SPECIAL DAMAGE, LOSS, COST OR EXPENSE OF ANY TYPE OR NATURE, REGARDLESS OF THE FORM OF THE ACTION OR THEORY OF RECOVERY, AND EVEN IF WE HAVE BEEN ADVISED OF THE POSSIBILITY OF ANY OF THE FOREGOING, EXCEPT AS SET FORTH IN THIS AGREEMENT. WE DO NOT MAKE ANY REPRESENTATIONS AND WARRANTIES WHETHER EXPRESS, STATUTORY, OR IMPLIED.

11.12

Choice of Law, Severability, Amendment

This Agreement shall be governed by and construed in accordance with the laws of the State of Maryland. If any word, phrase, sentence, paragraph, provision, or section of this Agreement shall be held, declared, pronounced, or rendered invalid, void, unenforceable, or inoperative for any reason by any court of competent jurisdiction, governmental authority, statute or otherwise, such holding, declaration, pronouncement, or rendering shall not adversely affect any other word, phrase, sentence, paragraph, provision, or section of this Agreement, which shall otherwise remain in full force and effect and be enforced in accordance with its terms.

This Agreement may be amended at any time by us. Any amendment will take effect upon 30 days' notice to you, and you will be deemed to have consented to such amendment unless you notify us within 30 days of delivery of notice that you do not consent to the amendment. If you do not consent to the amendment, the HSA will be closed and the account balance, less any outstanding fees, will be transferred to another custodian designated by you in accordance with the notice that you do not consent to the amendment or, if no custodian is designated in the notice that you do not consent to the amendment, distributed to you.

This Agreement may not be amended by you without our written consent.

11.13

Arbitration

You hereby agree that any dispute, claim, or controversy arising now or in the future under or relating in any way to your HSA or this Agreement, regardless of the nature of the cause(s) of action asserted (including claims for injunctive, declaratory, or equitable relief), shall be resolved by neutral binding arbitration. Claims subject to arbitration include claims that are made as counterclaims, cross claims, third-party claims, inter-pleaders, or otherwise. Arbitration replaces the right to go to court, and you therefore agree to waive any right that you or we might otherwise have had to a jury trial or the opportunity to litigate any claims in court before either a judge or jury. You further agree that you will not be able to bring a class action or other representative action (such as an action in the form of a private attorney general) to litigate any claims in court before either a judge or jury; nor will you be able to participate as a class member in a class action or other representative action in arbitration or in court before either a judge or jury.

This binding arbitration provision applies to any and all claims that you have against us, our parent, subsidiaries, affiliates, licensees, predecessors, successors, assigns, and against all of our respective employees, agents, or assigns, or that we have against you; it also includes any and all claims regarding the applicability of this arbitration clause or the validity of this Agreement, in whole or in part. It is made pursuant to a transaction involving interstate commerce, and shall be governed by the Federal Arbitration Act, 9 U.S.C. Sections 1-16, as it may be amended.

The party filing a claim in arbitration must file its claim before the American Arbitration Association under the rules of such arbitration administrator in effect at the time the claim is filed. Rules and forms may be obtained from, and claims may be filed with the American Arbitration Association, (1-800-778-7879 or adr.org). Arbitration hearings shall be held in Baltimore, Maryland and you waive any objection on grounds of venue, forum non-conveniens or any similar grounds. For disputes under $10,000.00 the arbitration may be conducted in person, by telephone, or based on written submission. Judgment upon any arbitration award may be entered in any court having jurisdiction.

Notwithstanding the other terms of this arbitration clause: (i) you may choose to file a case in small claims court for any dispute that could have been resolved in such a venue in your jurisdiction; and (ii) we shall have the right to bring suit against you in a court of competent jurisdiction for the recovery of any sums owed to us under the terms of this Agreement, including, but not limited to, fees, costs, overdrafts, expenses, and sums paid by us in error to or for the benefit of the HSA. All court costs, legal expenses, reasonable compensation of time expended by us in the performance of our duties, and other appropriate and pertinent expenses and costs may be collected by us from the HSA.

This arbitration clause shall survive: (i) termination or changes in the Agreement, and the relationship between you and us concerning the Agreement; and (ii) the bankruptcy of any party or any similar proceeding initiated by you or on your behalf. If any portion of this arbitration clause is deemed invalid or unenforceable, the remaining portions shall nevertheless remain in force.

11.14

Funds Availability

Our policy is to generally make funds contributed to your HSA available to you on the first business day after we receive your contribution. The availability of your HSA funds for withdrawal or distribution may vary depending upon the type of contribution. There may be some exceptions; see Sections below titled Longer Delays May Apply and Special Rules for New Accounts. Payroll contributions are made available once they are contributed into your HSA which is generally the first business day after we receive your employer's payroll. Electronic contributions, wire transfers, or ACH contributions are generally made available the first business day after we receive the funds. The first $200.00 of a day's check deposits will be made available on the first business day after the day we receive the deposit.

Longer Delays May Apply

In some cases, we will not make the first $200.00 of a business day's check deposits available to you on the first business day after we receive the check deposit.

Further, in some cases, we will not make all the funds that you deposit by check available to you on the first business day after the day we receive your deposit.

Funds from certain checks that you deposit may not be available until the second business day after the day we receive your deposit.

Funds you deposit by check may be delayed for a longer period under the following circumstances:

1. We believe a check you deposit will not be paid.
2. You deposit checks totaling more than $5,000.00 on any one day.
3. You redeposit a check that has been returned unpaid.
4. You have overdrawn your HSA repeatedly in the last 6 months.
5. There is an emergency, such as failure of communications or computer equipment.

We will notify you if we delay your availability to withdraw funds for any of these reasons, and we will tell you when the funds will become available.

Special Rules for New Accounts

If you are a new customer, the following special rules may apply during the first 30 days your HSA is open. Incoming wire transfers and electronic contributions, including payroll contributions and ACH contributions, will be available on the first business day after we receive the contribution. If you request that we process an electronic contribution on your behalf, we reserve the right to place an extended hold on those contributions. Funds from the first $5,000.00 of a day's total deposits of cashier's, certified, teller's, traveler's, and federal and state, and local government checks will be available on the second business day after the day of your deposit, if the deposit meets certain conditions. For example, the checks must be made payable to you, and you may be required to use a special deposit ticket. The excess over $5,000.00 will be available on or before the ninth business day after the day we receive your deposit.

We will notify you if we delay your ability to withdraw funds and we will tell you when the funds will be available.

Determining the Day of Receipt

For determining the availability of your contribution, every day is a business day, except Saturdays, Sundays, and federal holidays. The close of each business day varies but will be no earlier than 2 p.m. ET. If you make a contribution before the close of a business day on a business day that we are open, we will consider that day to be the day of your contribution. Contributions received after the close of the business day will be deemed received the next business day. If you make a contribution after the close of our business day or on a day we are not open, we will consider the day the contribution was made to be the next business day we are open.

Optum Financial®

Health Savings Account Fee and Interest Schedule

Effective: November 5, 2018

Fee Schedule

ConnectYourCare wants you to understand the fees associated with your Health Savings Account (HSA). In some cases, fees charged to your HSA may be less than the disclosed fees or one or more fees may not apply to your HSA. Also, some, or all, of the fees may be paid by your employer, insurer, or other third party. For example, your employer may pay the monthly maintenance/account fee on your behalf. If a third party stops paying your fees for any reason, CYC may collect the fees directly from your HSA at the disclosed rate.

For details regarding the general terms and conditions that apply to your HSA, please refer to the Custodial Agreement. The fees below may not apply to the Department of Employee Trust Funds (ETF) participating members.

Replacement Card	$0.00
Paper Statement, per mailing	$1.00 (no fee for electronic statement)
Reimbursement Check	$2.00 (no fee for electronic funds transfer)
Monthly Maintenance	$3.00 (if not otherwise paid by employer, insurer or other third party)
Deposited Item Returned, per item (NSF)	$3.00
Overdraft, per transaction	$20.00
Excess Contribution, per return	$15.00
Account Closure/Rollover or Trustee-to-Trustee Transfer	$20.00
Legal Process (e.g. attachment, levy or garnishment), per occurrence	$25.00

Interest Schedule

Your HSA balance is held in an interest-bearing, FDIC insured account at a member FDIC bank. For current interest rates, please visit your online portal or contact Optum Financial. Interest rates may change without notice. Interest is calculated and compounded monthly. If your HSA is closed before interest is credited, you will not receive the accrued interest for that month. We use the daily balance method to calculate interest on your HSA. This method applies a daily periodic rate to the principal in your HSA each day.

Balance	% Interest	Annual percentage yield (APY)
$0.01–$1,999.99	0.01%	0.01%
$2,000–$7,499.99	0.01%	0.01%
$7,500–$9,999.99	0.01%	0.01%
$10,000 or more	0.01%	0.01%

Optum Financial®

Notice of Privacy Practices

Effective: November 5, 2018

What does Optum Financial do with your personal information?

Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Social Security number and name, address, and date of birth and employment information • Account balances and transaction history; payment history, medical-related payments • Credit history and credit scores, depending on the products or services you have with us When you are no longer our customer, we continue to share your information as described in this notice.
How?	All financial companies need to share personal customer information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information, the reasons Optum Financial chooses to share and whether you can limit this sharing.

Reasons we can share your personal information	Does Optum Financial share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes – to offer our products and services to you	No	We don't share
For joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes – information about your transactions and experiences, which is not used by affiliates to market their products to you	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For our non-affiliates to market to you	No	We don't share

Questions?	Please call 1-844-973-3925, or go to optumfinancial.com/privacy, or log in to your HSA portal. Health Savings Accounts (HSAs) are offered through Optum Bank®, Member FDIC, or ConnectYourCare, LLC, each a subsidiary of Optum Financial. Please consult your HSA Custodial Agreement for further information.

Optum Financial®

Who we are	
Who is providing this notice?	Optum Financial includes a family of companies which provide or administer financial products for U.S. consumers, including OptumHealth Financial Services; ConnectYourCare, LLC; ConnectYourCare, Inc.; and Optum Bank.
What we do	
How does Optum Financial protect my information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. We maintain physical, electronic and procedural safeguards to protect your nonpublic personal information, including restrictions on access to your confidential information.
How does Optum Financial collect my personal information?	We collect your personal information, for example, when you: Open an account • Use your payment card or make deposits or withdrawal • Update your contact information Depending on your product, we also collect your personal information from others, such as credit bureaus, affiliates or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only: • Sharing for affiliates' everyday business purposes – information about your creditworthiness • Affiliates from using your information to market to you • Sharing for non-affiliates to market to you State laws and individual companies may give you additional rights to limit sharing.
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. Our affiliates include companies within UnitedHealth Group and those companies that share the Optum name; ConnectYourCare; UnitedHealthcare Insurance Company; nonfinancial companies such as Optum Insight and UHG Print Services; and others such as United HealthCare Services, Inc. and Optum Specialty Benefits, Inc.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. • Optum Financial does not share with nonaffiliates so they can market to you.
Joint Marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. • Optum Financial does not engage in any joint marketing.

Optum Financial®

Other Important Information	
Nevada Residents	We are providing you this notice pursuant to state law. You may be placed on our internal Do Not Call List by following the directions in the "To limit our sharing" section above. For more information, contact us at 1-877-292-4040 or ConnectYourCare, Privacy and Legal Information, PO Box 85960, 6300 Wayne Road, Westland, MI 48185. Or contact the Bureau of Consumer Protection, Office of the Nevada Attorney General, 555 E. Washington Ave, Suite 3900, Las Vegas, NV 89101; 1-702-486-3132; aginfo@ag.nv.gov.
Vermont Residents	We will not share information we collect about you with nonaffiliates, except as permitted by Vermont law, including, for example to process your transactions or to maintain your account.

DELTA DENTAL®

Delta Dental of Wisconsin

Enrollment/Change/Waiver Form - Dental

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

EMPLOYER USE ONLY

GROUP NUMBER _____ 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)	GENDER F ☐ M ◯ U ◯

HOME ADDRESS - STREET	CITY	STATE	ZIP

EMPLOYER NAME	EMPLOYER LOCATION	CITY	STATE	DATE OF HIRE (M/D/Y)

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

SPOUSE LAST NAME (IF DIFFERENT)	FIRST	M.I.	GENDER F ☐ M ◯ U ◯	DATE OF BIRTH (M/D/Y)
CHILD/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
◯ 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
EMPLOYER NAME	EMPLOYER LOCATION	CITY	STATE	◯ I have other dental coverage
				◯ I do not have other dental coverage

◯ **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.

DELTA DENTAL®

Delta Dental of Wisconsin

ETF Supplemental Dental Active Employee Enrollment Form

Please note that completing this form does not guarantee coverage

Plan Selection (Choose Preventive Plan and/or the Select or Select Plus Plan):

☐ Delta Dental PPO Plus Premier™ – **Preventive Plan** (option only available if **not** enrolling in health plan)

☐ Delta Dental PPO™ – **Select Plan** **OR** ☐ Delta Dental PPO Plus Premier™ – **Select Plus Plan**

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

EMPLOYEE LAST NAME	FIRST	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH M/D/Y	GENDER F ☐ M ☐

HOME ADDRESS – STREET	CITY	STATE	ZIP

DATE OF HIRE

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

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

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: _____) _____
- ☐ Cancellation of Benefits (Reason: _____) _____
- ☐ Loss of Dental Benefits _____
- ☐ Name Change (Former Name: _____) _____
- ☐ Address Change (_____) _____
- ☐ Group Transfer (From _____ to _____) _____

COVERAGE TYPE

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

Preventive Plan (if not enrolled in health plan)

☐ Self Only ☐ Entire Family

Select or Select Plus Plan (choose plan above)

☐ Self Only ☐ Self & Spouse

☐ Self & Child(ren) ☐ Entire Family

☐ **ACCEPT COVERAGE**

X _____ _____

Signature is Required — Date

FOR EMPLOYER USE ONLY

Effective Date: _____ Received By: _____ Received Date: _____

Employer Name: _____ Group Number: _____

Return To:
Your Human Resources Department

DELTA DENTAL®

DeltaVision®

Delta Dental of Wisconsin

ETF Supplemental Vision Active Employee Enrollment Form

Please note that completing this form does not guarantee coverage

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

EMPLOYEE LAST NAME	FIRST	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH M/D/Y	GENDER F ☐ M ☐

HOME ADDRESS – STREET	CITY	STATE	ZIP

DATE OF HIRE

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

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

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: _____) _____
- ☐ Cancellation of Benefits (Reason: _____) _____
- ☐ Loss of Vision Benefits _____
- ☐ Name Change (Former Name: _____) _____
- ☐ Address Change (_____) _____
- ☐ Group Transfer (From _____ To _____) _____

COVERAGE TYPE

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

Vision Plan

- ☐ Self Only
- ☐ Self & Spouse
- ☐ Self & Child(ren)
- ☐ Entire Family

☐ **ACCEPT COVERAGE**

X _____ _____

Signature is Required — Date

FOR EMPLOYER USE ONLY

Effective Date: _____ Received By: _____ Received Date: _____

Employer Name: _____ Group Number: _____

DeltaVision is underwritten by Wyssta Insurance Company.

Return To:
Your Human Resources Department

UWHealth

Supplemental Life/AD&D Insurance
Change & Cancellation Form

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Name:	**Social Security Number:**
Salary:	**Date of Birth:**
Date of Hire:	**Effective Date:**
Hours Worked/FTE	**Occupation**

Complete the below information to reduce or cancel Supplemental Life/AD&D coverage for yourself, spouse/domestic partner, or child.

Supplemental Life/AD&D Insurance – Employee

☐ I elect to **REDUCE** the Supplemental Life/AD&D coverage for myself to $_____

☐ I elect to **CANCEL** the Supplemental Life/AD&D coverage for myself

Supplemental Life Insurance – Spouse/Domestic Partner

☐ I elect to **REDUCE** the Supplemental Life/AD&D coverage for my spouse/domestic partner to $_____

☐ I elect to **CANCEL** the Supplemental Life/AD&D coverage for my spouse/domestic partner

Child(ren) Supplemental Life Insurance

☐ I elect to **CANCEL** the Supplemental Life/AD&D coverage for my dependent child(ren)

Employee Confirmation

I acknowledge that by completing this form my University of Wisconsin Medical Foundation's Group Supplemental Life/AD&D coverage selected above will be reduced to the amounts indicated above. I understand and agree that if I later decide to increase the coverage, I will be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

Signature:_____ **Date:** _____

Return completed form to the HR Service Center.
Changes are effective 1st of month following receipt of application.

INSTRUCTIONS FOR COMPLETING THE ACCIDENT PLAN APPLICATION

Please complete the application form to enroll for accident insurance. Premiums for this plan will be deducted through a payroll deduction.

- If you are enrolling in Employee coverage only, complete all fields in the employee information section.
- If you are enrolling in Employee + Spouse coverage, complete all fields in the Employee and Spouse sections.
- If you are enrolling in Employee + Child coverage, complete all fields in the Employee and Children sections.
- If you are enrolling in Employee + Family coverage, complete all fields in the Employee, Spouse and Children sections.
- Sign and date the application.
- RETURN the application to your HR/Payroll Specialist.
- Your election to enroll for coverage must be made within 30 days of your enrollment period.
- If you are not enrolling for the Accident Plan an application does not need to be submitted.

QUESTIONS: Contact your HR/Payroll specialist

Group Accident Insurance Enrollment

Securian Life Insurance Company
Group Customer Service
400 Robert Street North • St. Paul, Minnesota 55101-2098 • Fax 651-665-4827

EMPLOYER NAME: State of Wisconsin - ETF **POLICY NUMBER: 76038**

EMPLOYEE INFORMATION (always complete for coverage)

First name	Middle initial	Last name		Phone number

Street address	City	State	Zip code

Date of birth	Social Security number	Date of employment	Email address

Amount of insurance elected

☒ Supplemental Plan

SPOUSE INFORMATION (only complete if you want coverage)

First name	Middle initial	Last name	Phone number

Date of birth	Email address

CHILDREN INFORMATION (only complete if you want coverage)

Child name	Date of birth	Child name	Date of birth

AUTHORIZATION

I understand that Securian Life Insurance Company shall incur no liability until the first premium is paid, and that premiums for the contributory insurance will be deducted from my pay. The information submitted is true and complete to the best of my knowledge and belief. I have reviewed all applicable eligibility requirements for the coverage(s) I have elected and certify all such requirements have been met.

Employee signature	Employee name (please print)	Date signed
X		

EEID#:_____

ENROLLMENT FORM FOR GROUP ACCIDENT INSURANCE
FOR THE EMPLOYEES OF U.W. HOSPITAL & CLINICS

Underwritten by Zurich American Insurance Company
Policy Number: **GTU 2584087**

Reason for Submitting Form:

☐ Elect coverage ☐ Change Coverage ☐ Cancel Coverage ☐ Beneficiary Change
☐ Other:

Employee Information:			
Last Name:	First Name:	M.I.:	Occupation:
Social Security Number:		Sex:	Date of Birth:
Spouse Name:		Spouse Occupation:	
Beneficiary Designation & Relationship:		The beneficiary for **Spouse** and **Dependent Child(ren)** is the employee named on the enrollment form.	

Coverage Information:

Plan (check one): ➔	☐ Plan I – Employee Only	☐ Plan II – Family Coverage
Coverage Amount (check one):	Employee Plan Monthly Premium	Family Plan Monthly Premium
☐ $50,000	$1.50	$2.25
☐ $100,000	$3.00	$4.50
☐ $150,000	$4.50	$6.75
☐ $200,000	$6.00	$9.00
☐ $250,000*	$7.50	$11.25
☐ $300,000*	$9.00	$13.50
☐ $350,000*	$10.50	$15.75
☐ $400,000*	$12.00	$18.00
☐ $450,000*	$13.50	$20.25
☐ $500,000*	$15.00	$22.50

* Benefit amounts in excess of $250,000 may not exceed ten (10) times your base annual pay excluding overtime, bonuses, commissions and special compensation.

Signature Section:

☐ I elect the coverage above and authorize the monthly insurance premiums to be deducted from my earnings.
☐ I have been given the opportunity to apply for this insurance but I do not desire to participate at this time.
☐ I elect to cancel my coverage.

Your Signature:	Date:

For Employer Use Only:	
Date Received:	Effective date of coverage/change:
Assistant Initials:	PS Entry Date:

Wisconsin Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931
etf.wi.gov
1-877-533-5020 (toll free)
Fax: (608) 267-4549

Do not submit to your employer

Beneficiary Designation

Wis. Stat. § 40.02 (8) (a) and 40.74

Refer to instructions on reverse
Do not alter this form

Complete if applicable
Beneficiary of:
Alternate Payee of:

Type or print in ink

Your Information

Name *First*	*Middle I.*	*Last*	*Former/maiden*	**Social Security number or ETF ID**
Mailing address (*Street number and street name*)				**Birth date** (*MM/DD/YYYY*) / /
City	**State**	**ZIP Code**		**Weekday telephone number** (*Include area code*) ( ) -

Primary Beneficiary Designation - Any benefits payable by the Wisconsin Retirement System and Life Insurance program at my death shall be paid in EQUAL SHARES, unless otherwise specified, to the following primary beneficiary(ies) who survive me.

Name (*First, Middle I., Last*) or Name of trust AND trustee	Relationship	Birth date or Trust date	SSN or TIN	Phone	Address (*street, city, state, ZIP code*)
		/ /	- -		
		/ /	- -		
		/ /	- -		
		/ /	- -		
		/ /	- -		
		/ /	- -		

Secondary Beneficiary Designation - In the event all primary beneficiaries die before me, the death benefit shall be paid in EQUAL SHARES, unless otherwise specified, to the following secondary beneficiaries who survive me.

Name (*First, Middle I., Last*) or Name of trust AND trustee	Relationship	Birth date or Trust date	SSN or TIN	Phone	Address (*street, city, state, ZIP code*)
		/ /	- -		
		/ /	- -		
		/ /	- -		
		/ /	- -		
		/ /	- -		
		/ /	- -		

If you want this designation to **apply only to specific benefit plan(s) or account(s)**, use this space to specify the benefit plan(s) or account(s) to which you want this designation to apply. See "Effective for all benefit plans and accounts" section on the reverse side before completing this section.

Signature I understand that Wis. Stat. § 943.395 provide criminal penalties for making false or fraudulent claims on this form and hereby certify to the best of my knowledge and belief, the above information is true and correct.

SIGN

Signature (*Do not print*)	Date signed (MM/DD/YYYY) / /

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 the Department of Employee Trust Funds. The person filing the designation must still be alive when ETF receives the form. An acknowledgment will be sent when this designation has been reviewed and accepted. Invalid designations will be rejected.

Beneficiary Designation Instructions

Personally identifiable information such as your Social Security number, birth date, etc., will not be used for any purpose other than for the administration of the benefit programs administered by ETF.

Who Completes a Beneficiary Designation

Search "beneficiary" at etf.wi.gov for help on completing a beneficiary designation form.

If you are the owner of a Wisconsin Retirement System account from which a death benefit or life insurance benefit would be payable upon your death, you may file a *Beneficiary Designation*. Most WRS participants, some alternate payees (former spouses/domestic partners) of participants and some beneficiaries of deceased participants are eligible to file. **If no *Beneficiary Designation* is on file with ETF, WRS benefits, death benefits, and life insurance benefits will be paid according to the statutory standard sequence in effect on the date of death as explained in the "Naming Standard Sequence" section.**

Special Note to Annuitants: If you selected a WRS joint and survivor annuity when you retired, you can never change the named survivor that you named on your WRS annuity application. Filing a *Beneficiary Designation* form does not change your named survivor.

Completing a Beneficiary Designation

Clarity. Our objective is to ensure prompt payment of any death benefits available upon your death, as specified by you on the *Beneficiary Designation* form. Clarity is necessary when you complete a *Beneficiary Designation* form, in order to avoid any questions as to your intent. ETF staff will review your designation and may reject it if it is unclear or confusing.

Note: Nicknames, overwriting, erasures, "white-out," crossed- out words, numerals denoting order of beneficiaries, special instructions and notations, references to future events, or use of the word "or" in naming beneficiaries will result in our **rejecting your designation**. Designations by letter, previously submitted designations that have been altered, designations with extra non-form pages attached **will also be rejected**.

Simplicity is important. Because your designation may remain in effect for many years and applies to all benefit plans and accounts to which you may become entitled, we recommend against filing lengthy or complex designations. If you wish to name a large number of beneficiaries, anticipate frequent changes in your beneficiaries, prefer to make special arrangements for each benefit plan or account, or want to impose special conditions on some benefits, you should consider naming your estate or a trust. Your death benefits administered by ETF would then be distributed according to your will or trust document. Payment is issued to the trust or estate, not to the trustee or estate representative.

Top of form. Your name, mailing address, Social Security number or ETF ID, birth date and telephone number should be typed or printed in ink (not pencil) at the top of the *Beneficiary Designation*. This information is required.

Sign and date. After designating a beneficiary or beneficiaries, sign and date the designation at the bottom of the page. Unsigned and/or undated forms will be rejected. Forms dated with a future rather than a current date will be rejected.

Guardian/Conservators. A legal guardian or conservator of the estate who has appropriate legal authority may file a *Beneficiary Designation* form on behalf of a participant. The guardian or conservator must also submit a photocopy or facsimile of the court order of guardianship or conservatorship.

Power of Attorney for Finances. A Power of Attorney for Finances who has the appropriate legal authority may file a *Beneficiary Designation* form on behalf of a participant. To file a *Beneficiary Designation* form, the Power of Attorney for Finances must have the specific authority to create or change a beneficiary designation as provided in s. 244.41(1) Wis. Stats. The Power of Attorney or participant must submit a photocopy or facsimile of the signed and executed Power of Attorney document.

Submit the form to ETF at the address listed at the top of the form. *Make a photocopy of the completed form and keep for your records.* An acknowledgment notice will be sent to you.

Effective for all benefit plans and accounts. Unless otherwise specified on the *Beneficiary Designation* form (in the box below the secondary section, above the signature line), a *Beneficiary Designation* form filed with ETF will apply to the benefits payable upon your death from all benefit plans and accounts administered by ETF. You may designate beneficiaries for separate benefit plans and WRS accounts. ***Separate benefit plans are life insurance and WRS benefits.*** This does not include benefits from the Deferred Compensation Program. The separate WRS accounts you may hold are your own account and/or those you may own as a beneficiary or an alternate payee.

If you wish to designate different beneficiaries for separate benefit plans or accounts, please use the space on this form directly above the signature block. If you file a *Beneficiary Designation* form for a specific benefit plan or account, and subsequently file a form which does not specify a benefit plan or account, the new designation will supersede all previously filed designations.

Please contact the administrator of the Deferred Compensation Program for details regarding naming or changing beneficiaries for your Deferred Compensation Program account.

Other Life Insurance. The designation of a beneficiary filed with ETF does not apply to any life insurance program not administered by ETF.

When effective or invalid. Once a properly completed *Beneficiary Designation* is received and approved by ETF, it remains in effect until you file a new designation or until there are no further benefits payable. If you subsequently reestablish eligibility for benefits after closing an account, the previously filed *Beneficiary Designation* is invalid.

EXCEPTION: This designation will be set aside, and standard sequence will govern payment of your retirement account death benefits, if ETF makes a mandatory distribution of your retirement account to you. Designations continue to be applicable to any life insurance or beneficiary account that may be payable.

NOTE: A divorce, annulment, or similar event will *not* invalidate a *Beneficiary Designation* that named your former spouse. To remove a former spouse as a beneficiary, you must file a new designation.

Payment progression. Your death benefits will be paid first to your primary beneficiaries. If some of your primary beneficiaries die before you, your death benefit will be divided among those primary beneficiaries who are still living. Secondary beneficiaries will receive benefits only if no primary beneficiary survives you.

If you wish to specify who shall receive a primary beneficiary's share if a primary beneficiary is deceased, you must use an *Alternate Beneficiary Designation* (ET-2321) form. You can request this form from ETF.

Equal shares unless otherwise specified. If you name two or more persons as beneficiaries at one level (primary or secondary), payment will be made in equal shares to the beneficiaries at that level unless you specify a percentage for different beneficiaries.

If you specify percentages to be paid to beneficiaries at one level, the percentages at each level must total 100%.

You must list the percentage in the same box as the beneficiary's name.

Continue to back for further instructions

Options Available for Designating a Beneficiary

Naming specific beneficiaries (Primary, Secondary). The *Beneficiary Designation* form provides space to name primary and secondary beneficiaries. You may not make an irrevocable designation of any beneficiary. If more space is needed, complete and submit a second form page and clearly mark them as page 1 of 2, etc., signing and dating each page. Do not attach extra non-form pages or list beneficiaries on the back.

If you list primary or secondary beneficiaries, be sure to include the full name, relationship, birth date, Social Security number, phone number, and address of each additional beneficiary. This will speed payment of the death benefits to your beneficiary(ies).

Naming standard sequence. Currently, under standard sequence established in Wis. Stat. § 40.02 (8) (a), any benefit payable is paid to the person or persons in the lowest numbered group below. No payment will be made to a person included in any group if there is a living person or persons in any of the preceding groups. Payment to two or more persons included in any group will be made in equal shares.

The standard sequence described below is subject to change, based on changes in state statutes. If benefits are paid according to standard sequence, the statutory standard sequence in effect at the time of your death will determine your beneficiary(ies).

The present statutory standard sequence is as follows:

Group 1. Surviving spouse or domestic partner.

Group 2. Children (natural or legally adopted). If one of your children dies before you, that child's share is divided between your deceased child's children.

Group 3. Parent(s)

Group 4. Brother(s) and Sister(s). If one of your siblings dies before you, that sibling's share is divided between your deceased sibling's children.

If there are no survivors in Groups 1 through 4, any death benefits will be paid to your estate.

If you want to name standard sequence as beneficiary, simply enter the words "standard sequence." **Do not include any specific names.**

Naming your estate. To name your estate as your beneficiary, enter the word "Estate" on the beneficiary designation form. Do not include the name of your personal representative or executor.

If you designate your estate, your death benefits will be distributed according to your Last Will and Testament or according to Wisconsin's intestacy laws if you do not leave a will. The death benefits will be paid directly to your estate in a lump sum. It will be the responsibility of your personal representative or executor to distribute the funds according to your will, or if you do not leave a will, according to the intestacy laws.

Naming a Trust as Beneficiary. You can name a living trust or a testamentary trust as your beneficiary. Death benefits will be issued payable to the trust, not to the trustee. We recommend that you consult with your attorney and/or financial advisor to ensure that you fully understand the implications of setting up a trust, including the tax consequences. See etf.wi.gov for more information on naming your trust as a beneficiary.

Living trust. If you designate a living trust as your beneficiary, your beneficiary designation **must** include all of the following information:

1. The name of the trust (this must be listed first) – if naming a trust or subtrust please visit etf.wi.gov for information;
2. The date the trust was created;
3. The name of the trustee, followed by the word "trustee", or if you cannot provide a trustee, ETF may accept another contact person;
4. The trustee's address;
   (*Note*: the trustee's birth date and SSN are not required.)
5. If you are currently the trustee of your living trust, you **must** provide both the name *and* address of your successor trustee for us to contact after your death.
6. (optional) The taxpayer identification number of the trust if one has been assigned.

Example:

The John and Jane Doe Living Trust, created April 1, 2008 ID #xxx-xx-xxxx
Jane Smith, Trustee
123 Main St., Anytown, WI 54321

Testamentary trust. A testamentary trust is created by your last will and testament, and does not come into existence until after your death. Usually a will must be probated before the death benefits can be paid to the testamentary trust. If you designate a testamentary trust as your beneficiary, if possible, your beneficiary designation should include the following information:

1. The name of the trust (this must be listed first) – if the trust under the will doesn't yet have a name, please provide enough information so that we can identify the trust at a future date by using the phrase: "trust for the benefit of [insert name of beneficiary[s]] or trust under article 'x' of my will created under my last will and testament";
2. The words "created under my last will and Testament"' (do *not* include a date created);
3. The name of the trustee (or successor trustee), followed by the word "trustee." If you cannot provide a trustee, ETF may accept another contact person;
4. The trustee's address.

Example:

The John and Jane Doe Trust, created under my last Will and Testament
Jane Smith, Trustee
123 Main St., Anytown, WI 54321

Future children. Children not yet born (or adopted) may be included on a *Beneficiary Designation* form only by use of the following statement: **"I also include as beneficiaries as if each were specifically and individually named herein, any and all of my natural and legally adopted children."** This will include all marital and non-marital children (as long as any relevant paternity is established), whether the child's date of birth is before or after your date of death. You may substitute "grandchildren" for "children" in the above example.

Naming a Charity, Religious Organization, Business, or Other Non-Profit Organization as Beneficiary. Please list the full legal name, tax identification number, and current address of the organization so that ETF can best carry out your wishes.

Federal Distribution Requirements. Federal tax law requires retirement benefits to be distributed (paid) to a participant or beneficiary by certain deadlines. After your death, if we cannot locate your beneficiaries within the legal deadlines, the benefit will be forfeited. Therefore, it is very important for you to keep address information for your beneficiaries up to date.

Questions: If you have questions about this form, please contact ETF in writing or call 1-877-533-5020, or Wisconsin Relay at 711.