Welcome to the City of Madison

Employee Orientation

Introductions

- **Welcome!**
- **Check-In Question**

Agenda

- ❑ City of Madison Mission, Vision, Values, and Service Promise
- ❑ Racial Equity and Social Justice at the City
- ❑ Administrative Procedure Memoranda (APM's)
- ❑ Employee Assistance Program (EAP)
- ❑ Employee Perks
- ❑ Initial Employment Forms
- ❑ Pay & Leave Benefits
- ❑ Insurance & Other Benefits
- ❑ Associations Presentation

✓ Check it off as you go!
✓ Sign and date at the end and return to Human Resources in-person, Inter-d or fax.

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City of Madison Mission, Vision, Values, and Service Promise

Welcome to the City of Madison!

Equity
We are committed to fairness, justice, and equal outcomes for all.

Civic Engagement
We believe in transparency, openness, and inclusivity. We will protect freedom of expression and engagement.

Well-Being
We are committed to creating a community where all can thrive and feel safe.

Shared Prosperity
We are dedicated to creating a community where all are able to achieve economic success and social mobility.

Stewardship
We will care for our natural, economic, fiscal, and social resources.

When you think about the City of Madison's values, what do you think these might look/sound/feel like for YOU in your new role?

Racial Equity and Social Justice at the City

RESJI@CITYOFMADISON.COM

FOR MORE INFORMATION

Agenda

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City Rules (APM's)
Employee Assistance Program
Employee Perks

Mayoral Administrative Procedure Memoranda (APM's)

- Rules that guide **ALL** City Employees at work to ensure welcoming, safe, and fair to all employees and members of the community.
- Process
- Can find them on EmployeeNet
  - 2-33 Standard Expectations and Rules of Conduct
  - 2-23 Drug and Alcohol Testing Policy/Drug-Free Workplace Memo
  - 3-5 Prohibited Harassment and/or Discrimination Policy
  - 2-52 Inclusive Workplace: Transgender, Gender Non-Conforming, and NonBinary Employees
  - 2-14 Designation of Family Partner
- Ethics Code
- IT Records
- Worker's Compensation

Employee Assistance Program (EAP)

- Confidential **free** services designed to help City of Madison employees, families of employees, and employee spouses or significant others prevent or resolve personal, family, and workplace problems
- **Services**
  - Information, support, and resource referral
  - Connections Newsletter
  - Critical Incident Stress Management
  - Free Trainings
  - Webpage: www.cityofmadison.com/employee-assistance-program
  - Email: EAP@cityofmadison.com

City of Madison Employee Perks

- Free Annual Bus Pass
- City Sponsored Committees – MAC, WIC
- Affinity and Identity Based Groups
- Trainings available through HR
- Madison Credit Union
- Discounts
  - Nationwide Pet Insurance
  - Select Overture Center Performances
  - Cell Phone Plans (check with your provider)
  - Dell Employee Purchase Program

MAC
Multicultural Affairs Committee

Wic Women's Initiatives
COMMITTEE

Agenda

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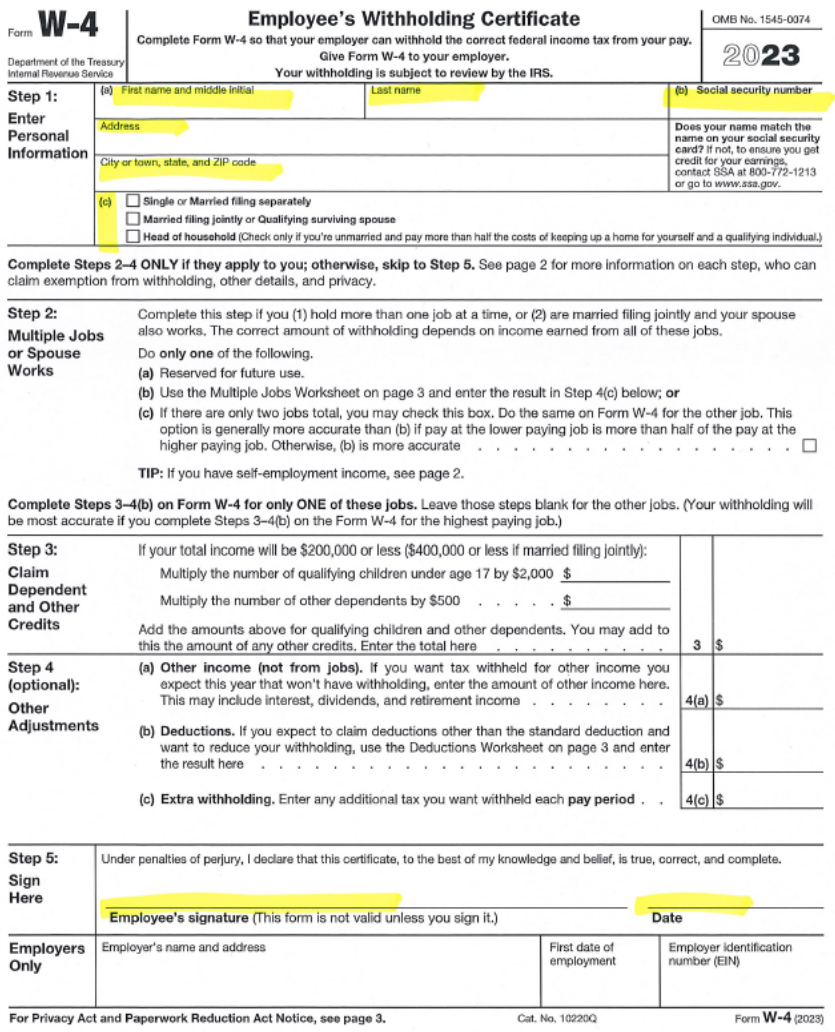
Initial Employment Forms

W-4 Federal Withholding Form

- ❑ Complete applicable sections of form
- ❑ Utilize the Multiple Jobs worksheet, as needed
- ❑ Make sure you sign and date the document
- ❑ You can submit a new form at anytime by contacting your payroll clerk Central Payroll through Employee Self Service (ESS)



Form **W-4** — **Employee's Withholding Certificate**

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Give Form W-4 to your employer. Your withholding is subject to review by the IRS.

Department of the Treasury, Internal Revenue Service

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address

City or town, state, and ZIP code

Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov.

(c) ☐ Single or Married filing separately
☐ Married filing jointly or Qualifying surviving spouse
☐ Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . 3 $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . 4(a) $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . 4(b) $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . 4(c) $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address | First date of employment | Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 3. Cat. No. 10220Q Form **W-4** (2023)

WT-4 – Wisconsin Withholding Form

- ❑ Enter total exemptions on line 1(d)
- ❑ Make sure you sign and date the document
- ❑ You can submit a new form at any time by contacting your payroll clerk, Central Payroll or through Employee Self Service (ESS)

Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting **WT-4**

Employee's Section (Print clearly)

Employee's legal name *(first name, middle initial, last name)*			Social security number	☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, check the Single box.
Employee's address *(number and street)*			Date of birth	
City	State	Zip code	Date of hire	

FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

Complete Lines 1 through 3

1. (a) Exemption for yourself – enter 1 .....
   (b) Exemption for your spouse – enter 1 .....
   (c) Exemption(s) for dependent(s) – you are entitled to claim an exemption for each dependent .....
   (d) Total – add lines (a) through (c) .....
2. Additional amount per pay period you want deducted (if your employer agrees) .....
3. I claim complete exemption from withholding (see instructions). Enter "Exempt" .....

I CERTIFY that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled. If claiming complete exemption from withholding, I certify that I incurred no liability for Wisconsin income tax for last year and that I anticipate that I will incur no liability for Wisconsin income tax for this year.

Signature _____ Date Signed _____

I-9 Employment Eligibility Verification

- ❑ Not necessary for current employees*
- ❑ Complete the top portion – it is not necessary to include your social security number on this page
- ❑ Must have 1 document from list A or 1 document from lists B and C

*A rehired employee who last worked less than two years prior to the rehire date is not required to complete a new I-9.

I-9 Form

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code

I-9 Form – List of Acceptable Documents

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

Self-Identification Form & Emergency Contact

Self-Identification Form

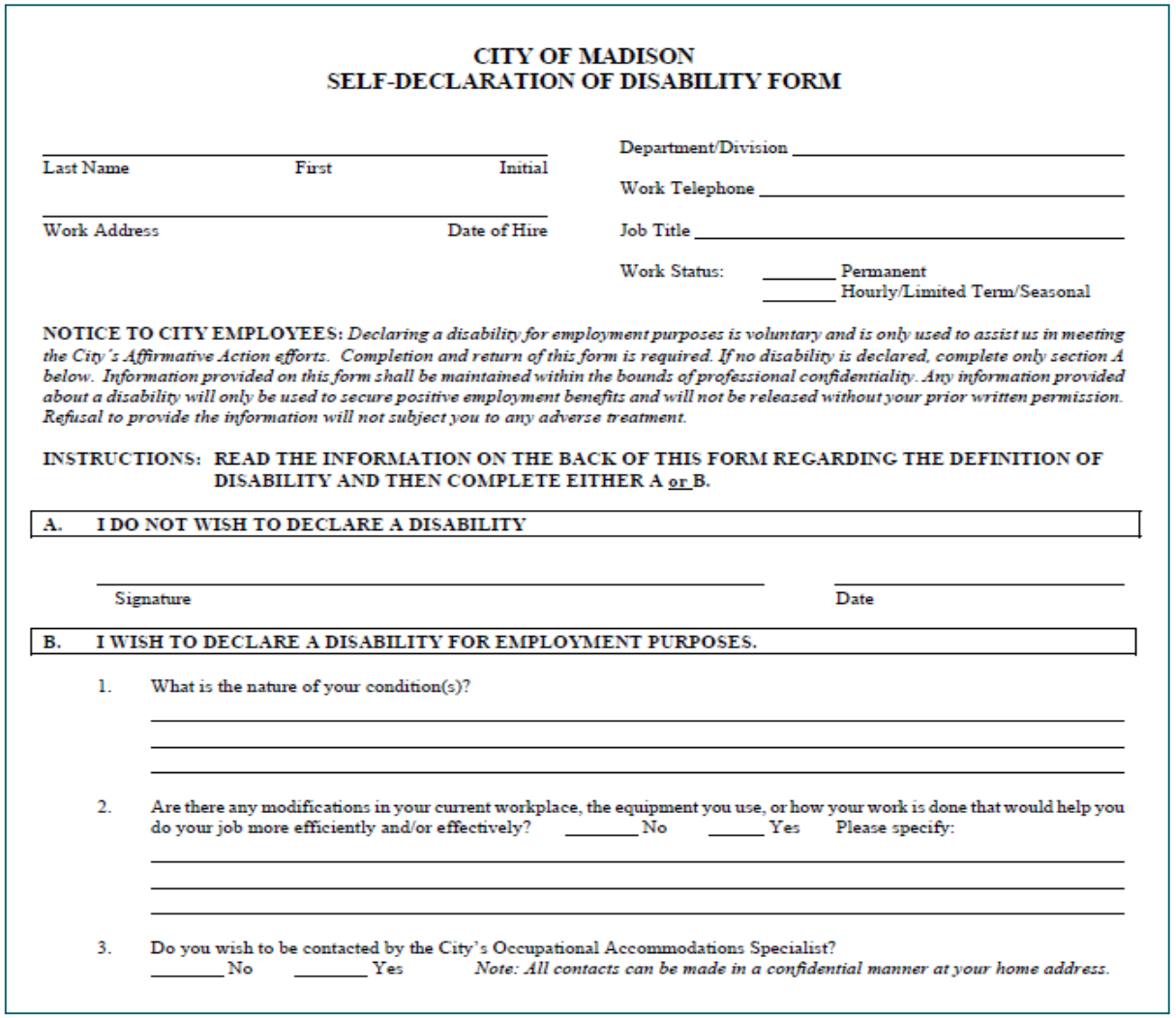
- ❑ Allows for reporting requirements to be met in compliance with Federal Law
- ❑ Disclosure is voluntary

Emergency Contact

- ❑ Complete entire form
- ❑ Try to ensure phone numbers included match employee work hours
- ❑ Sign and date

Declaration of Disability Form

- Complete entire form whether declaring a disability or not
- Allows Accommodations Specialist to initiate discussion about reasonable accommodations



CITY OF MADISON
SELF-DECLARATION OF DISABILITY FORM

Last Name First Initial

Work Address Date of Hire

Department/Division

Work Telephone

Job Title

Work Status: _____ Permanent
_____ Hourly/Limited Term/Seasonal

NOTICE TO CITY EMPLOYEES: *Declaring a disability for employment purposes is voluntary and is only used to assist us in meeting the City's Affirmative Action efforts. Completion and return of this form is required. If no disability is declared, complete only section A below. Information provided on this form shall be maintained within the bounds of professional confidentiality. Any information provided about a disability will only be used to secure positive employment benefits and will not be released without your prior written permission. Refusal to provide the information will not subject you to any adverse treatment.*

INSTRUCTIONS: READ THE INFORMATION ON THE BACK OF THIS FORM REGARDING THE DEFINITION OF DISABILITY AND THEN COMPLETE EITHER A or B.

A. I DO NOT WISH TO DECLARE A DISABILITY

Signature Date

B. I WISH TO DECLARE A DISABILITY FOR EMPLOYMENT PURPOSES.

1. What is the nature of your condition(s)?

2. Are there any modifications in your current workplace, the equipment you use, or how your work is done that would help you do your job more efficiently and/or effectively? _____ No _____ Yes Please specify:

3. Do you wish to be contacted by the City's Occupational Accommodations Specialist?
_____ No _____ Yes *Note: All contacts can be made in a confidential manner at your home address.*

Direct Deposit Authorization Form

- ❑ May use up to 3 accounts, but must have set amounts with the remainder into 1 account
- ❑ Changes can be made at any time
- ❑ May terminate through ESS or fill out Direct Deposit Termination paper form
- ❑ In ESS you do not need to list previous account information
  - ❑ **Paper Form:** You will list previous account information for termination of Direct Deposit
- ❑ Fill out account information (voided check not required if you know your account and routing numbers)
- ❑ Sign and date at the bottom

Direct Deposit Authorization Form

City of Madison
Direct Deposit Authorization Agreement

I hereby authorize the City of Madison to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account(s) indicated below and the financial institution(s) named below to credit and debit the same entries to such account(s). If this is changing banking information, please provide the previous account information.

PREVIOUS FINANCIAL INSTITUTION 1: _____ **NEW FINANCIAL INSTITUTION 1:** _____

PREVIOUS ROUTING NUMBER 1: _____ **NEW ROUTING NUMBER 1:** _____

PREVIOUS ACCOUNT NUMBER 1: _____ **NEW ACCOUNT NUMBER 1:** _____

AMOUNT 1: Net Check NET CHECKING: ☐ SAVINGS ☐

PREVIOUS FINANCIAL INSTITUTION 2: _____ **NEW FINANCIAL INSTITUTION 2:** _____

PREVIOUS ROUTING NUMBER 2: _____ **NEW ROUTING NUMBER 2:** _____

PREVIOUS ACCOUNT NUMBER 2: _____ **NEW ACCOUNT NUMBER 2:** _____

AMOUNT 2: $ _____ AMOUNT 2: $ _____ CHECKING ☐ SAVINGS ☐

PREVIOUS FINANCIAL INSTITUTION 3: _____ **NEW FINANCIAL INSTITUTION 3:** _____

PREVIOUS ROUTING NUMBER 3: _____ **NEW ROUTING NUMBER 3:** _____

PREVIOUS ACCOUNT NUMBER 3: _____ **NEW ACCOUNT NUMBER 3:** _____

AMOUNT 3: $ _____ AMOUNT 3: $ _____ CHECKING ☐ SAVINGS ☐

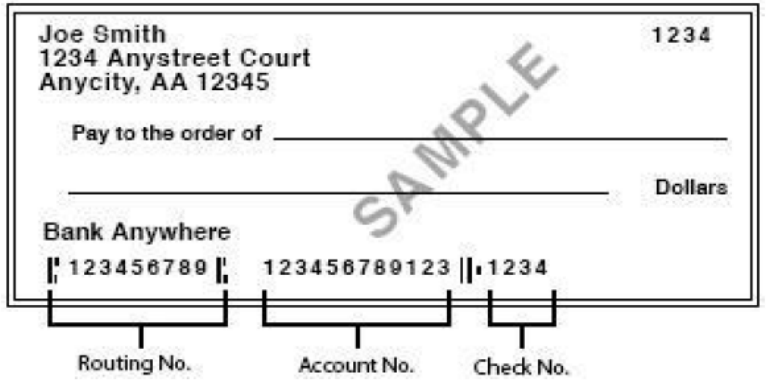
This authority is to remain in full force and effect until the City of Madison Payroll Office has received written notification from me on its termination in such time and in such manner as to afford the City of Madison a reasonable time to act on it. I understand that, due to circumstances that are beyond the City's control, there may be instances that may delay this deposit.

MUNIS EMPLOYEE NUMBER REQUIRED: _____ NAME: _____

PREVIOUS EMAIL: _____ NEW EMAIL:* _____

SIGNATURE: _____ DATE: _____

*As a participant in Direct Deposit, you will no longer receive a printed check. You will receive an electronic Direct Deposit advice via the email address you provide.



Pay and Leave Benefits

Getting Paid!!!

- ❑ Pay checks issued every two weeks
- ❑ Shaded dates are pay days
- ❑ Step increases after 6, 18, 30, and 42 months
  - *Salary schedules found online at: http://www.cityofmadison.com/finance/salarySchedule/*
- ❑ Longevity increases begin in your 5th year
  - *Longevity pay schedule found in the Employee Benefits Handbook*

Sick Leave / Floating Holidays

- **Paid Sick Leave**
  - Earn 0.5 day per pay period. Accrues to 150 day limit. Balance over 150 days (or ½ of excess balance) cashes out at the end of each year. *See Employee Benefits Handbook for details.*
  - Must be in paid status for 60% of pay period to earn.
  - For illness or injury (employee or family member). Department rules for reporting absences apply.
- **Floating Holidays**
  - 3.5 days per year (Teamsters receive 5 days after one year of service; none in the first year).
  - Can be used during probation (unlike vacation)
  - Typically not allowed to carry over (exception if start date is on or after November 1; or per contract)
    - Some contracts may allow payout.
- *If you have questions about sick leave or floating holidays, refer to the Employee Benefits Handbook*

Vacation

- **Paid Vacation Leave**
  - Most employees begin with 10 days per year
    - *Prorated for part-time employees*
  - Earn additional days every few years
    - *See vacation schedule in Employee Benefits Handbook*
  - Cannot be used during first 6 months of employment
  - Department rules apply to use of leave

Holidays and Paid Leave

- **Paid City Holidays**
  - New Year's Day, Martin Luther King Jr. Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Thanksgiving, Christmas
  - Sunday holidays celebrated Monday
  - Saturday holidays results in an extra vacation day for the year (can be used after the holiday for which it is earned)
- **City Paid Leave Days**
  - Ho-Chunk Day (day after Thanksgiving)
  - Christmas Eve
  - New Year's Eve
  - No double time paid

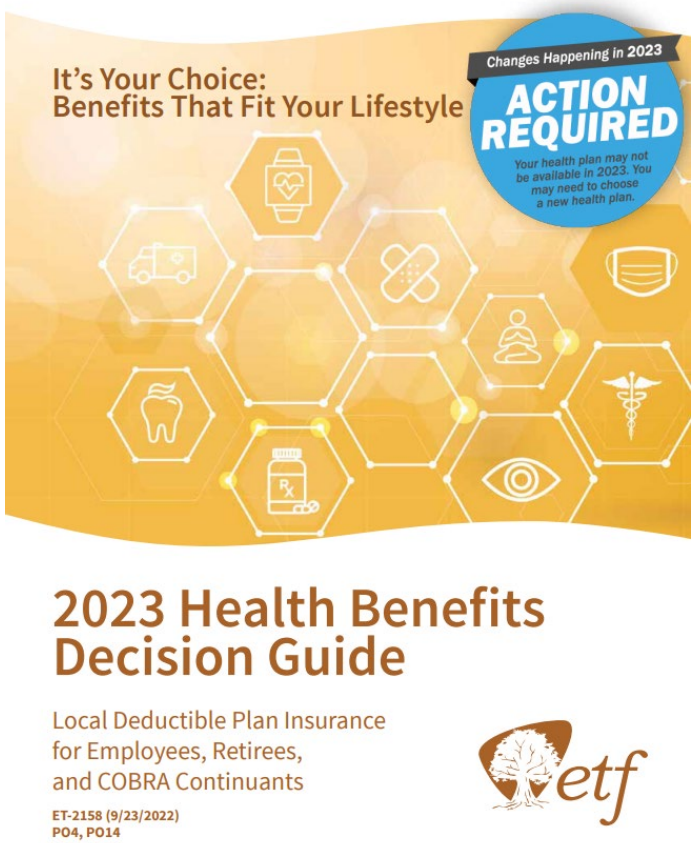
Insurance and Other Benefits

Returning Completed Form

- ❑ Submit Benefit Enrollment Forms within ____ calendar days from date of hire
  - ❑ Health, Dental, & Vision Insurance
  - ❑ Life Insurance
  - ❑ Disability Insurance
  - ❑ Flex Spending
- ❑ Benefit forms to be submitted to the Human Resources Department by _____.
- ❑ Failure to submit forms may result in waiting periods and/or underwriting

Health Insurance Information

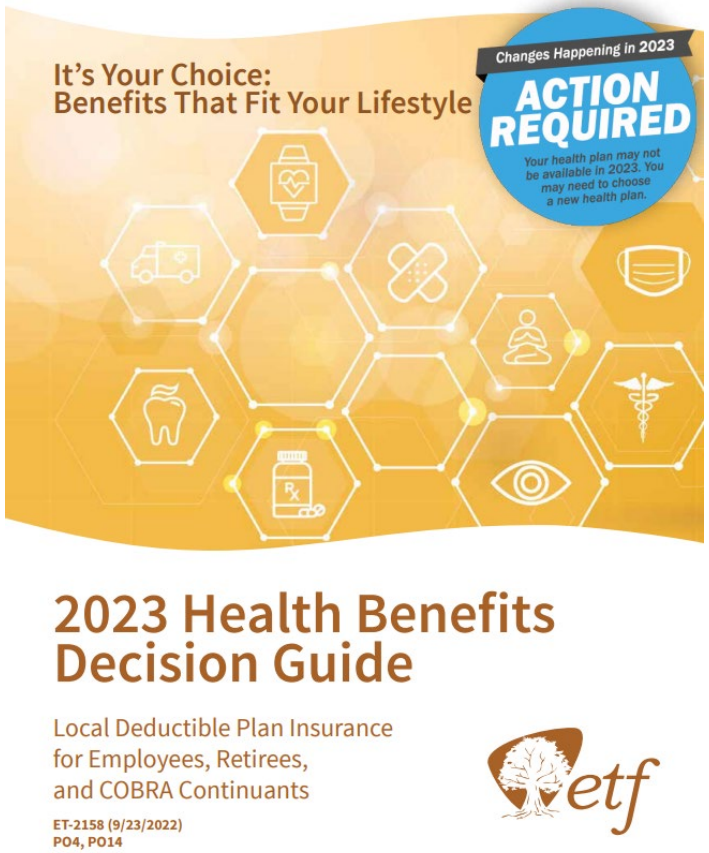
- **City Employees have 3 plans available in Dane County**
  - Dean Health Care
  - Group Health Cooperative
  - Quartz-UW Health
- **Plus**
  - Standard Plan
  - Other plans outside Dane County



etf
WISCONSIN DEPARTMENT OF EMPLOYEE TRUST FUNDS

Health Insurance Information

- **Decision Guide**
  - Includes summary of Uniform Benefits on Page 6 – provides information on benefit coverage
  - Annual open enrollment period for enrollment, changes, or cancellation without qualifying event
  - Midyear enrollment, changes, or cancellation requires qualifying event
  - More information can be found on Individual Plan websites



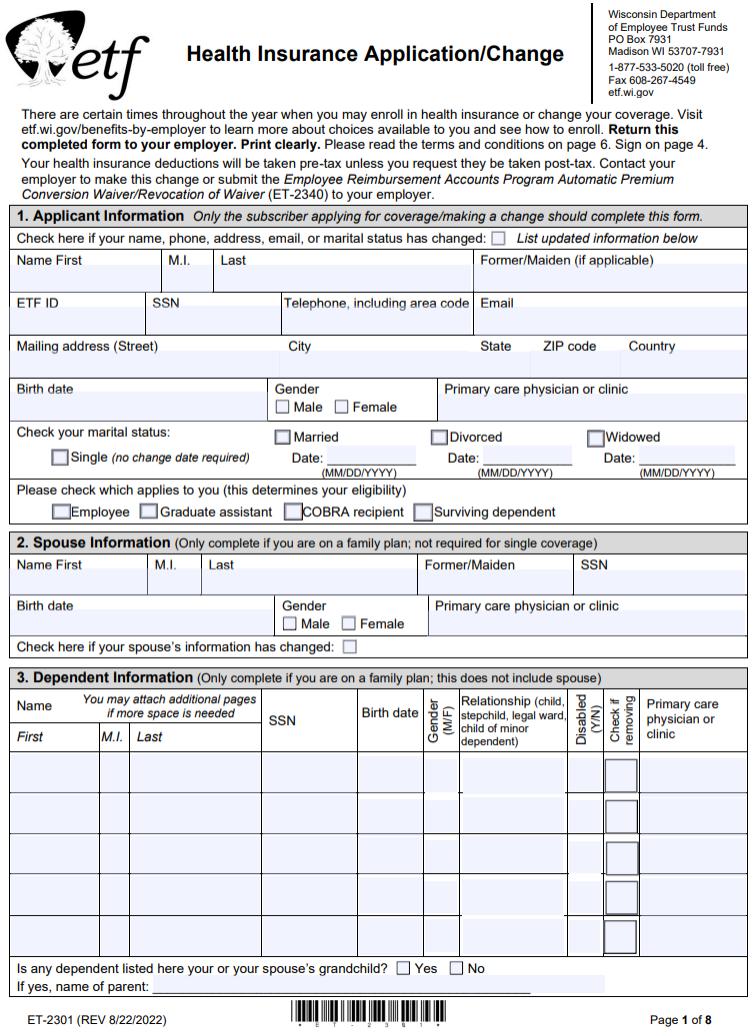
etf
WISCONSIN DEPARTMENT OF EMPLOYEE TRUST FUNDS

Prescription Pharmacy Manager

- Prescription Pharmacy Manager under all plans is **Navitus**
  - Navitus is a third-party administrator of your prescription drug program which negotiates rebates and discounts on behalf of the City's Group Health Insurance Program
  - Navitus member card is different from your health plan membership card
- Includes co-payments for most prescriptions
  - Based on formulary established by a committee of physicians and pharmacists
  - Includes four levels of co-payments:
    - Level 1: $5
    - Level 2: 20% of Navitus negotiated cost ($50 max per fill)
    - Level 3: 40% of Navitus negotiated cost ($150 max per fill)
    - Level 4: $50 Copay (must be filled at Lumicera or UW specialty pharmacies)
    - More information on page 7 of *It's Your Choice Decision Guide*

NAVITUS

Health Insurance Application



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 *Employee Reimbursement Accounts Program 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	Telephone, including area code	Email

Mailing address (Street)	City	State	ZIP code	Country

Birth date	Gender	Primary care physician or clinic
	☐ Male ☐ Female	

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

Birth date	Gender	Primary care physician or clinic
	☐ Male ☐ Female	

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	Birth date	Gender (M/F)	Relationship (child, stepchild, legal ward, child of minor dependent)	Disabled (Y/N)	Check if removing	Primary care physician or clinic
First	*M.I.*	*Last*							

Is any dependent listed here your or your spouse's grandchild? ☐ Yes ☐ No
If yes, name of parent: _____

ET-2301 (REV 8/22/2022) Page 1 of 8

Page 1

- ❑ **Section 1:**
  - ❑ Fill in all boxes
  - ❑ Make sure you include your Social Security Number (ETF ID may not have been assigned yet)
- ❑ **Section 2:**
  - ❑ Complete if applicable (only required if spouse will be covered)
- ❑ **Section 3:**
  - ❑ Complete if applicable (only required if child(ren) will be covered).
  - ❑ Ensure all names, birth dates, and SS numbers are included in Dependent Information

Health Insurance Application

Name: _____ ETF ID: _____

4. Are you eligible to enroll or make a change?
You can modify your benefits during the annual IYC open enrollment, 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 health benefits open enrollment (coverage effect January 1).
- ☐ New hire (when do you want coverage to 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 health benefits open enrollment (or your initial hire period), include birth/adoption, marriage and divorce. Visit etf.wi.gov for a *Life Change Event Guide*.

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. Choose an It's Your Choice (IYC) Plan Design
Compare factors like monthly payments, coverage levels and out-of-network benefits, and provider availability. See your health 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.

Select one:
- ☐ IYC health plan *(You must select a health plan in section 6.)*
- ☐ Access Plan *(Your health plan will be Dean Health Plan. Skip section 6.)*

Make your plan design (chosen above) 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 chose 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.

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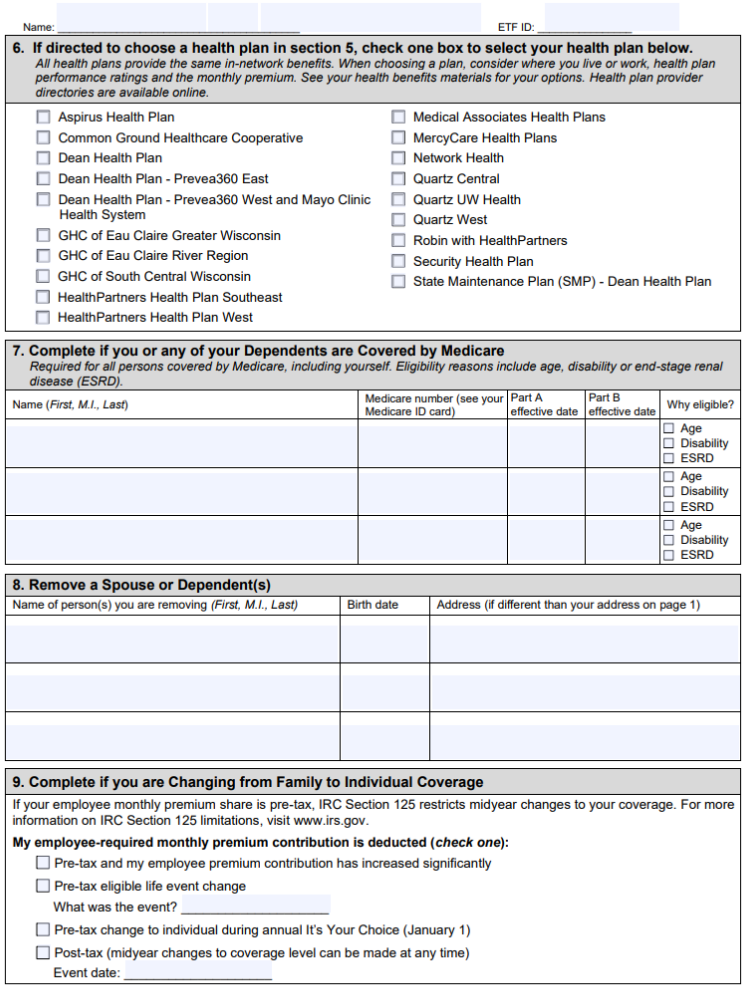
Page 2

- ❑ **Section 4:**
  - ❑ Check *New Hire*
  - ❑ Check *When my employer contributes to my premium, I choose to decline*, or *As soon as possible* (if paying 1st month's premium – make arrangements with Central Payroll for payment)
- ❑ **Section 5:**
  - ❑ Select *IYC* or *Access*, and indicate *Single* or *Family*

  The City's Health insurance program does not include HDHP or Dental, so those boxes do not apply
- ❑ **Section 6:**
  - ❑ Check the box of the health plan that you selected (if not Access Plan)

Health Insurance Application



Name: _____ ETF ID: _____

6. If directed to choose a health plan in section 5, check one box to select your health plan below.
All health plans provide the same in-network benefits. When choosing a plan, consider where you live or work, health plan performance ratings and the monthly premium. See your health benefits materials for your options. Health plan provider directories are available online.

- ☐ Aspirus Health Plan
- ☐ Common Ground Healthcare Cooperative
- ☐ Dean Health Plan
- ☐ Dean Health Plan - Prevea360 East
- ☐ Dean Health Plan - Prevea360 West and Mayo Clinic Health System
- ☐ GHC of Eau Claire Greater Wisconsin
- ☐ GHC of Eau Claire River Region
- ☐ GHC of South Central Wisconsin
- ☐ 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) - 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 It's Your Choice (January 1)
- ☐ Post-tax (midyear changes to coverage level can be made at any time)
  Event date: _____

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Page 3

- ❑ **Section 7:**
  - ❑ Fill out all of Section 7 if applicable
- ❑ **Section 8-10:**
  - ❑ Skip these Sections
- ❑ **Section 11:**
  - ❑ Complete this Section if you have additional coverage that will overlap with the insurance provided by the City

Health Insurance Application

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

Are you electing to receive the opt-out incentive for 2023? ☐ 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. 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.

Signature	Date (MM/DD/YYYY)

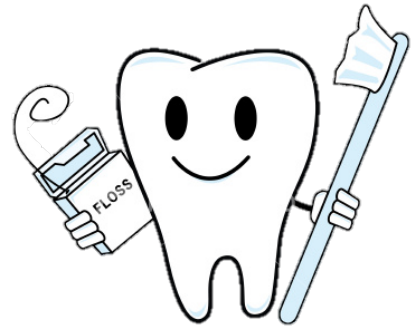
Page 4

- ❑ **Section 12:**
  - ❑ Skip Section 12
- ❑ **Section 13:**
  - ❑ Sign and date

This form must be turned in directly to Human Resources within 30 days from date of hire even if you are choosing to decline coverage!

Dental Insurance

- **Provider: Delta Dental**
  - Available to all permanent City Employees with no waiting period after effective date
  - Preferred Provider Organization (PPO)/Premier Plan – See Delta's website for PPOP and Premier Network Providers
    - Three levels of benefits available
    - Highest level of benefits if you choose a Preferred (PPO) network Dentist
    - Second highest level of benefits if you choose a Premier network Dentist
    - Out of network Dentists result in lowest level of benefits
  - Premium taken out of second biweekly paycheck of the month (for the following month's coverage)

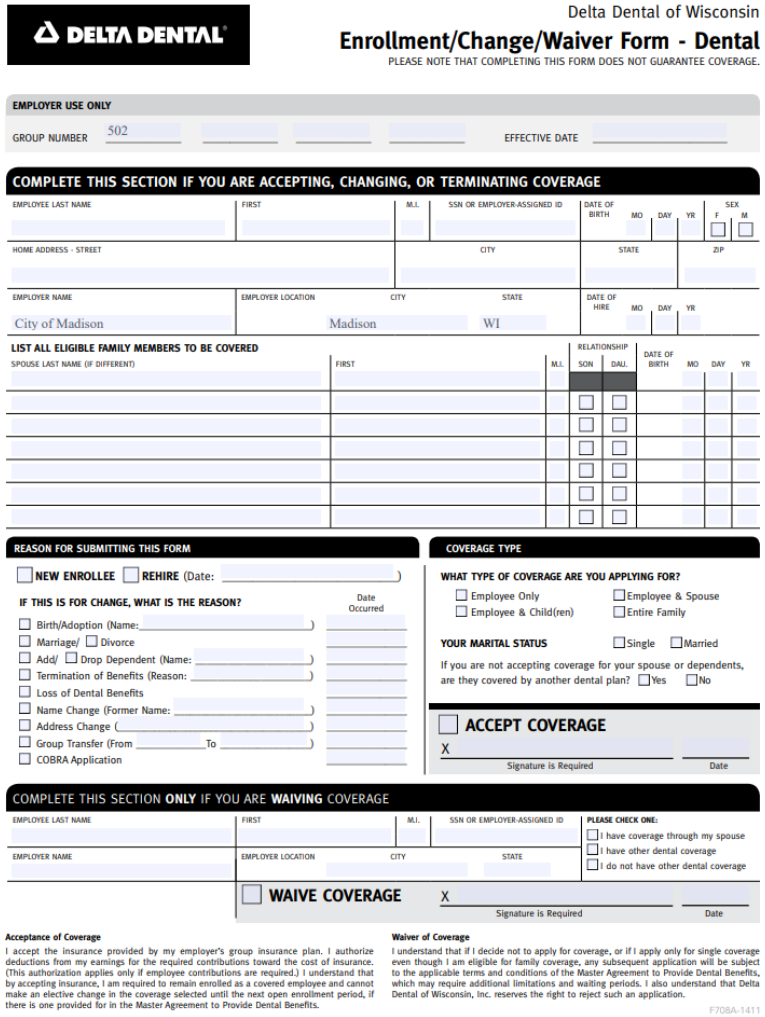


2023 Monthly Delta Dental Premiums

Employee Only: $36.60 (Single)	Employee + Spouse: $83.73
Employee + Child(ren): $84.42	Employee + Spouse + Child(ren): $127.10 (Family)

DELTA DENTAL®

Dental Insurance Application



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 502 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 MO DAY YR | SEX F M

HOME ADDRESS - STREET | CITY | STATE | ZIP

EMPLOYER NAME: City of Madison | EMPLOYER LOCATION: Madison | CITY | STATE: WI | DATE OF HIRE MO DAY YR

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

SPOUSE LAST NAME (IF DIFFERENT) | FIRST | M.I. | RELATIONSHIP SON DAU. | DATE OF BIRTH MO DAY YR

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:

EMPLOYER NAME | EMPLOYER LOCATION | CITY | STATE

- ☐ I have coverage through my spouse
- ☐ 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.

F708A-1411

- **Application**
  - Complete paper application and return to HR within 30 days of date of hire even if waving coverage!!
  - City group number is 502
  - Enrollment only upon hire or in Open Enrollment period or with qualifying event
  - Dental cannot be terminated mid-year except with qualifying event

DELTA DENTAL®

Vision Insurance

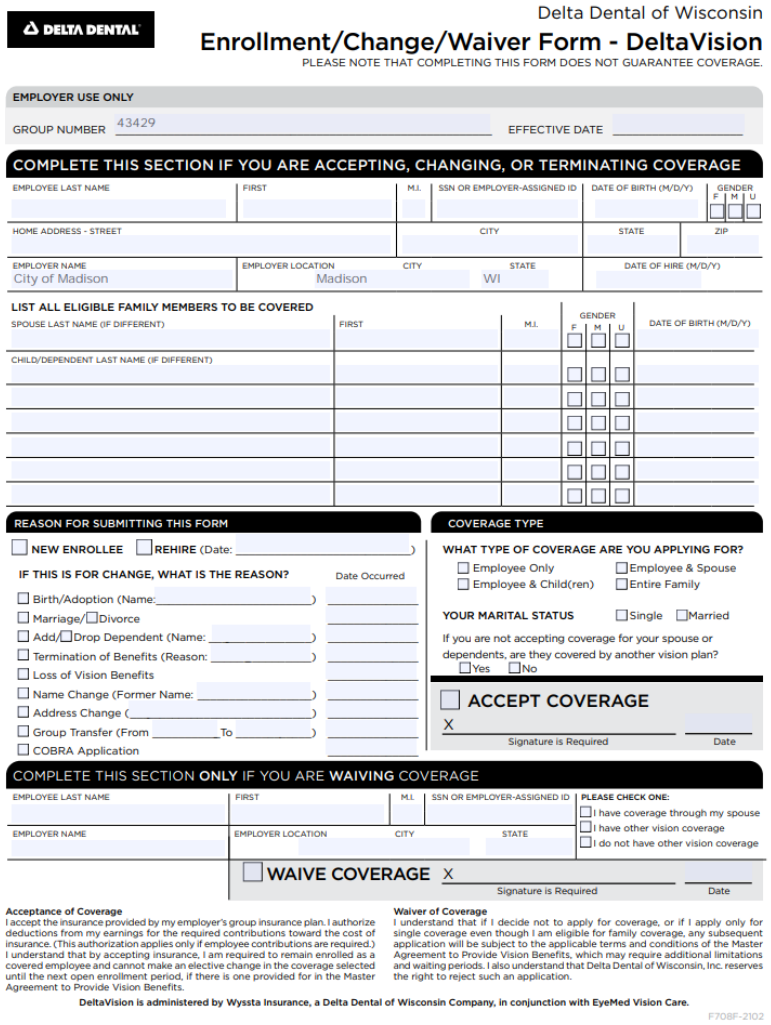
- **Provider is DeltaVision**
  - Available to all permanent City employees with no waiting period after effective date
  - City group number is 43429
  - Network Benefit/Non-Network Reimbursement – See Delta's website for Network providers
  - Premium taken out of second biweekly paycheck of the month (for the following month's coverage)

2023 Monthly DeltaVision Premiums

Employee Only: $5.97 (Single)	Employee+Spouse: $11.94
Employee+Child(ren): $12.19	Employee+Spouse+Child(ren): $18.16 (Family)

DeltaVision®

Vision Insurance Application



DELTA DENTAL

Delta Dental of Wisconsin

Enrollment/Change/Waiver Form - DeltaVision

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

EMPLOYER USE ONLY

GROUP NUMBER 43429 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 City of Madison | EMPLOYER LOCATION Madison | CITY | STATE WI | 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 Vision 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 vision plan?
☐ Yes ☐ No

☐ **ACCEPT COVERAGE**

X Signature is Required Date

COMPLETE THIS SECTION ONLY IF YOU ARE WAIVING COVERAGE

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

EMPLOYER NAME | EMPLOYER LOCATION | CITY | STATE

☐ **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 Vision 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 Vision 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.

DeltaVision is administered by Wyssta Insurance, a Delta Dental of Wisconsin Company, in conjunction with EyeMed Vision Care.

F708F-2102

- **Application**
  - Complete paper application and return to HR within 30 days of date of hire even if waiving coverage!!
  - Enrollment only upon hire in Open Enrollment period or with qualifying event
  - Vision insurance cannot be terminated mid-year except with qualifying event

DeltaVision®

Flexible Spending

- Your contributions will be deducted in equal amounts from each paycheck, **pre-tax, throughout the plan year.**
- **You will have access to your total Healthcare FSA annual contribution immediately at the start of the plan year. Dependent Care FSA funds are available up to the current account balance only.**

- ❑ Enrollment Forms must be completed and turned into HR within 30 days of hire
- ❑ Annual Enrollment form required each year if participating
- ❑ Healthcare Flexible Spending Account
  - ❑ $3,050 maximum allowed annually (2023)
- ❑ Dependent Care Flexible Spending Account
  - ❑ $5,000 maximum allowed annually (regardless of number of dependents)
  - ❑ $2,500 maximum allowed annually for married individuals filing separately

- Flexible spending funds cannot be used toward employee health, dental, or vision premium contributions, but can be used for the annual deductibles

TASC®

Flexible Spending

- **Process**
  - Your TASC Card can be used to make eligible purchases directly from vendors
  - Requests for reimbursement can be made via TASC Mobile App, online, or paper form (fax or mail)
  - Reimbursements can be directly deposited in checking/savings account
  - Funds cannot be transferred between health and daycare accounts
  - Eligible claims must be incurred during the plan year (with grace period thru March 15) and submitted by March 31
  - For more information, including information on eligible purchases, go to www.tasconline.com

Flex Spending Enrollment Form

TASC

EMPLOYEE ENROLLMENT FORM
Flexible Spending Account (FSA)
City of Madison

Instructions: Please sign, date, and complete each line on the enrollment form. Enter zero (0) where no amount is being elected. Return the completed and signed form to your employer for processing.

For Employer to complete where applicable:

Client/Company Name:	City of Madison	TASC ID:	4422-0923-3494
Participant Plan Effective Date:		First Payroll Date:	

INDIVIDUAL/PARTICIPANT INFORMATION

All fields are required for account setup. Information is confidential and is not used for marketing purposes.

First Name:		MI:		Last Name:	
TASC ID (if known):		Email Address:			
Primary Phone:		Mobile Phone:			
Primary Address:	Address Line 1:			Apt:	
	Address Line 2:				
	City:				
	State:		ZIP/Postal Code:	+4	
Date of Birth:		Hire Date:		Payroll Frequency:	

ANNUAL ELECTIONS

Prior to completing your election amounts below, please refer to the instructions on page 2.

	I select the following benefits and amount(s) to be deducted pretax:	Employee Annual Election Amount	EMPLOYER Annual Contribution	Maximum Employee Annual Election
☐	Healthcare FSA	$	$	$
☐	Dependent Care FSA (Daycare Expenses)	$	$	$

TASC CARD

You will receive one TASC Card to use for your benefit account(s). You may request **one additional card** for your spouse or dependent free of charge. Cards are mailed to your home address 7-10 days after your enrollment has been processed.

To request an additional TASC Card for your spouse or dependent, print their name below (or request via TASC web portal):

1	Spouse or Dependent Name (First, MI, Last):	
2	Dependent Name (First, MI, Last):	
3	Dependent Name (First, MI, Last):	

****AUTHORIZATION SIGNATURE REQUIRED ON PAGE 2****

- **Total Administrative Services Corporation (TASC)**
- **Enrollment Form**
  - Complete paper application and return to HR within 30 days of date of hire
  - Enrollment only upon hire or in Open Enrollment period or with qualifying event
  - Flex spending contributions cannot be terminated or changed mid-year except with qualifying event
  - Once first payroll has been processed, neither coverage, election, nor contribution can change without a qualifying event
- **Examples of qualifying events**

TASC

Income Continuation Insurance

- **Also called Wage Insurance, Disability Insurance**
  - Provided through The Hartford
  - Insures employees up to 65% of regular salary ($1,875 maximum weekly benefit)
  - Benefits cover non-work-related injury and illness
  - Provides short (3 years) and long-term benefits (up to retirement)
  - Must exhaust all available sick leave before payments start
- **Enrollment**
  - Coverage begins on date of enrollment
  - Enrollment required within 30 days of date of hire
  - Enrollment card must be filled out even if waiving coverage and turned in to HR
  - No other opportunity to enroll without underwriting

Income Continuation Insurance

City of Madison
SHORT TERM & LONG TERM DISABILITY INSURANCE
ENROLLMENT/CHANGE FORM

Submit completed form to:
City of Madison Human Resources Department
215 Martin Luther King Jr Blvd Suite 261, Madison, WI 53703

Check all applicable boxes:

☐ **Initial Enrollment*** ☐ **Beneficiary Designation Change** ☐ **Name Change** ☐ **Waive/Cancel Coverage**

*** Enrollment beyond 31 days from date first eligible requires approved Evidence of Insurability application**

SECTION 1: ***Employee Information*** **(COMPLETION OF THIS SECTION IS REQUIRED)**		
PRINT NAME *(Last, First, Middle Initial)*		**DATE OF BIRTH** *(mm/dd/yyyy)*
List any Former Name(s) *(Last, First, Middle Initial)* **(Separate multiple former names with a semicolon (;))**		
DEPARTMENT NAME	**DATE OF PERMANENT HIRE**	**MUNIS ID #**

SECTION 2: ***Beneficiary Designation***

BENEFICIARY DESIGNATION *(See reverse side for suggested wording)*

Primary: _____

_____

Secondary: _____

_____

SECTION 3: ***Acceptance of Coverage and/or Acknowledgment of Beneficiary Designation***

☐ **I hereby request the amount(s) and form(s) of insurance coverage for which I am or may become eligible under the insurance policy or policies. I authorize the deduction from my earnings of the amount required to cover my share of the premiums, if any. I reserve the right to revoke this deduction authorization at any time on written notice.**

☐ **Under and subject to the terms of the Group Policy, I hereby annul and revoke any former Designation of Beneficiary by me made, and I now designate my Beneficiary or Beneficiaries as indicated above.**

Signature _____

Date Signed _____

SECTION 4: ***Waive or Cancel Coverage*** **(COMPLETE THIS SECTION ONLY IF WAIVING/CANCELING COVERAGE)**

☐ **I do not wish to participate in the City of Madison's Group Short Term & Long Term Disability Insurance Plan.**

Signature _____

Date Signed _____

FOR EMPLOYER USE ONLY
EFFECTIVE DATE OF COVERAGE *(mm/dd/yyyy)*

INSTRUCTIONS

1. **Complete all sections of the form that are relevant to the enrollment/change that you are making.**
2. **The Signature of the Insured must be in non-erasable ink.**
3. **If the proposed beneficiary is a married woman, fill in her own given first and middle names, not those of her husband.**
4. **If you have named more than one beneficiary and have not designated the share for each, the benefits will be paid equally or to the survivor.**
5. **If your beneficiary is a minor, benefits will not be released directly to the minor child but instead to the court-appointed guardian of the estate (or property) of the minor child. Guardianship of a minor child's "person" is not the same as guardianship of a minor child's property.**

EXAMPLE WORDING OF TYPICAL BENEFICIARY DESIGNATIONS

1. **One beneficiary only:** Mary E. Doe, Wife. (A married woman should not be designated as Mrs. John Doe)
2. **Two beneficiaries (equal amounts):** John H. Doe, Father; and Mary E. Doe, Mother, equally or the survivor
3. **Three or more beneficiaries (equal amounts):** John H. Doe, Father; Mary E. Doe, Mother; and Stella Doe, Sister, equally or the survivor(s).
4. **Unequal amounts:** 75% to John H. Doe, Husband; 25% to Elizabeth M. Jones, Mother.
5. **Primary and Contingent beneficiaries:** John H. Doe, Husband, if living; otherwise to Jeff W. Doe, Son; and Jane M. Smith, Daughter, equally or the survivor.
6. **Partnership beneficiary:** Smith, Jones, and Brown, a partnership consisting of John A. Smith, Elizabeth M. Jones, and Henry D. Brown.
7. **Common Disaster Clause:** John H. Doe, Husband, if living on the 15th day after the death of the insured; otherwise to Jeff W. Doe, Son; and Jane M. Smith, Daughter, equally or the survivor.
8. **Estate of the Insured** (certified estate papers issued by the Court are required)
9. **Trust** (a Charitable, Living, or Testamentary trust may be named. Employees are strongly encouraged to seek professional advice to correctly provide this option.)

For additional information on this plan, visit http://www.cityofmadison.com/human-resources/benefits/wage-insurance

Income Continuation Insurance

- **Wage Insurance Premiums**
  - Taken out of **second check of each month**
  - Percent of premium based on combination of bi-weekly wages, accumulated sick leave, and sick leave used and accrued per annual tracking period (Sept-Sept), and adjusted annually
  - Premium paid by City of accumulated sick leave over 100 or 120 days, depending upon compensation group
  - Employee must be employed for 6 months as of recalculation in order to be eligible for premium to change. If employment begins after April, first recalculation will be October of following year.

Sick Leave Used	Sick Leave Accrued	Employee Pays
0-3.00 days	10.00-13.00 days	0%
3.01-4.00 days	9.00-9.99 days	20%
4.01-5.00 days	8.00-8.99 days	40%
5.01-6.00 days	7.00-7.99 days	60%
6.01-7.00 days	6.00-6.99 days	80%
7.01+ days	0-5.99 days	100%

Life Insurance

- **Life Insurance** (Employee, Dependent)
  - Provided through The Hartford
  - Employee coverage available in four levels
    - Basic (highest annual earnings rounded up)
    - Basic + 50% Supplemental (1.5 X highest earnings)
    - Basic + 100% Supplemental (2 X highest earnings)
    - Basic + 200% Supplemental (3 X highest earnings)
  - Dependent coverage available in two levels
    - 1 unit ($5,000 per child and $10,000 for spouse)
    - 2 units ($10,000 per child and $20,000 for spouse)
- **Enrollment**
  - Within 30 days of date of hire, must return form even if waiving
  - Enrollment after initial enrollment period requires underwriting or qualifying event

Group Term Life Insurance

City of Madison
GROUP TERM LIFE INSURANCE, DEPENDENT LIFE, and ACCIDENTAL DEATH AND DISMEMBERMENT ENROLLMENT/CHANGE FORM

Submit completed form to:
City of Madison Human Resources Department
215 Martin Luther King Jr Blvd Suite 261, Madison, WI 53703

Check all applicable boxes:

☐ **Initial Enrollment*** ☐ **Reinstate Coverage** ☐ **Reduce Coverage** ☐ **Remove Dependent Coverage**
☐ **Increase Coverage*** ☐ **Information Change** ☐ **Beneficiary Change** ☐ **Terminate Coverage**

* **Enrollment beyond 31 days from date first eligible, or Increase Coverage, requires qualifying event or approved Evidence of Insurability application**

SECTION 1: ***Employee Information and Coverage Elections*** **(COMPLETION OF THIS SECTION IS REQUIRED)**

PRINT NAME *(Last, First, Middle Initial)*	**DATE OF BIRTH** *(mm/dd/yyyy)*

List any Former Name(s) *(Last, First, Middle Initial)* **(Separate multiple former names with a semicolon (;))**

DEPARTMENT NAME	**DATE OF PERMANENT HIRE**	**MUNIS ID # (EMPLOYEE ID #)**

SELECT EMPLOYEE COVERAGE:
☐ **BASIC COVERAGE only**
☐ **BASIC plus SUPPLEMENTAL COVERAGE:**
☐ **PLUS 50%** ☐ **PLUS 100%** ☐ **PLUS 200%**

SELECT DEPENDENT COVERAGE:
(units of coverage for employee's spouse and/or child(ren))
☐ **1 UNIT** or ☐ **2 UNITS** or ☐ **NONE**
Beneficiary for Dependent Coverage is the Employee

SECTION 2: ***Beneficiary Designation***

BENEFICIARY DESIGNATION: *PRINT (See reverse side for suggested wording)*

Primary: _____

_____

Secondary: _____

_____

SECTION 3: ***Acceptance of Coverage and/or Acknowledgment of Beneficiary Designation***

☐ **I hereby request the amount of life insurance for which I am eligible and authorize the deduction from my earnings of the amount required to cover my share of the premiums. I reserve the right to revoke this deduction authorization and thereby understand that coverage ceases at any time on written notice.**

☐ **Under and subject to the terms of the Group Policy, I hereby revoke any former Designation of Beneficiary by me made, and I now designate my Beneficiary or Beneficiaries as indicated above.**

Signature _____

Date Signed _____

SECTION 4: ***Waive or Cancel Coverage*** **(COMPLETE THIS SECTION ONLY IF WAIVING/CANCELING COVERAGE)**

☐ **I do <u>not</u> wish to participate in the City of Madison's Group Life Insurance, Dependent Life, and AD&D Plan.**

Signature_____

Date Signed_____

INSTRUCTIONS

1. **Complete all sections of the form that are relevant to the enrollment/change that you are making.**
2. **The Signature of the Insured must be in non-erasable ink.**
3. **If the proposed beneficiary is a married woman, fill in her own given first and middle names, not those of her husband.**
4. **If you have named more than one beneficiary and have not designated the share for each, the benefits will be paid equally or to the survivor.**
5. **If your beneficiary is a minor (under age 18 in the State of Wisconsin), benefits will not be released directly to the minor, but instead to the court-appointed guardian of the estate (or property) of the minor. Guardianship of a minor's "person" is not the same as guardianship of a minor's property.**

EXAMPLE WORDING OF TYPICAL BENEFICIARY DESIGNATIONS

1. **One beneficiary only:** Mary E. Doe, Wife. (A married woman should not be designated as Mrs. John Doe)
2. **Two beneficiaries (equal amounts):** John H. Doe, Father, and Mary E. Doe, Mother, equally or the survivor
3. **Three or more beneficiaries (equal amounts):** John H. Doe, Father, Mary E. Doe, Mother, and Stella Doe, Sister, equally or the survivor(s).
4. **Unequal amounts:** 75% to John H. Doe, Husband, 25% to Elizabeth M. Jones, Mother.
5. **Primary and Contingent beneficiaries:** John H. Doe, Husband, if living; otherwise to Jeff W. Doe, Son, and Jane M. Smith, Daughter, equally or the survivor.
6. **Partnership beneficiary:** Smith, Jones, and Brown, a partnership consisting of John A. Smith, Elizabeth M. Jones, and Henry D. Brown.
7. **Common Disaster Clause:** John H. Doe, Husband, if living on the 15th day after the death of the insured; otherwise to Jeff W. Doe, Son, and Jane M. Smith, Daughter, equally or the survivor.
8. **Estate of the Insured** (certified estate papers issued by the Court are required)
9. **Trust** (a Charitable, Living, or Testamentary trust may be named. Employees are strongly encouraged to seek professional advice to correctly provide this option.)

For additional information on this plan, visit http://www.cityofmadison.com/human-resources/benefits/life-insurance

Life Insurance

- **"Term" insurance**, meaning coverage for the term of which premium is paid
- **Beneficiaries** can be anyone, even an organization (not animals)
  - Beneficiary can be changed at any time by filling out a change form
- **Life Insurance Premium**
  - Based on age and benefit amount
  - Inexpensive – increases over time
  - Taken from 1st paycheck of mo.
  - Payments continue into retirement
  - No premium after 70 if working, 65 if retired, and still get 25+ percent of Basic coverage paid!

Age Group	Cost per $1000 Coverage
Under 25	.05
25-29	.06
30-34	.08
35-39	.09
40-44	.10
45-49	.15
50-54	.23
55-59	.43
60-64	.57
65-69*	.57
Over 69*	**Free - basic coverage only**

***Over age 65 rates and coverage apply only if working**

Pension

- Defined Benefit Plan through Employee Trust Funds – Wisconsin Retirement System
  - Automatically enrolled
  - Comes out of paycheck each pay period pre-tax
- Eligibility
  - Must be 60% full-time equivalent or more for permanent employees expected to work at least 12 months and hired after July 1, 20211
  - Hourly employees must work 12 months and 1,200 hours
  - Employees hired after July 1, 2011, become vested after 5 years of WRS creditable service

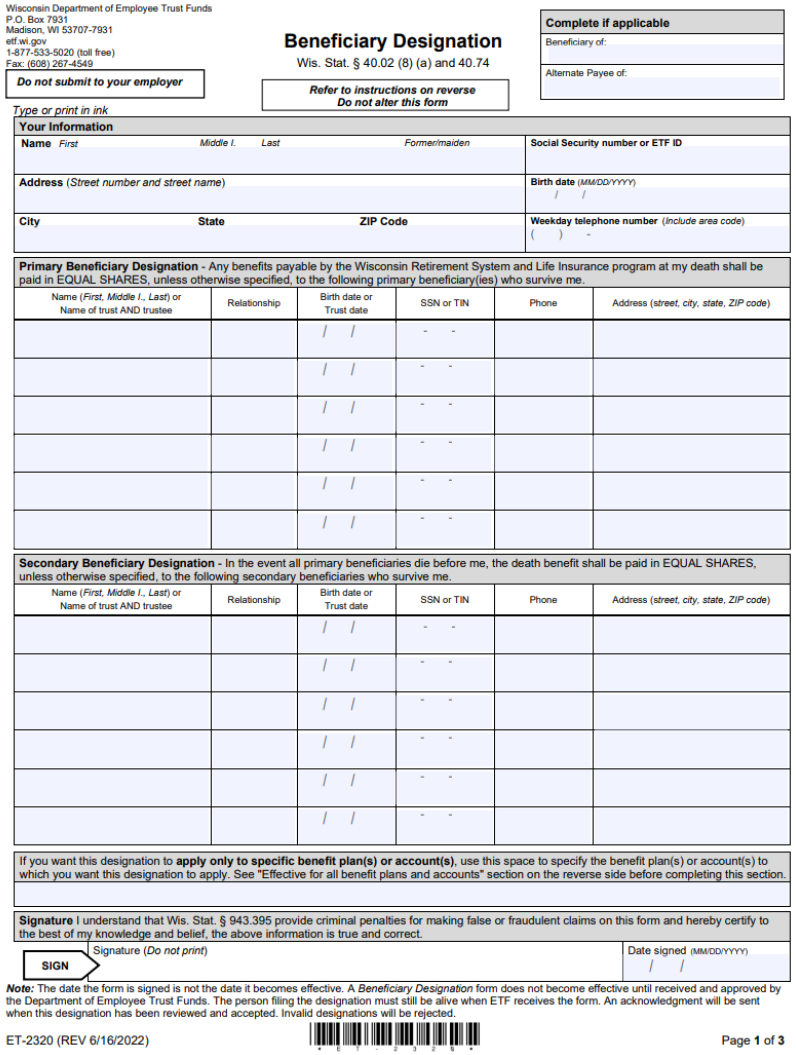
Pension

- **Contributions**
  - **Mandatory**
    - City pays employer portion of 6.80% (2023 rate)
    - Employee pays employee portion of 6.80% (2023 rate)
  - **Voluntary**
    - Additional contributions can be made after taxes to supplement regular WRS contributions
    - Additional contributions are subject to federal limits
  - **Service Credit Purchase**
    - You left WRS employment, took a separation benefit and returned to WRS employment. You may be eligible to buy **Forfeited Service.**
    - You are not a teacher and you began your WRS service before January 1, 1973. You may be eligible to buy **Qualifying Service.**
    - You have worked for a non-WRS public employer at the federal, state, or local level. You may be eligible to buy **Other Governmental Service.**
    - http://etf.wi.gov/publications/et4121.pdf

Pension

- **Funds**
  - Contributions automatically placed in Core Trust Fund which is more stable and invested in a combination of bonds, fixed income securities and common stock
  - Employees can opt to place 50% of contributions in more risky variable fund which is invested in diversified equity portfolio
  - Variable Fund may be effective on first day of WRS coverage if received within 30 calendar days after date WRS participation begins.
  - Employees can sign up for variable at any time but contributions to variable do not start until Jan. 1 of next year.
  - Once variable is dropped, however, there is no re-entry.
- **Retirement**
  - Normal age is 65, or 54 for protective service employees
  - Minimum age is 55, or 50 for protective service employees
  - No age reduction factor for monthly benefit if employee has 30 years creditable service and retires at age 57 or later
  - Intent is that benefit will provide total retirement income of between 50% and 85% of salary for career employee when added to Social Security

Pension



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**

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.

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- **Beneficiary Designation**
  - If no form is filled out ETF will follow standard sequence
  - Incomplete form will not be considered valid
  - No white outs, cross outs, or changes are allowed
  - Rejected forms will be returned to you
  - Remember it is in effect until you change it! It is your responsibility to ensure it remains up-to-date and accurate

Deferred Compensation

- **457 Plans**
  - Similar to 401k but for public employees, with no City match to employee contributions
  - Voluntary investment opportunity offered through outside providers
    - Mission Square
    - Fidelity
  - Contribution limits of $22,500 or (over 50) $30,000
  - Contributions can be started, stopped, or changed at any time, and minimum contribution usually $25
  - While working for City, funds can only be withdrawn if approved through Emergency Withdrawal process
  - Contact MissionSquare or Fidelity for more information

Fidelity INVESTMENTS

MissionSquare RETIREMENT

Mandatory Paperwork

Mandatory Paperwork Due to HR by _____.

- ❑ Orientation Checklist – Signed & Dated
- ❑ W-4 and Wisconsin Withholding Forms
- ❑ I-9 Form
- ❑ Self-Declaration of Disability Form
- ❑ Emergency Contact Form
- ❑ Self-Identification Form

Return to Human Resources

- In-Person at MMB Suite 261 (215 Martin Luther King Jr. Blvd, Madison, WI 53703)
- Inter-D
- Email benefits@cityofmadison.com (Type “#secure” in subject line of email message sent from City email account)

Return Completed Benefit Forms to HR by _____.

- ❑ Health, Dental, & Vision Insurance
- ❑ Life Insurance
- ❑ Disability Insurance
- ❑ Flex Spending

Failure to submit forms may result in waiting periods and/or underwriting.

Return to Human Resources

- In-Person at MMB Suite 261 (215 Martin Luther King Jr. Blvd, Madison, WI 53703)
- Inter-D
- Email benefits@cityofmadison.com (Type “#secure” in subject line of email message sent from City email account)

Congrats & welcome!

What questions do you have?

Denise Nettum or Katarina Klafka
608-266-4615
benefits@cityofmadison.com

Agenda

- ✓ City of Madison Mission, Vision, Values, and Service Promise
- ✓ Racial Equity and Social Justice at the City
- ✓ Administrative Procedure Memoranda (APM's)
- ✓ Employee Assistance Program (EAP)
- ✓ Employee Perks
- ✓ Initial Employment Forms
- ✓ Pay & Leave Benefits
- ✓ Insurance & Other Benefits
- ❑ Associations Presentation

✓ Check it off as you go!
✓ Sign and date at the end and return to Human Resources in-person, Inter-d or fax.

Associations Presentation