Welcome to the City of Madison

Employee Orientation

Introductions

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

Agenda

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

✓ Check it off as you go!
✓ Sign, date, and return to Human Resources by required deadlines.

Associations Presentation

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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 (APMs)
Employee Assistance Program
Employee Perks

Mayoral Administrative Procedure Memoranda (APMs)

- APMs are rules that guide **ALL** City employees at work and ensure a welcoming, safe, and fair environment for all employees and members of the community.
- You can find all APMs on EmployeeNet. Copies of some core APMs are also in your orientation bag, including:
  - 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
- Also included in your orientation bag is information about:
  - The City Ethics Code
  - IT Records Management
  - Worker's Compensation

Employee Assistance Program (EAP)

- The City's EAP provides 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
  - Phone: (608) 266-6561 (internal) | 1-800-236-7905 (external 24/7 EAP)

City of Madison Employee Perks

- Free Tap Card Bus Pass
- Affinity and Identity Based Groups
- Trainings available through HR
- Madison Credit Union
- Well Wisconsin Program + $150 Wellness Incentive
- Discounts
  - Nationwide Pet Insurance
  - Select Overture Center Performances
  - Cell Phone Plans (check with your provider)
  - Dell Employee Purchase Program

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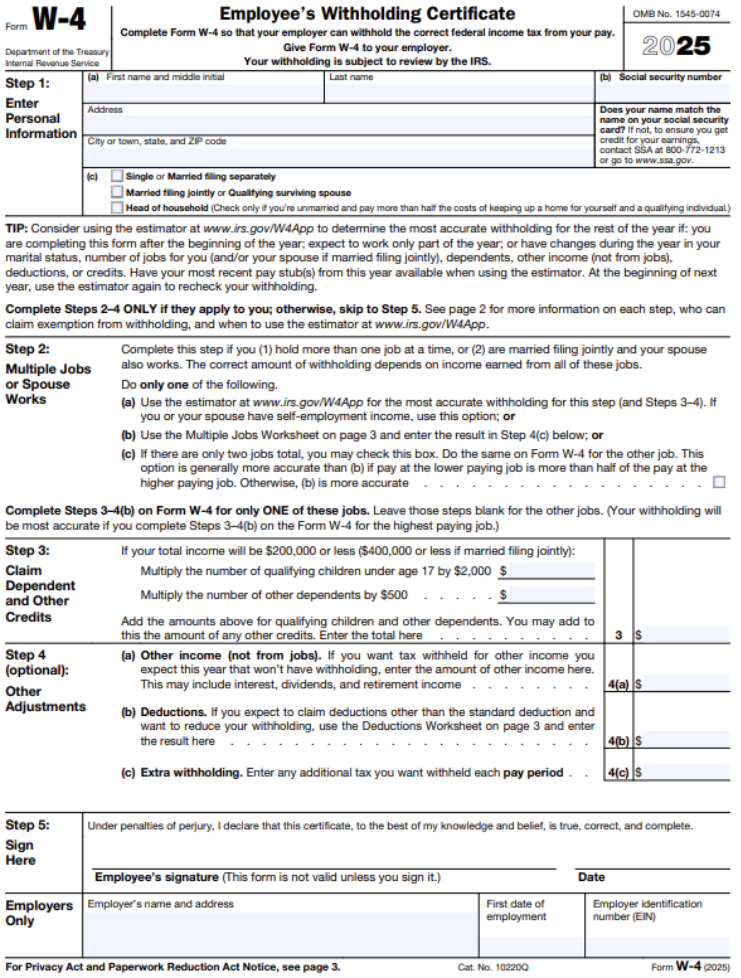
Initial Employment Forms

W-4 Federal Withholding Form

- ❑ Complete all applicable sections of form
- ❑ Make sure you sign and date the document and put your SSN in box 1b!
- ❑ Utilize the Multiple Jobs worksheet if needed

Note: You can submit updates at any time either via Employee Self Service (ESS) or by submitting a new form to your Payroll Clerk/HR



Form **W-4** — Department of the Treasury, Internal Revenue Service

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.

OMB No. 1545-0074

2025

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.)

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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, and when to use the estimator at *www.irs.gov/W4App*.

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) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(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 . . . . . ☐

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** (2025)

WT-4 – Wisconsin Withholding Form

- ❑ Enter total exemptions on line 1(d)
- ❑ Make sure you sign and date the document and put your SSN and DOB on the form!

Note: you can submit updates at any time either via Employee Self Service (ESS) or by submitting a new form to your Payroll Clerk/HR

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
Employee's address *(number and street)*			Date of birth
City	State	Zip code	Date of hire

☐ Single
☐ Married
☐ Married, but withhold at higher Single rate.
Note: If married, but legally separated, check the Single box.

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 **each** from lists B and C
- ❑ Section 1 **must** be completed on the day of hire
- ❑ Section 2 (Verification) **must** be completed within 3 business days of hire to comply with Federal regulations

*A rehired employee who last worked less than 1 year 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 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the Instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			Additional Information		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.	First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

I-9 Form – List of Acceptable Documents

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: 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 individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Self-Identification Form & Emergency Contact

Self-Identification Form

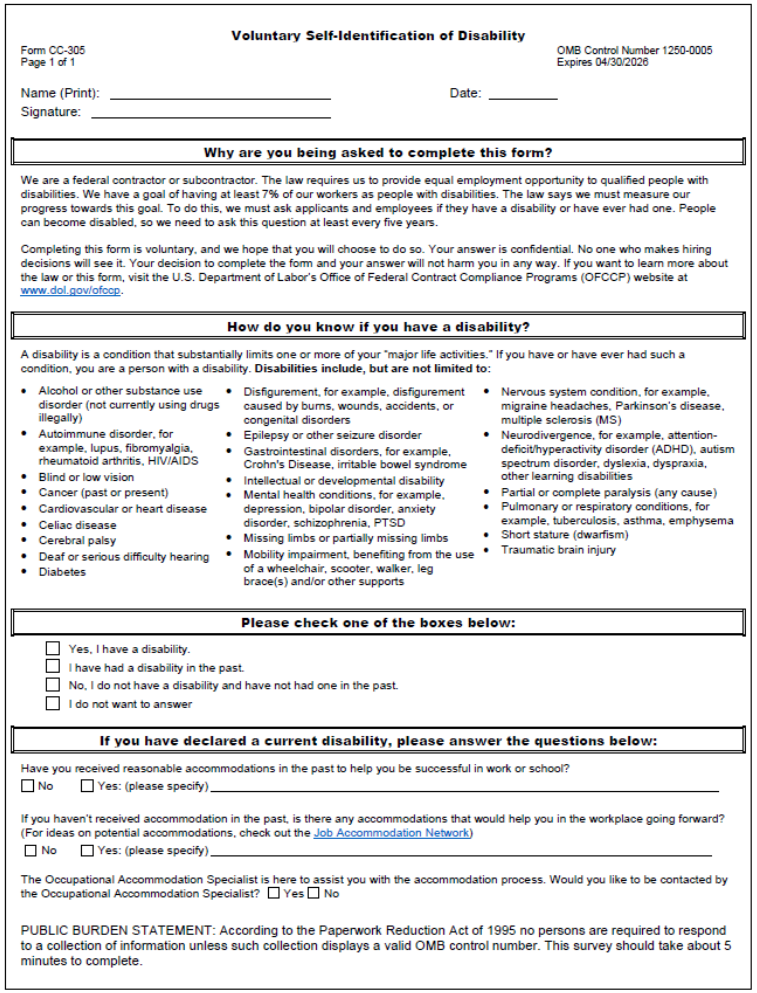
- ❑ Allows for reporting requirements to be met in compliance with Federal Law
- ❑ Disclosure is voluntary

Emergency Contact Form

- ❑ Complete entire form
- ❑ 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



Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 04/30/2026

Name (Print): _____ Date: _____

Signature: _____

Why are you being asked to complete this form?

We are a federal contractor or subcontractor. The law requires us to provide equal employment opportunity to qualified people with disabilities. We have a goal of having at least 7% of our workers as people with disabilities. The law says we must measure our progress towards this goal. To do this, we must ask applicants and employees if they have a disability or have ever had one. People can become disabled, so we need to ask this question at least every five years.

Completing this form is voluntary, and we hope that you will choose to do so. Your answer is confidential. No one who makes hiring decisions will see it. Your decision to complete the form and your answer will not harm you in any way. If you want to learn more about the law or this form, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

A disability is a condition that substantially limits one or more of your "major life activities." If you have or have ever had such a condition, you are a person with a disability. **Disabilities include, but are not limited to:**

- Alcohol or other substance use disorder (not currently using drugs illegally)
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, HIV/AIDS
- Blind or low vision
- Cancer (past or present)
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or serious difficulty hearing
- Diabetes
- Disfigurement, for example, disfigurement caused by burns, wounds, accidents, or congenital disorders
- Epilepsy or other seizure disorder
- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome
- Intellectual or developmental disability
- Mental health conditions, for example, depression, bipolar disorder, anxiety disorder, schizophrenia, PTSD
- Missing limbs or partially missing limbs
- Mobility impairment, benefiting from the use of a wheelchair, scooter, walker, leg brace(s) and/or other supports
- Nervous system condition, for example, migraine headaches, Parkinson's disease, multiple sclerosis (MS)
- Neurodivergence, for example, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, dyslexia, dyspraxia, other learning disabilities
- Partial or complete paralysis (any cause)
- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
- Short stature (dwarfism)
- Traumatic brain injury

Please check one of the boxes below:

☐ Yes, I have a disability.
☐ I have had a disability in the past.
☐ No, I do not have a disability and have not had one in the past.
☐ I do not want to answer

If you have declared a current disability, please answer the questions below:

Have you received reasonable accommodations in the past to help you be successful in work or school?
☐ No ☐ Yes: (please specify) _____

If you haven't received accommodation in the past, is there any accommodations that would help you in the workplace going forward? (For ideas on potential accommodations, check out the Job Accommodation Network)
☐ No ☐ Yes: (please specify) _____

The Occupational Accommodation Specialist is here to assist you with the accommodation process. Would you like to be contacted by the Occupational Accommodation Specialist? ☐ Yes ☐ No

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

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 via ESS or by submitting a new form
- ❑ May terminate through ESS or fill out a 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 ☐

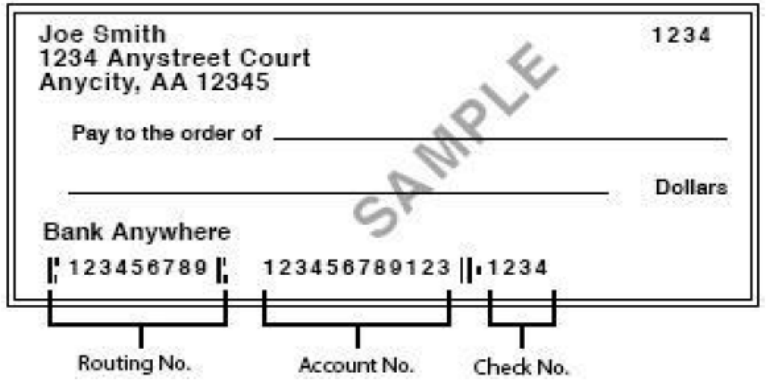
This authority is to remain in full force and effect until the City of Madison Payroll Office has received written notification from me on its termination in such time and in such manner as to afford the City of Madison a reasonable time to act on it. I understand that, due to circumstances that are 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!!!

- ❑ Paychecks are issued every two weeks
- ❑ Shaded dates on the Payroll Calendar are paydays
- ❑ 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 of sick leave per pay period (13 days/year)
  - Accrues to a 150-day carryover limit; balances over 150 days may cash out at the end of the year – see your Handbook/contract (where applicable) for details
  - You must be in paid status for 60% of a given pay period to earn sick leave that pay period
  - Can be used for illness or injury (employee or eligible 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, you are not allowed to carry these over – the only exception is if your start date is on or after November 1
    - Some contracts may allow payout
- If you have questions about sick leave or floating holidays, refer to your handbook and/or labor contract (if applicable).

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
  - Some time can be used upon successful completion of the 3-month onboarding report – ask your supervisor about this when you do your 3-month report!
  - 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

Paid Parental Leave (PPL)

- 6 weeks paid leave to care for and bond with a newborn or newly adopted child, as outlined in the PPL APM and Policy
- Must be employed by the City for at least 12 months to be eligible
- Not granted automatically – application required
- Questions about PPL, including any questions about the application process, should be directed to the Leave and Benefits Assistant at FMLA@cityofmadison.com

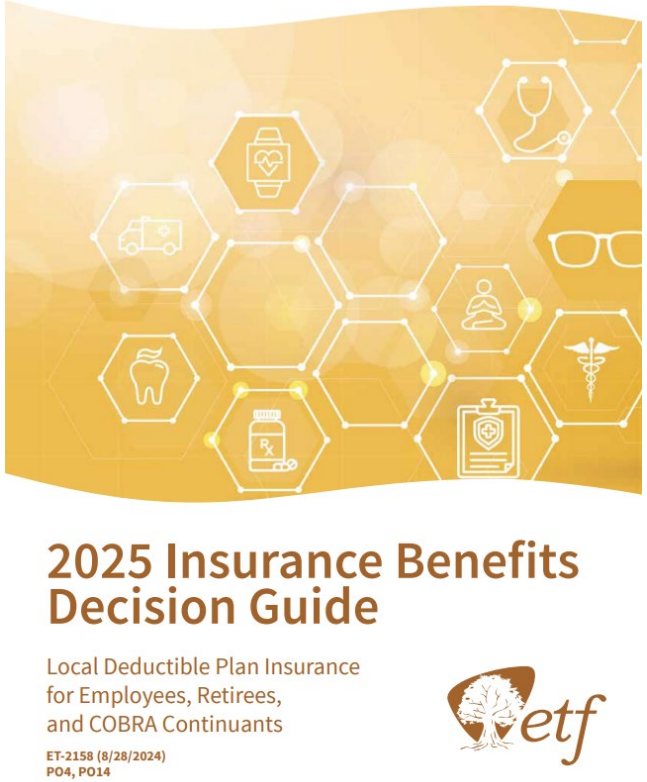
Insurance and Other Benefits

Returning Completed Forms

- ❑ HR must be **in receipt** of the following Benefit Enrollment Forms **within 30 calendar days** of your first workday in your new position:
  - ❑ Health Insurance
  - ❑ Dental Insurance
  - ❑ Vision Insurance
  - ❑ Life Insurance
  - ❑ Disability Insurance (aka Wage Insurance, Income Continuation Insurance)
  - ❑ Flex Spending
- ❑ Benefit forms must be **received in** the Human Resources Department by the deadline. Failure to submit forms timely will result in waiting periods and/or underwriting.

Health Insurance Information

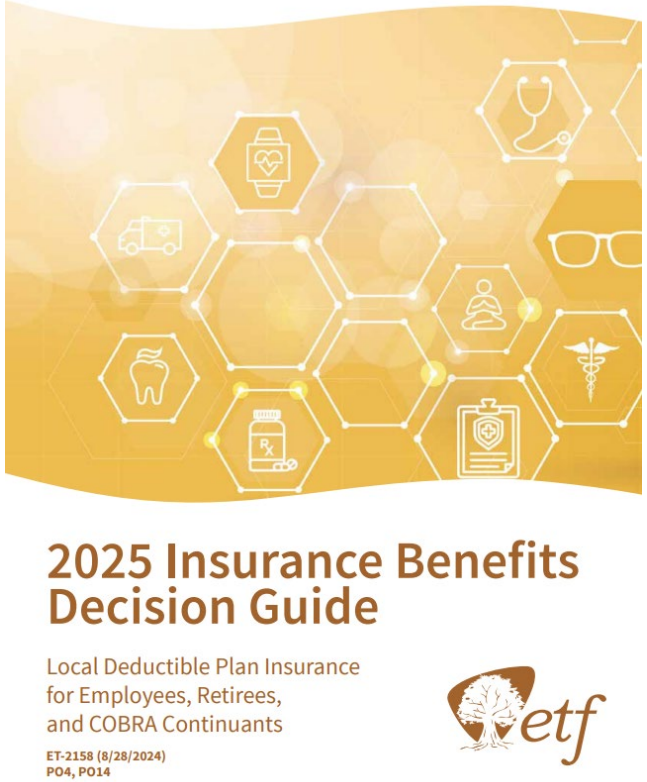
- For health insurance, the City participates in the Department of Employee Trust Funds (ETF) Program Option 14 – Local Deductible Without Dental.
- PO 14 has **uniform benefits.** Deductibles, prescription coverage, copays, etc. are all the same across plans.
- Employees can sign up for any of the ETF health plan options. Only three of the HMO options have coverage in Dane County:
  - Dean Health Care
  - GHC-SCW Dane Choice
  - Quartz-UW Health



etf
WISCONSIN DEPARTMENT OF EMPLOYEE TRUST FUNDS

Health Insurance Information

- **Decision Guide**
  - Includes a summary of Uniform Benefits on Pages 4 and 5, and provides information on health benefit coverage
  - Each fall, there is an annual Open Enrollment period for enrollment, changes, or cancellation without a qualifying event
    - Open Enrollment changes are effective January 1st of the upcoming year
  - Midyear enrollment, changes, or cancellation all require an eligible qualifying event (deadlines apply)
  - More information can be found on Individual Plan websites



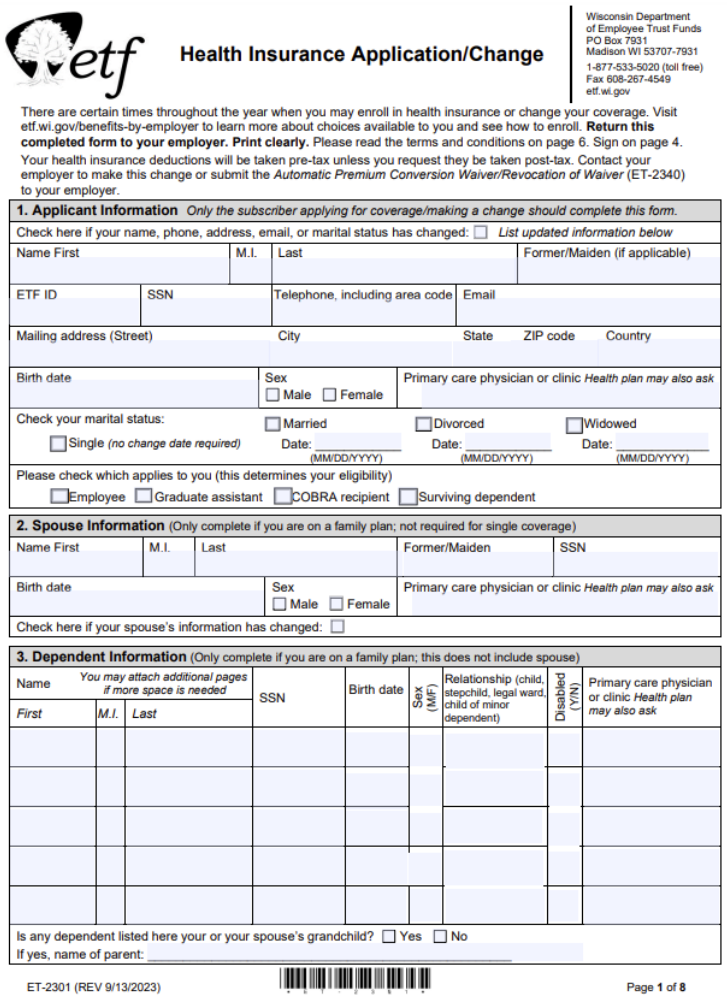
etf
WISCONSIN DEPARTMENT OF EMPLOYEE TRUST FUNDS

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
  - The 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 5 of the ETF Decision Guide

NAVITUS

Health Insurance Application



etf **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	Telephone, including area code	Email

Mailing address (Street)	City	State	ZIP code	Country

Birth date	Sex ☐ Male ☐ Female	Primary care physician or clinic *Health plan may also ask*

Check your marital status: ☐ Married Date: (MM/DD/YYYY) ☐ Divorced Date: (MM/DD/YYYY) ☐ Widowed Date: (MM/DD/YYYY)
☐ Single *(no change date required)*

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	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	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: _____

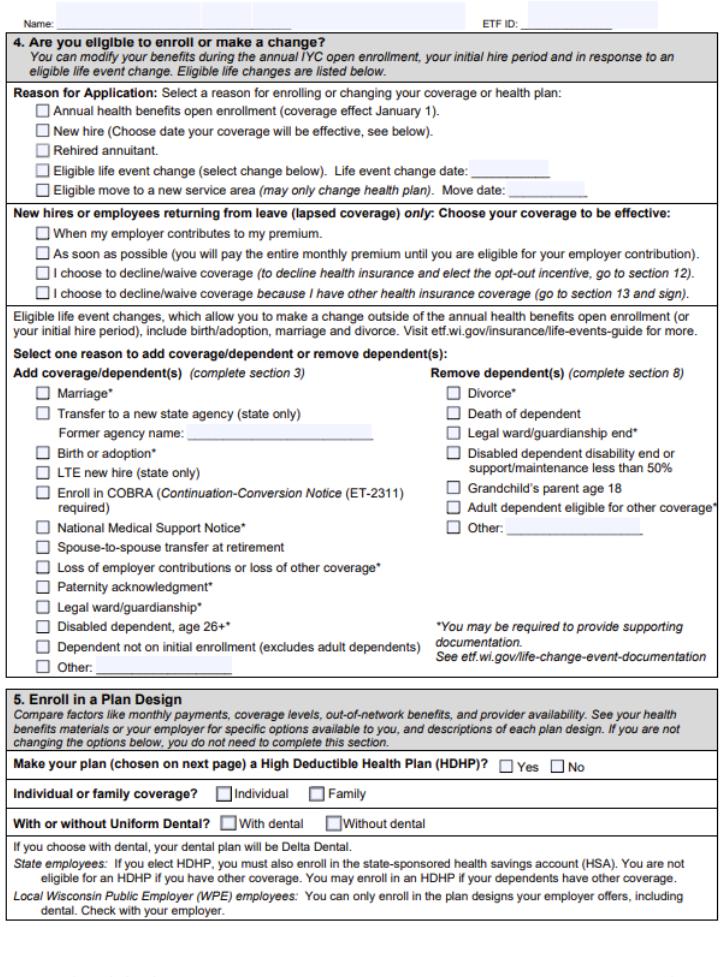
ET-2301 (REV 9/13/2023) Page 1 of 8

Page 1

- ❑ **Section 1:**
  - ❑ Fill in all boxes, including date (if applicable) for marital status
  - ❑ 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) – documentation required if covering spouse
- ❑ **Section 3:**
  - ❑ Complete if applicable (only required if child(ren), stepchild(ren), or permanent legal ward(s) will be covered) – documentation required if covering any dependent(s)
  - ❑ Ensure all details are included in Dependent Information (e.g. legal name, Social Security Number, date of birth, sex, relationship, etc.)

etf WISCONSIN DEPARTMENT OF EMPLOYEE TRUST FUNDS

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 (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 health benefits open enrollment (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 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.

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

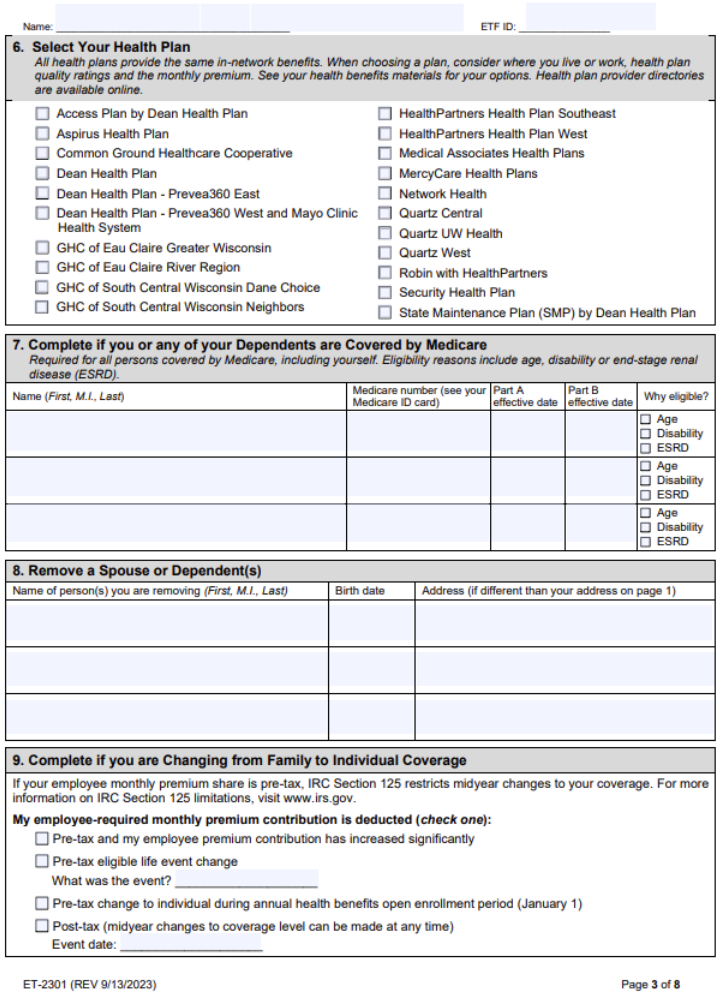
If you choose with dental, your dental plan will be Delta Dental.
State employees: If you elect HDHP, you must also enroll in the state-sponsored health savings account (HSA). You are not eligible for an HDHP if you have other coverage. You may enroll in an HDHP if your dependents have other coverage.
Local Wisconsin Public Employer (WPE) employees: You can only enroll in the plan designs your employer offers, including dental. Check with your employer.

ET-2301 (REV 9/13/2023) Page 2 of 8

Page 2

- ❑ **Section 4:**
  - ❑ Check New Hire
  - ❑ Check one of the following:
    - ❑ **When my employer contributes to my premium** (first box)
    - ❑ **As soon as possible** (second box) – coverage starts on the next 1st of the month; employee must pay **total** premium (employee + employer portions) for that month's coverage
    - ❑ **I choose to decline** (fourth box)
- ❑ **Section 5:**
  - ❑ Indicate Individual or Family
  - ❑ The City's Health insurance program **does not include** HDHP or Dental, so those boxes do not apply
    - ❑ If you want to enroll in dental, make sure you submit the separate dental application!

Health Insurance Application



Name: _____ ETF ID: _____

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 health 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 - 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 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 health benefits open enrollment period (January 1)
- ☐ Post-tax (midyear changes to coverage level can be made at any time)
  Event date: _____

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Page 3

- ❑ **Section 6:**
  - ❑ Check the box of the health plan that you selected
- ❑ **Section 7:**
  - ❑ Fill out all of Section 7 if applicable; skip if not applicable
- ❑ **Section 8-9:**
  - ❑ Skip these Sections

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)

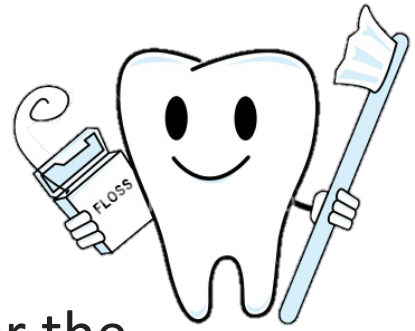
This form must be turned in directly to Human Resources within **30 calendar days** from date of hire even if you are waiving coverage!

Page 4

- ❑ **Section 10:** skip
- ❑ **Section 11:**
  - ❑ Complete this Section if you have additional coverage that will **overlap** with the insurance provided by the City; otherwise, check “no”
- ❑ **Section 12:** skip, does not apply to City employees
- ❑ **Section 13:**
  - ❑ Sign and date

Dental Insurance

- **Provider: Delta Dental**
  - Available to all permanent City Employees with no waiting period **after** the effective date
  - Preferred Provider Organization (PPO)/Premier Plan – See Delta's website for PPO 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)

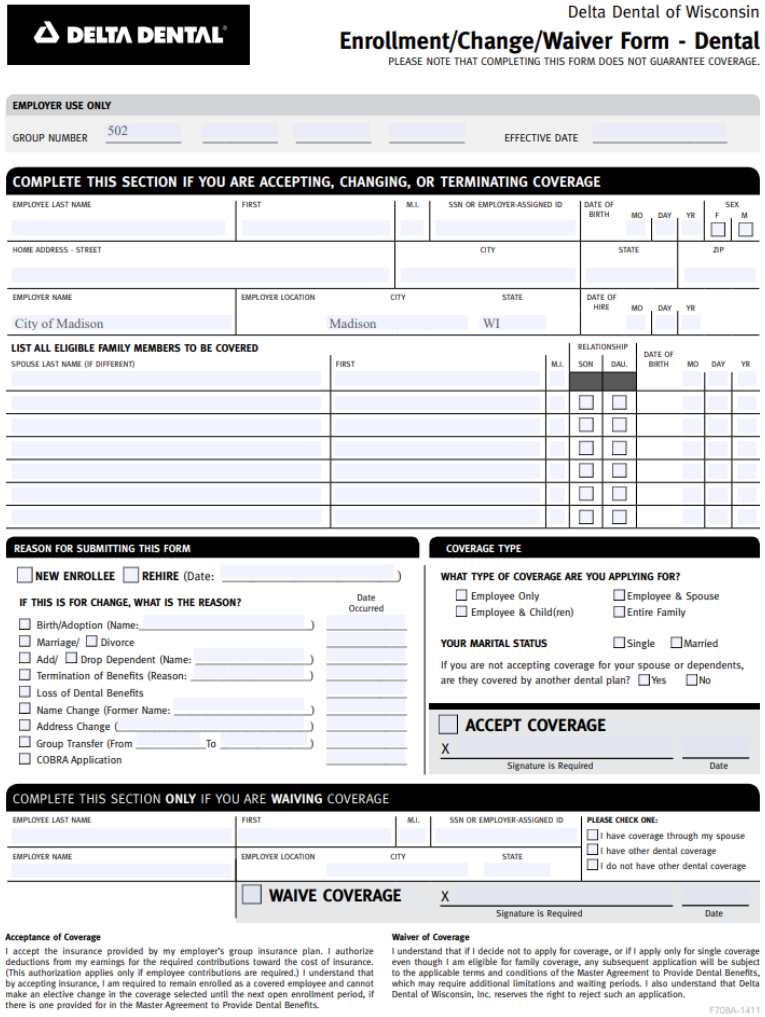


2025 Monthly Delta Dental Premiums

Employee Only: $38.25 (Single)	Employee + Spouse: $87.50
Employee + Child(ren): $88.22	Employee + Spouse + Child(ren): $132.82 (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:

- ☐ I have coverage through my spouse
- ☐ I have other dental coverage
- ☐ I do not have other dental 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 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 calendar days** of date of hire even if you are waiving coverage!
  - City group number is 502
  - Enrollment only upon hire, in the annual Open Enrollment period, or with a midyear qualifying event
  - Dental cannot be terminated mid-year except with an eligible qualifying event
  - Deadlines apply to all qualifying events

DELTA DENTAL®

Vision Insurance

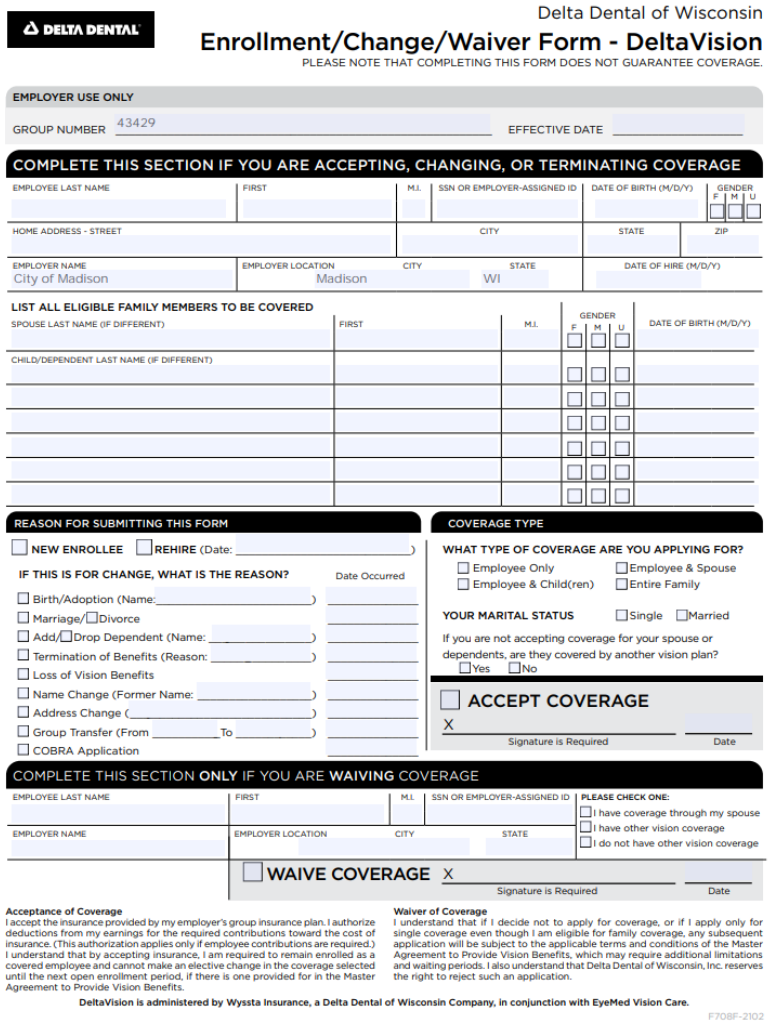
- **Provider is DeltaVision**
  - Available to all permanent City employees with no waiting period **after** the effective date
  - City group number is 43429
  - Network Benefit/Non-Network Reimbursement – See Delta's website for Network providers
  - Premium taken out of second biweekly paycheck of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

2025 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 calendar days** of date of hire even if waiving coverage!
  - Enrollment only upon hire, in the annual Open Enrollment period, or with an eligible midyear qualifying event
  - Vision insurance cannot be terminated midyear except with a qualifying event
  - Deadlines apply to all qualifying events

DeltaVision®

Life Insurance

- Provided through The Hartford
- **Employee Coverage** is available in four levels:
  - Basic (highest annual earnings of record rounded up)
  - Basic + 50% Supplemental (Basic x 1.5)
  - Basic + 100% Supplemental (Basic x 2)
  - Basic + 200% Supplemental (Basic x 3)
- The City's coverage is **group term insurance**, meaning coverage for the term of which the premium is paid
- The initial Basic coverage amount is determined by your annual starting pay rounded up to the next highest thousand (if not already an even multiple of $1,000)

Life Insurance

- **Dependent coverage** is available in 1-2 units ($1.75 each):
  - 1 unit: $10,000 coverage for child(ren), $10,000 coverage for spouse
  - 2 units: $15,000 coverage for child(ren), $20,000 coverage for spouse
- In order to enroll in dependent coverage, you must be enrolled in at least the Basic level of employee coverage.
- Each unit of dependent coverage is an “umbrella” that covers any/all eligible dependent(s), which for dependent coverage purposes includes spouses to age 65 and/or dependent child(ren) to age 26.
  - Because the Hartford prohibits dual/double coverage on the City's plan, unit(s) of dependent coverage only apply to a spouse/child(ren) who do not have their own City life insurance coverage, and eligible child(ren) can only be covered by one set of City dependent coverage unit(s) at a time.

Life Insurance

- **Enrollment/Changes:**
  - After the initial new hire enrollment window, enrollment (and/or increasing coverage) requires either:
    1. An eligible qualifying life event, such as birth/adoption, marriage, or divorce (limitations and deadlines apply), or
    2. Approval via the medical underwriting process
  - Life insurance coverage can be reduced or cancelled at any time.
- **Beneficiaries:**
  - Can be a person/people, trust(s), or organization(s); you cannot designate animals/pets as beneficiaries.
  - Your beneficiary designation is in effect until you actively change it – qualifying events **do not negate** prior designations.

Life Insurance

- **Life Insurance Premium**
  - Based on age and benefit amount; premiums and coverage are recalculated annually each summer
  - Inexpensive – increases over time
  - Taken from 1st paycheck of mo.
  - Payments can continue into retirement
  - No premium after 70 if working, 65 if retired, and still get 25+ percent of Basic coverage paid!
- Application must be received in HR **within 30 calendar days** of date of hire whether enrolling in **or** waiving coverage

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**

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

Income Continuation (Wage, Disability) Insurance

- **Also called Wage Insurance, Short/Long-Term 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
  - After the initial enrollment window ends, enrollment in wage insurance is only possible through medical underwriting approval. **There is no other opportunity to enroll without underwriting.**
  - Application must be received in HR **within 30 calendar days** of date of hire whether enrolling in **or** waiving coverage

Income Continuation (Wage, Disability) Insurance

- **Wage Insurance Premiums:**
  - Taken out of the **second check of each month**
  - The percent of the premium paid by the employee vs. City is based on a combination of bi-weekly wages, accumulated sick leave, and sick leave used/accrued per annual tracking period (Sept-Sept), and is adjusted annually
  - 100% of the premium is paid by the City if accumulated sick leave is over 100 or 120 days, depending on comp group
  - An employee must be employed for 6 months as of the annual recalculation in order to be eligible for their premium to change. If employment begins after April, the first recalculation will be October of the 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%

Income Continuation (Wage, Disability) 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

Flex Spending

- Flexible Spending Accounts (FSA) allow you to defer funds from your paycheck pretax for use towards eligible expenses. City FSA is administered by Total Administrative Services Corporation (TASC).
- Annual Enrollment is required **each year** if participating.
  - If you enroll, your contributions will be deducted in equal amounts from each paycheck **pretax** throughout the Plan Year.
- Two types of accounts are available: Healthcare Flexible Spending Accounts (Medical FSA) and Dependent Care Flexible Spending Accounts (DCAP).

Healthcare Flexible Spending Account (Medical FSA): $3,300 maximum allowed annually (2025)
Dependent Care Flexible Spending Account (DCAP):

- $5,000 maximum allowed annually per household (regardless of number of dependents)
- $2,500 maximum allowed annually for married individuals filing separately

TASC

Flex Spending

- **Medical Flex Spending:**
  - You will have access to your **total** Medical/Healthcare FSA annual contribution at the start of the Plan Year (or once your election is processed, if enrolling as a new hire).
  - Medical Flex Spending funds cannot be used toward employee health, dental, or vision premium contributions, but can be used for the annual deductibles.
  - If your spouse has a Health Savings Account (HSA) through their employer, you are **ineligible** to participate in Medical Flex Spending. (You can still participate in DCAP if you have eligible dependents.)
- **Dependent Care (DCAP):**
  - Dependent Care (DCAP) FSA funds are available **up to the current account balance** only.
  - DCAP is **not** for dependent or spouse medical expenses – it is only for the cost of care for eligible dependent(s) that enables you to work, such as daycare expenses.
  - The TASC card can only be used for Medical FSA expenses; DCAP claims must be submitted for reimbursement.

TASC®

Flex Spending

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

TASC®

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****

- **Enrollment Form**
  - Complete paper application and return to HR within **30 calendar days** of date of hire **if enrolling**
  - Enrollment only upon hire, in annual Open Enrollment period, or with a midyear qualifying event
  - Once the first payroll with your Flex election has been processed, neither coverage, election, nor contribution can change without a qualifying event
  - Flex spending contributions cannot be terminated or changed midyear except with an eligible qualifying event – deadlines and restrictions apply
- **Examples of qualifying events**

TASC

Pension

- Defined Benefit Plan through the Department of Employee Trust Funds (ETF) – Wisconsin Retirement System (WRS)
  - Participation is mandatory and automatic if eligible
  - 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, 2011
  - 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 6.95% (2025 rate)
    - Employee pays employee portion of 6.95% (2025 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

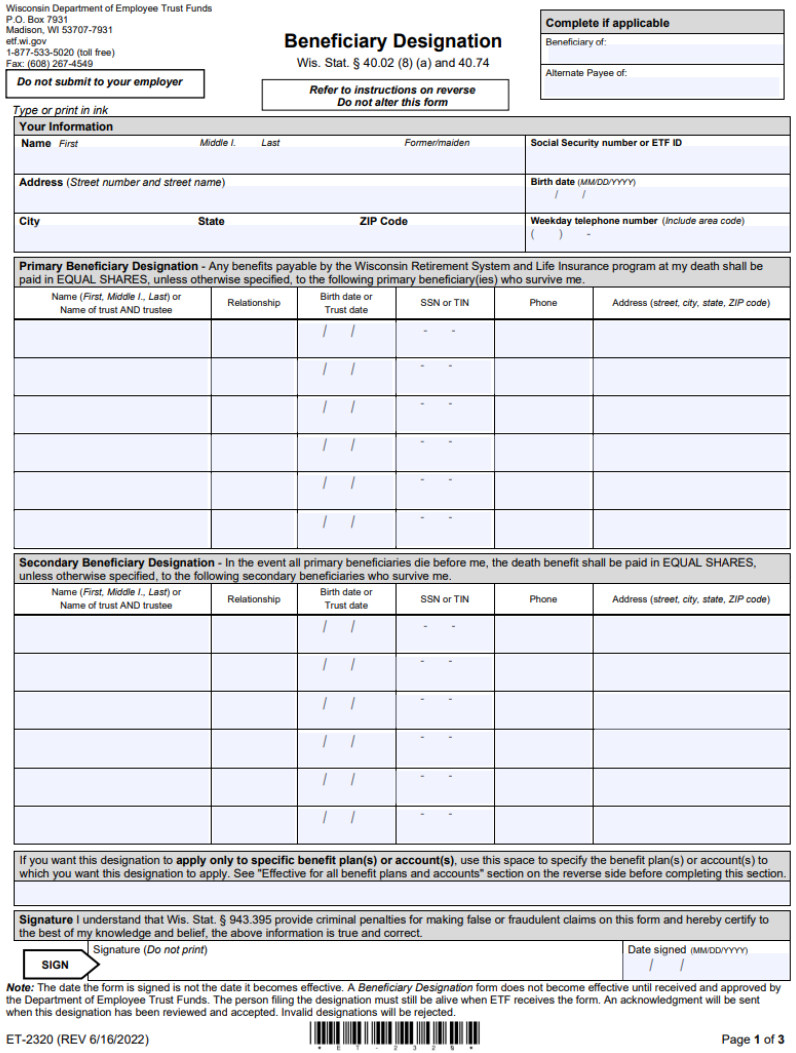
Pension

- **Funds**
  - Contributions are automatically placed in the **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 into the riskier **Variable Trust Fund (VTF),** which is invested in a diversified equity portfolio.
  - Employees can opt into the VTF at any time. If the enrollment form is received more than 30 calendar days after the date WRS participation begins, VTF participation will not start until the next January 1st.
    - VTF enrollment may be effective on the first day of WRS coverage if ETF receives the form within 30 calendar days after the date WRS participation begins.
  - If an employee enrolls in the VTF and then elects to stop VTF contribution, there is no re-entry to the VTF.

Pension

- **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.

ET-2320 (REV 6/16/2022) Page 1 of 3

- **Beneficiary Designation**
  - If no form is filled out, ETF will follow the standard sequence
  - Incomplete forms 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(b) 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 limit of $23,500, or age 50 or over up to $31,000 (2025 limits)
  - 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

Initial Employment Forms to HR within First Week and I-9 within 3 business days.

- ❑ Orientation Checklist – items checked off, 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
- Fax to (608) 267-1115
- Email benefits@cityofmadison.com using email encryption

Return Completed Benefit Forms to HR by _____ (within 30 calendar days).

As enrollments or waivers:

- ❑ Health Insurance
- ❑ Dental Insurance
- ❑ Vision Insurance
- ❑ Life Insurance
- ❑ Disability (Wage) Insurance

Only if enrolling:

- ❑ Flex Spending

Failure to submit forms timely 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
- Fax to (608) 267-1115
- Email benefits@cityofmadison.com using email encryption

Congrats & welcome!

What questions do you have?

Tory Larson or Katarina Klafka
608-266-4615
benefits@cityofmadison.com

Calculation Assistance

Due dates, health insurance start dates, and life insurance costs

Benefits Paperwork Due Dates

- **When is my benefits paperwork due?**
  - Does the month of hire have 30 days? If so, 30 calendar days is the same date in the next month → April 2nd start date = May 2nd deadline
  - Does the month of hire have 31 days? If so, 30 calendar days is the date in the next month **minus one** → May 2nd start date = June 1st deadline
  - Did you start in February? If so, 30 calendar days is the date in the next month **plus two** for a non-Leap Year, or **plus one** for a Leap Year.

HR **strongly** recommends you return your benefits paperwork within 1-3 weeks of your hire date to ensure we receive it before the deadline!

Health Insurance Start Dates

- **When will my health insurance begin?**
  - If your start date is on or before the first Monday of a given month, then the employer contribution to your health insurance will start on the first day of the **following month.** → April 1st start date = May 1st health insurance start date.
  - If your first day is after the first Monday of a given month, then the employer contribution to your health insurance will start on the first day of the **month after next**. → April 8th start date = June 1st health insurance start date.
    - In this scenario, you can opt to start your health insurance "As soon as possible" instead. If you opt for ASAP coverage, your health insurance will begin on the **next** 1st of the month, and you will be responsible for the **total** cost of the premium for that first month of coverage before the employer contribution begins. Please contact HR for more details.

Life Insurance Premiums – New Hires

- **How do I calculate my life insurance premium?**
  - Take your annual salary and round up to the next highest $1,000. This is your initial Basic Coverage amount.
  - Divide by $1,000.
  - Multiply the divided number by the "cost per $1,000 coverage" factor for your age group.
  - The result is your premium for Basic Only coverage.
    - If you are considering supplemental coverage, multiply your Basic Only premium by 1.5 for Basic + 50%, by 2 for Basic + 100%, or by 3 for Basic + 200%.
- **Example:** A new employee has a $49,500 annual salary and is 40 years old.
  - $50,000 Basic Only coverage
  - $50,000 / $1,000 = 50
  - 50 x $0.10 = $5.00 per month Basic Only premium

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**