



**City of Madison**  
**SHORT TERM & LONG TERM DISABILITY INSURANCE**  
**(WAGE 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 30 calendar days from date first eligible requires an approved Evidence of Insurability (EOI) Application

|                                                                                                                                                                                                                                                                                                                                                                                |                               |                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|------------------------------------------|
| <b>SECTION 1: <i>Employee Information</i> (COMPLETION OF THIS SECTION IS REQUIRED)</b>                                                                                                                                                                                                                                                                                         |                               |                                          |
| <b>PRINT NAME</b> <i>(Last, First, Middle Initial)</i>                                                                                                                                                                                                                                                                                                                         |                               | <b>DATE OF BIRTH</b> <i>(mm/dd/yyyy)</i> |
| <b>List any Former Name(s)</b> <i>(Last, First, Middle Initial)</i> <b>(Separate multiple former names with a semicolon (;))</b>                                                                                                                                                                                                                                               |                               |                                          |
| <b>DEPARTMENT NAME</b>                                                                                                                                                                                                                                                                                                                                                         | <b>DATE OF PERMANENT HIRE</b> | <b>MUNIS ID #</b>                        |
| <b>SECTION 2: <i>Beneficiary Designation</i></b>                                                                                                                                                                                                                                                                                                                               |                               |                                          |
| <b>BENEFICIARY DESIGNATION</b> <i>(See reverse side for suggested wording)</i>                                                                                                                                                                                                                                                                                                 |                               |                                          |
| Primary: _____                                                                                                                                                                                                                                                                                                                                                                 |                               |                                          |
| Secondary: _____                                                                                                                                                                                                                                                                                                                                                               |                               |                                          |
| <b>SECTION 3: <i>Acceptance of Coverage and/or Acknowledgment of Beneficiary Designation</i></b>                                                                                                                                                                                                                                                                               |                               |                                          |
| <input type="checkbox"/> 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. |                               |                                          |
| <input type="checkbox"/> 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 _____                                                                                                                                                                                                                                                                                                                                                              |                               |                                          |
| <b>SECTION 4: <i>Waive or Cancel Coverage</i> (COMPLETE THIS SECTION ONLY IF WAIVING/CANCELING COVERAGE)</b>                                                                                                                                                                                                                                                                   |                               |                                          |
| <input type="checkbox"/> I do <u>not</u> wish to participate in the City of Madison's Group Short Term & Long Term Disability Insurance Plan.                                                                                                                                                                                                                                  |                               |                                          |
| Signature _____                                                                                                                                                                                                                                                                                                                                                                |                               |                                          |
| Date Signed _____                                                                                                                                                                                                                                                                                                                                                              |                               |                                          |

|                                                       |
|-------------------------------------------------------|
| <b>FOR EMPLOYER USE ONLY</b>                          |
| <b>EFFECTIVE DATE OF COVERAGE</b> <i>(mm/dd/yyyy)</i> |

## 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. Typed signatures, including DocuSign, are not accepted.
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 15<sup>th</sup> 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 <https://www.cityofmadison.com/human-resources/benefits/wage-insurance>