NOTICE & AGENDA
MOUNTAIN BAY METROPOLITAN
POLICE DEPARTMENT
OVERSIGHT BOARD

Date: Wednesday, November 14, 2024
Time: 4:00 p.m.
Place: This meeting will be held via
https://us02web.zoom.us/j/6953385367
Or via telephone: 646-558-8656, enter, 6953385367# then enter #
Or at the Rothschild Village Hall

Pursuant to State Statutes, the following subject matter will come before the Board for consideration and possible action:

1. Call to Order
2. Announcements and Statements from the Audience
   (This is the only opportunity for the public to address any items of concern including items on the agenda. Public comment is not allowed without Board action when an agenda item is discussed. Due to open meeting laws, the Board will not be able to have a dialog with the person making public comments. If the person making public comments would like answers to questions, then they will need to leave their phone number with the Clerk so they can be contacted by staff to have their questions answered. Public comments will be limited to 3 minutes per person. No action will be taken during public comments.)
3. Discussion and Possible Action Regarding Resolution of Inclusion Under Group Life Insurance
4. Discussion and Possible Action Regarding Resolution of Inclusion Under the State of Wisconsin Deferred Compensation Program
5. Discussion and Possible Action Regarding Resolution of Inclusion Under the Income Continuation Insurance Plan
6. Adjourn

Signed: *Elizabeth Felkner,* WCMC
Presiding Officer or Designee

Posted at the: Rothschild Village Hall, MBMPD Office, Weston Village Hall, & Rothschild Post Office
By: EF
Date: 11/11/2024

Daily Herald Notified:
Via: FAX
By: EF
Date: 11/11/2024

NOTE: Please note, upon reasonable notice, efforts will be made to accommodate the needs of disabled individuals through appropriate aids and services. For additional information or to request this service, contact the Village Clerk's Office, (715) 359-3660, during the normal hours of operation.

If there is a quorum of any other governmental body present at the meeting, the existence of the quorum shall not constitute a meeting as no action of such body is contemplated.

Resolution for Inclusion Under Group Life Insurance

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

RESOLVED, by the _____ of the _____ of _____
Governing body Employer legal name

that pursuant to the provisions of Chapter 40 of the Wisconsin Statutes such _____
Governing body

hereby determines to be included under the following Group Life Insurance program(s) provided by Chapter 40 of the Wisconsin Statutes for its eligible personnel:

Check box(es) for coverage desired:

- ☐ Basic Group Life Insurance (1x earnings)
- ☐ Supplemental Group Life Insurance (1x earnings)
- ☐ Additional Group Life Insurance
  - ☐ 1 Unit (1x earnings)
  - ☐ 2 Units (2x earnings)
  - ☐ 3 Units (3x earnings)
- ☐ Spouse and Dependent Group Life Insurance
- ☐ Amount of insurance for any insured employee who attains age 65 on or after the effective date of this resolution shall be 50% rather than 25%

BE IT FURTHER RESOLVED, that the proper officers are herewith authorized and directed to take all actions and make such deductions and submit such payments as are required by the Group Insurance Board of the State of Wisconsin to provide such group life insurance.

BE IT FURTHER RESOLVED, that the _____ WRS Agent submit a certified copy of this
Employer name
resolution to the State of Wisconsin Department of Employee Trust Funds.

Certification

I hereby certify that the foregoing resolution is a true, correct and complete copy of the resolution duly and regularly passed by the _____ of the _____ of _____ on the
Governing body Employer name

____ day of _____, and that said resolution has not been repealed or amended, and is now in full force and effect.

Dated this ____ day of _____.

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

Federal Tax Identification Number (FEIN) _____

Employer Identification Number (EIN) **69-036-**_____ Number of eligible employees: _____

WRS agent signature: _____ WRS agent title: _____

Mailing address: _____

Telephone: _____

Email: _____

For ETF use only
EFFECTIVE DATE OF COVERAGE ENTERED BY ETF:

The resolution shall be effective on the first of the fourth month after receipt in the office of the Department of Employee Trust Funds. Submit completed form to ETF at ETFSMBESSNewEmployer@etf.wi.gov or fax to 608-267-4549.

Resolution for Inclusion Under the State of Wisconsin Deferred Compensation Program

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

Be it resolved by the _____ of the _____ that
(Governing body) (Employer)
pursuant to the provisions of Section 40.81(1), Subchapter VII of Chapter 40 of the Wisconsin Statutes which provides in part as follows:

> An employer other than the State may provide for its employees the Deferred Compensation Plan established by the Board under Section 40.80. Any employer, including this state, who makes the Plan under Section 40.80 available to any of its employees, shall make it available to all its employees under procedures established by the department under this subchapter.

Such _____ hereby determines to be included under the State of Wisconsin Deferred
(Governing body)
Compensation Program ("the Plan") provided by Subchapter VII of Chapter 40 of the Wisconsin Statutes and regulated by Chapter ETF 70 of the Wisconsin Administrative Code for its eligible personnel, and

Be it further resolved, the proper officers are herewith authorized and directed to take all actions and make such reductions and submit such deferrals as are required by the Department of Employee Trust Funds of the State of Wisconsin pursuant to Subchapter VII of Chapter 40 of the Wisconsin Statutes, and

Be it further resolved, that _____ agrees to be bound by the Terms and
(Employer)
Conditions of the contracts between the State, its investment providers, and its Plan Administrator, and the "Plan and Trust Document" and the "Employer Guide" as amended from time to time. The employer certifies it has received a copy of the Plan and Trust document.

Be it further resolved, that the _____ representative submits a certified copy of
(Employer)
this Resolution and "Designation of Agent" to the State of Wisconsin, Department of Employee Trust Funds and the Plan Administrator.

Be it further resolved, that the _____ recognizing the Deferred Compensation
(Governing body)
Board's responsibility for maintaining the integrity of the Plan, the _____ hereby resolved
(Governing body)
that the proper officers of _____ are hereby authorized and directed to cooperate fully with
(Employer)
the Plan Administrator in accordance with procedures established by the Department of Employee Trust Funds.

Be it further resolved, that the _____ of the _____ acknowledges
(Governing body) (Employer)
and submits that the Plan offered under Section 40.80 et seq., Subchapter VII of Chapter 40 of the Wisconsin Statutes is not and cannot be used as an alternative or replacement plan for purposes of FICA taxes. The Plan is meant to act as a supplemental retirement benefit in addition to social security (FICA) benefits.

Dated this _____ day of _____, 20____.

Employer: _____ Governing body: _____

_____ _____
Authorized signature Authorized signature

_____ _____
Print name Print name

Designation of Agent

The person in the following position is hereby designated as the agent in matter pertaining to the State of Wisconsin Deferred Compensation Program.

Note: Employer email addresses will be automatically subscribed to ETF E-mail Updates, an ETF email service providing employers with important ETF benefits administration information. It is your responsibility to read, forward to others in your agency as necessary, and take the necessary action related to information in each ETF E-mail Update. Add etfwi@public.govdelivery.com to your email address book to prevent news from ETF from ending up in a SPAM folder. If you have questions, please call the Employer Communication Center at 1-877-533-5020.

Agent: _____

Title of position of designated agent: _____

Alternate agent: _____

Address: _____

Telephone, including area code: _____

Email: _____

Office hours: _____

Federal employer ID number: _____

WRS ID number (if applicable): _____

Certification

I hereby certify that the foregoing Resolution is a true, correct, and complete copy of the

Resolution duly and regularly passed by the _____ of
(Governing body)

_____ of _____ on the _____ day of
(Employer name) (City)

_____, 20____, and that this Resolution has not been repealed or amended, and is now in full force and effect.

Dated this _____ day of _____, 20____.

_____
Employer representative title

_____
Employer representative signature

Number of eligible employees: _____

Resolution for Inclusion Under the Income Continuation Insurance Plan

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

RESOLVED, by the Mountain Bay Metropolitan Police Department Oversight Board (Governing Body) of the Police Department of the Mountain Bay Metropolitan Police Department (Employer Legal Name)

that pursuant to the provisions of Section 40.61 of the Wisconsin Statutes,

Mountain Bay Metropolitan Police Department Oversight Board (Governing Body) hereby determines to offer the Income Continuation Insurance Plan

to eligible personnel through the program of the State of Wisconsin Group Insurance Board, and agrees to abide by the terms of the plan as set forth in the contract between the Group Insurance Board and the Administrator.

The resolution shall be effective on the later of the 1st of the month on or after 90 days following its receipt at the Department of Employee Trust Funds, or

January 1, 2025 (specify a later effective date, 1st of month only); and

The proper officers are herewith authorized and directed to take all actions and make salary deductions for premiums and submit payments required by the State of Wisconsin Group Insurance Board to provide such Income Continuation Insurance.

Employers are required to pay a *minimum* contribution, which is equal to the gross premium for the 180-day elimination period. Employers may choose to contribute more to employees' premiums to an amount equal to the gross premium for a *shorter* elimination period. As elimination periods become shorter, the premium cost increases.

An employee can choose a shorter elimination period than that offered by their employer, and pay the difference in cost between their choice and the elimination period the employer for which the employer has elected to pay the gross premium.

For example, if an employer elects to pay for the full 90-day elimination period, = their employees will not have out-of-pocket premiums unless the employee elects the 60-day or 30-day elimination period. If the employee elected a shorter elimination period, the employee will pay the premium difference between that and the 90-day elimination period.

Elect one elimination period that your employer will pay the gross ICI premium for:

- ☐ 30-day elimination period ☐ 60-day elimination period
- ☐ 90-day elimination period ☐ 120-day elimination period
- ☐ 180-day elimination period *(required minimum contribution)*

Complete the Certification on the next page.

Certification

I hereby certify that the foregoing resolution is a true, correct and complete copy of the resolution duly and regularly passed by the above governing body on the 13th day of November, 2024 and that said resolution has not been repealed or amended, and is now in full force and effect.

Dated this 13th day of November, 2024.

Federal tax identification number (FEIN/TIN)	Authorized employer representative signature
69-036- ETF employer identification number	Authorized employer representative printed name
Number of eligible employees _____	Authorized representative title
Employer county	
Employer benefit contact email address	Mailing address

Submit completed form to ETF at ETFSMBESSNewEmployer@etf.wi.gov or fax to 608-267-4549.

For ETF use only - EFFECTIVE DATE OF COVERAGE ENTERED BY ETF: