# Resolution of Inclusion Under the Wisconsin Retirement System

Wis. Stat. §§ 40.21, 40.22

Wisconsin Department of Employee Trust Funds
1-877-533-5020 (toll free)
Fax 608-266-5801
etf.wi.gov

The (Governing Body) _____ of the (Employer Legal Name) _____ authorizes and approves participation in the Wisconsin Retirement System on the effective date of January 1, _____.

Eligible employees will participate in the WRS beginning on the effective date pursuant to the participation option chosen below. **This resolution must be received by, and is irrevocable after, November 15 prior to the effective date.**

**Eligible Employee Participation Options** (check one)

☐ All current and future eligible employees will participate in the WRS.

☐ This employer will provide a one-time offer to current eligible employees to elect or waive WRS participation as of the above effective date. All eligible employees hired after the above effective date must be enrolled in the WRS.

***Note:*** *Employees who waive WRS coverage and continue to be employed by this employer will never be eligible for future WRS coverage and any other related benefits that may be available because of WRS participation.*

☐ Only future eligible employees hired by this employer on or after the effective date of this resolution will be enrolled in the WRS.

**Prior Service** (Optional)

*If nothing is selected, the default is 0%. Read page 2 of this form for information about Prior Service.*

☐ The employer will pay the cost of providing _____% prior service credit for WRS-eligible employees who worked for the employer before the WRS effective date.

**Eligible Employee Participation Exclusion** (Applies to all participation options — check only if applicable)

☐ This employer will exclude employees of a public utility under Wis. Stat. § 196.01(5) from WRS participation pursuant to Wis. Stat. § 40.21(7)(b).

**Certification**

I hereby certify that this resolution is a true, correct, and complete copy of the resolution adopted by the above governing body on _____ (MM/DD/YYYY).

☐ I further certify that this employer is not operating, administering, or otherwise participating in an alternative or replacement retirement plan which replaces or exempts the employer from FICA taxes.

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

_____
Total number of **all** employees (includes WRS eligible and ineligible)

_____ _____
Federal tax identification number Employer County

_____
Certifying Officer signature

_____
Certifying Officer printed name

_____
Certifying Officer title

_____
Employer benefit contact email address

| *For ETF use only* | |
|---|---|
| *Date Received:* | *ETF Employer ID:* |
| *Effective Date:* | *Initials:* |