

LONG TERM DISABILITY ENROLLMENT/CHANGE FORM

(*Please print or type*)

**ENROLLMENT CHANGE** Effective Date of Coverage or Change \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Unit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee’s Name (*Last, First, M.I*.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_ Gender M F Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ St: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Telephone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours Worked Weekly \_\_\_\_\_\_\_

Annual Income:

*(Must be completed before enrollment can take place)*

$ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* New Enrollee Date Hired \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Single **To enroll, you must be full time,**
* Terminating Coverage Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Married **regularly working 20 hours per**
* **DECLINE COVERAGE** **week.**

***Elimination Period*** (*Check One*) 60  90  DAYS(*Check One*)  With Accrued Sick Time Used  Without Sick Time Used

120  150  180  DAYS With Accrued Sick Time Used

***Request For Change***

* Name Change To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* New Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Fraud Statement*** *Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act which is a crime.*

I hereby authorize my employer to deduct from my earnings any payments, if applicable, for this coverage. By signing this enrollment, I hereby have read and understand the limitations that apply to Long Term Disability coverage. These limitations are listed on the back of this form.

Employee Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employers – For those DECLINING, keep this form for your records.**

(See other side)

# LIMITATIONS WHICH APPLY TO LONG TERM DISABILITY COVERAGE

Long Term Disability Coverage does not cover any disability that:

* Is due to intentionally self-inflicted injury (while sane or insane).
* Starts during the first 12 months of your current Long Term Disability Coverage, if it is caused or contributed to by a “preexisting condition”. A disease or injury is a preexisting condition if, during the 3 months before the date you last became covered:

It was diagnosed or treated; or

Services were received for the disease or injury; or

You took drugs or medicines prescribed or recommended by a physician for that condition.

* Results from your committing, or attempting to commit, an assault, battery, or felony.
* Is due to war or any act of war (declared or not declared).
* Is due to: insurrection; rebellion; or taking part in a riot or civil commotion.
* On any day during a period of disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense:

The person will not be deemed to be disabled; and

No benefits will be payable.