

SOM LONG TERM DISABILITY ENROLLMENT FORM



Name	Empl ID#	SS#
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Long Term Disability Insurance *(Standard Insurance Company)*

This optional insurance provides enrolled employees who have an eligible disability with up to 60% income replacement up to \$15,000 per month (less certain income from other sources). Benefits become payable after a 180-day elimination period. Qualifying individuals receiving income replacement benefits will also have a monthly annuity benefit of 15% credited to their 401(a) defined contribution retirement account.

Individuals eligible to enroll in this LTD Policy are: All School of Medicine faculty, the University President, the UUHC Chief Executive Officer, and the following SOM administrative and professional staff: VP Health Sciences; Assoc. VP Health Sciences; Asst. VP Health Sciences; Clinical Administrative Manager, Administrative Manager II; Administrative Manager I; Chief Information Officer; Chief Financial Officer; Assistant Director of Moran Eye Center; Administrative Director; and Manager.

I understand that if I enroll during my Initial Enrollment Period (3 months following date of hire or transfer into a position eligible to enroll in this coverage), I will not be required to provide evidence of insurability. If I wish to enroll after my Initial Enrollment Period, I will be required to apply and provide evidence of insurability.

I understand that my position and rate of pay determines the policy I am enrolled in and my premium. I agree that if my position and/or rate of pay changes, my policy and premium will change accordingly.

I AM ELIGIBLE AND WISH TO ENROLL IN THE SCHOOL OF MEDICINE LONG TERM DISABILITY INSURANCE PLAN

YES WAIVE

To calculate your expected monthly premium, use the following table:	
Monthly Wage Base (Annual Salary divided by 12) not to exceed \$15,000.00	\$ _____
Multiply by Premium Rate	x .01340
Monthly Premium (will be deducted from pay one-half on 7 th and one-half on 22 nd of each month)	\$ _____

I have read and understand the information provided. I agree to the terms of the insurance selected with this form. I certify the information I have provided on all parts of this form is true and correct. I hereby authorize payroll deduction of premiums as required.

Employee Signature: _____ Date: _____