

HPP LONG TERM DISABILITY ENROLLMENT FORM



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

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

Basic Option

The Basic Option provides enrolled employees who have an eligible disability with 60% income replacement up to \$8,000 per month (less certain income from other sources). Benefits become payable after a 30-day elimination period. Qualifying individuals receiving income replacement benefits will also have a monthly annuity benefit of 3% credited to their TIAA-CREF retirement account.

To calculate your expected monthly premium, use the following table:

Monthly Wage Base not to exceed \$13,333.33 (Annual Salary divided by 12)	\$ _____	
Multiply by Premium Rate	x .0106	
Monthly Premium (will be deducted from pay one-half on 7 th and one-half on 22 nd of each month)	\$ _____	

I WISH TO ENROLL IN THE BASIC OPTION
 YES WAIVE

Physician Option

To be eligible for the Physician Option, you must be an eligible Physician, check with the Benefits Department if you are not certain if you qualify for this option

The Physician Option provides enrolled employees who have an eligible disability with 60% income replacement up to \$15,000 per month (less certain income from other sources). Benefits become payable after a 30-day elimination period. Qualifying individuals receiving income replacement benefits will also have a monthly annuity benefit of 3% credited to their TIAA-CREF retirement account.

To calculate your expected monthly premium, use the following table:

Monthly Wage Base not to exceed \$25,000 (Annual Salary divided by 12)	\$ _____	
Multiply by Premium Rate	x .0139	
Monthly Premium (will be deducted one-half on 7 th and one-half on 22 nd of each month)	\$ _____	

I AM ELIGIBLE AND WISH TO ENROLL IN THE PHYSICIAN OPTION
 YES WAIVE

School of Medicine Faculty and Staff

Individuals eligible for the School of Medicine LTD Plan may only enroll in the SOM LTD plan (they cannot enroll in the HPP LTD Plan) and must obtain enrollment forms through their department. *Individuals eligible to enroll in the SOM LTD Policy are: All SOM faculty, the University President, 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 Financial Officer; Assistant Director of Moran Eye Center; Administrative Director; and Manager.*

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

Employee Signature: _____ Date: _____