

## Voluntary Short Term Disability Employee Enrollment Form

### TO BE COMPLETED BY EMPLOYER

Name of Employer (Use Name from Group Billing Notice or Master Application)

Group Number

### TO BE COMPLETED BY EMPLOYEE

Your Name	Last	First	Middle Initial	Date of Birth
				/ /
Social Security Number		Date Employed Full-Time		Coverage Effective Date
- -				/ /
Occupation				
Annual Earnings		Hours Worked Per Week		Sex
\$				M F
Beneficiary			Relationship	

### BENEFIT LEVELS

Select the Benefit Level (A-W) that meets your needs from the chart below and enter the Benefit Level letter in the box on the right.

Benefit Level	Weekly Benefit	Your Annual Salary Must Be at Least	Benefit Level	Weekly Benefit	Your Annual Salary Must Be at Least
A	\$150	\$11,700	M	\$750	\$58,500
B	\$200	\$15,600	N	\$800	\$62,400
C	\$250	\$19,500	O	\$850	\$66,300
D	\$300	\$23,400	P	\$900	\$70,200
E	\$350	\$27,300	Q	\$950	\$74,100
F	\$400	\$31,200	R	\$1,000	\$78,000
G	\$450	\$35,100	S	\$1,050	\$81,900
H	\$500	\$39,000	T	\$1,100	\$85,800
I	\$550	\$42,900	U	\$1,150	\$89,700
J	\$600	\$46,800	V	\$1,200	\$93,600
K	\$650	\$50,700	W	\$1,250	\$97,500
L	\$700	\$54,600			

Benefit Level Selected

**Weekly Benefits will Equal the Amount Selected, Not to Exceed 66⅔% of Basic Weekly Earnings**

I elect the above benefits which I have selected from all those for which I am eligible. If any contribution from me is necessary to pay part of the cost of the insurance, I authorize my employer to deduct the necessary contribution from my wages.

**FRAUD WARNING (Not Applicable in AZ, FL, MD, VA or MN): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.**

**FRAUD WARNING (FL only): Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an**

Date \_\_\_\_\_ Your Signature \_\_\_\_\_

Do Not Write in This Box Unless Instructed To Do So

If you are refusing coverage, sign below and return this form to your employer.

I acknowledge that I have been offered Voluntary Short Term Disability Insurance by my employer. I hereby wish to waive my right to be insured under this plan. I am aware that I must furnish evidence of insurability satisfactory to Companion Life Insurance Company, at my own expense, if I should apply at a later date. The company shall have the right to decline coverage.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_