

VOLUNTARY STD INCOME PROTECTION (VIP)

ENROLLMENT FORM

(PLEASE PRINT)

New Enrollee

Benefit Change

Decline Coverage

(List current VIP Benefit: \$ _____)

EMPLOYEE INFORMATION		EMPLOYER INFORMATION	
Employee's Name (First, MI, Last)		Employer's Name	Group #
Social Security No	Employee's State of Residence	Employee's Salary <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual \$ _____	
Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Hours Worked Weekly	Dept/Location
Occupation (Be Exact)		Date Employed Full-time	VIP Benefit Plan

BENEFIT SELECTION – Must be completed. Ask your employer for the details about the plan(s) available to you, your cost and whether you will be required to complete Evidence of Insurability (EOI). If you are a late applicant or if you are applying for an increase in coverage, you will be required to submit Evidence of Insurability.

I hereby apply for a Weekly Benefit of: \$ _____ Premium (to be completed by employer): \$ _____

Benefit Guidelines and Pre-Existing Conditions Exclusion:

- Your weekly benefit may not exceed 70% of your basic weekly income (excluding bonus, overtime or any extra compensation other than commissions).
- If you are eligible for state-mandated temporary disability benefits, or any employer-paid income replacement plan, the combination of your state mandated benefit or other income benefit and your VIP weekly benefit may not exceed 70% of your basic weekly earnings.
- Pre-existing Condition Exclusion: During the first year of your coverage, benefits will not be paid on any condition for which you received medical treatment or advice within 12 months before your effective date of coverage.

If your earnings are based in whole or in part on commissions, commissions will be averaged over the 12-months period prior to the date disability begins.

Are you actively at work on the date of this application? Yes No

Do you presently have other disability coverage? Yes No If yes, give monthly amount \$ _____

Do you intend to replace existing coverage with this policy? Yes No

Please check the box next to the statement that applies to you.

(Check One Only):

- I represent that the information provided above is true and correct. If the Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work.
- I have been given an opportunity to participate in my employer's Voluntary STD Income Protection Program, and I decline to participate. I understand that if I apply for this coverage at a later date, satisfactory Evidence of Insurability may be required.

Warning: Any person who knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

Employee's Signature

Date Signed

Home Office Use Only
Eff. Date