



Income Protection Benefits

Concordia College

Information About You

Long Term Disability Benefits Enrollment Form

Name:	Social Security Number/Employee ID Number:
Date of Birth:	Date of Hire:

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please enter or check your coverage elections and details. *You may only elect – and will be covered for – levels of coverage included in your employer’s contract.*
- **Step 2:** Please sign, date and return this form to Human Resources.

Contributory Long Term Disability Insurance

You have the opportunity to enroll in the Contributory Long Term Disability Insurance. Contributory Long Term Disability Insurance helps to replace your income if you are sick or injured and cannot work and is designed to begin after you have been disabled for a predetermined waiting period, known as the elimination period of 180 days. This plan provides you with income protection to replace up to 60% of your Earnings to a maximum monthly benefit of \$4,500.

- I elect to **purchase** Contributory Long Term Disability coverage and have my premiums deducted from my paycheck on a **post-tax** basis (non-taxable benefit).
- I elect to **purchase** Contributory Long Term Disability coverage and have my premiums deducted from my paycheck on a **pre-tax** basis (taxable benefit).
- I **decline** to purchase Contributory Long Term Disability coverage.

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Contributory Long Term Disability Insurance coverage described in the Benefit Highlight Sheets and offered through Concordia College.

I understand and agree that if I decline coverage now, but later decide to enroll, I will be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the policyholder (your employer) can fully describe the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit is reduced at a specified age stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I authorize my employer to make the appropriate payroll deductions from my earnings.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed _____ Date _____

Underwritten by Hartford Life And Accident Insurance Company. The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies: Simsbury, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued.