Underwritten by:
Life Insurance Company of North America
Connecticut General Life Insurance Company
Cigna Life Insurance Company of New York

Calhoun County

Long Term Disability Insurance
Enrollment Form
Court Employees Class 2

Please complete this form in its entirety. Blank fields will cause significant delays in processing.

Employee Social Security Number _____

Gender ☐ M ☐ F

Date of Birth _____

Hours Worked Per Week _____

Employee First Name _____

M.I. _____

Last _____

Employee Street Address _____

City _____

State _____

Zip Code _____

Original Date of Hire _____

Annual Salary _____

Occupation _____

60% to $3,000 - 360 Day Elimination Period

Rates* per $100 of Covered Salary			
Age	**Rate**	**Age**	**Rate**
< 25	$0.063	50 – 54	$0.675
25 - 29	$0.063	55 – 59	$0.750
30 - 34	$0.158	60 – 64	$0.488
35 - 39	$0.225	65 – 69	$0.488
40 - 44	$0.330	70 +	$0.488
45 - 49	$0.503		
*LTD rates are based on five-year increments. Rates increase as you age.			

To calculate the per-paycheck cost for this coverage, complete the calculations below.

Note: *If your annual salary exceeds $60,000, use $60,000 as your annual salary in the calculation.*

_____ ÷ 100 = _____ X _____ = _____ ÷ _____ = _____

Annual Salary | Your Rate | Annual Cost | # Paychecks per Year | **Cost per Paycheck***

* Final cost may vary slightly due to rounding.

☐ **Yes,** I would like to participate. I authorize my employer to deduct from my salary or wages the necessary premium for this coverage. My signature verifies the accuracy of information contained on this form.

I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would otherwise become effective. **I have also read and understand the information in the Plan Highlights, including all statements regarding exclusions and benefit amounts and offsets.**

☐ **No,** I do not wish to participate. I understand that evidence of insurability will be required, at my own expense, if I decide to elect this coverage in the future.

Employee Signature: _____ Date: _____

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SIGN HERE