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
Non-Court Class 1

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 (mm/dd/yyyy) ______________________

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 - 180 Day Elimination Period

Rates* per $100 of Covered Salary			
Age	**Rate**	**Age**	**Rate**
< 25	$0.09	50 – 54	$0.855
25 - 29	$0.128	55 – 59	$0.96
30 - 34	$0.150	60 – 64	$0.63
35 - 39	$0.203	65 – 69	$0.63
40 - 44	$0.338	70 +	$0.63
45 - 49	$0.60		
*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: ______________

Return Forms To: ______________________________ By: ______________