Illinois State University
Voluntary Group Long Term Disability

Employee Enrollment Form **Policy Number: 92821**

EMPLOYEE INFORMATION - Failure to accurately complete the questions on this enrollment request may affect the existence or amount of coverage requested. *(Please print or type)*

Employee Name _____ Proposed Effective Date: _____

Department: _____ Sex: _____

Job Title:_____ ANNUAL Earnings: $_____

Employee Social Security Number:_____ Hire Date: _____

Employee UID Number: _____ # Hours per week: _____

Employee Date of Birth:_____

ACCEPTANCE

Your plan offers you 66.67% of your monthly pre-disability income minus any applicable offsets to a maximum of $12,000. Please check below and sign at the bottom to elect coverage.

____ **Yes**, I would like to participate in The Prudential Insurance Company of America Voluntary Group LONG TERM DISABILITY Insurance Plan.

I hereby apply for a monthly benefit in the amount of _____ subject to the terms of the group policy issued by The Prudential Insurance Company of America for a monthly premium of $_____.

I understand that by signing and submitting this form to elect coverage, I am authorizing payroll deductions from my salary. I further certify that any information disclosed on this enrollment request is accurate and that my answers to any questions are true and complete. I understand that I must be actively at work on the effective date or coverage will be deferred until I return to work.

REFUSAL

____ **No**, I do not wish to participate. I understand that I will not be entitled to any benefits under this coverage and will not be able to enroll at a later date without providing proof of good health satisfactory to The Prudential Insurance Company of America and that I can be turned down for coverage on the basis of health. **Coverage not elected will be assumed refused, even if not specifically refused.**

Notice: Payroll deductions may begin prior to the effective date of your insurance.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employees Signature _____ Date: _____

The Long Term Disability Coverage is underwritten by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Please refer to the Booklet-Certificate for all plan details, including any exclusions, limitations and restrictions which may apply. Contract Series: 83500.

Please return completed enrollment form to
HUMAN RESOURCE CUSTOMER SERVICE CENTER
CAMPUS BOX 1300

Prudential

INST-A0038