Educators Mutual Life Insurance Company

202 N. Prince Street • P.O. Box 83149 • Lancaster PA 17608-3149

Group Voluntary Short Term Disability Enrollment/Change/Waiver Form

EMPLOYEE INFORMATION

Name of Employer	**Group Number**
Employee Name (last, first, middle)	**Social Security #**

Residence Address

Street ______________________________

City ______________________ State ______________ Zip Code ________

Birth Date ____/____/____	**Sex** ❑ Male ❑ Female	**Marital Status** ❑ Single ❑ Married

Occupation / Job Title	**# of Hours Worked Weekly** (excluding overtime)

Date of Hire Full-time: ____/____/____

Part-time: ____/____/____

Are you currently actively at work? ❑ **Yes** ❑ **No**

Basic Salary (excluding overtime) $________ ❑ Annual ❑ Hourly

Average Commissions (if applicable) $__________

COVERAGE SELECTION

I am electing Voluntary Short Term Disability coverage: YES ❑ NO ❑

If your Employer selected the Flat Amount Option, select your Flat Amount Benefit $____________

(You may select an amount from $100 to the maximum selected by your Employer, in increments of $50, not to exceed 66 2/3% of your basic weekly earnings**)**

Were you covered under short term disability coverage provided by this employer? YES ❑ NO ❑
If YES, list name and effective date of prior short term disability coverage:

Are you covered under any other short term disability coverage? YES ❑ NO ❑
If YES, list name, effective date of other short term disability coverage, name of carrier and policy number:

IMPORTANT ENROLLMENT NOTICES

If you received medical care or advice within the 90 days preceding your original effective date for an illness or physical condition, you may not be covered for that illness or physical condition for up to one year under this plan. This exclusion applies only to an illness or physical condition for which medical care or advice has been received within the 12 months (90 days in Pennsylvania) preceding your original effective date. Please consult your certificate of coverage for specific information regarding this preexisting condition exclusion that applies to you.

ENROLLEE'S DECLARATION

When this insurance becomes effective, I authorize my employer to deduct any required contribution for this insurance from my earnings. To the best of my knowledge and belief, all of the statements and answers given in this application are true and complete and I have read and understand the above fraud statement.

Signature	**Date**

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF PENNSYLVANIA, KENTUCKY AND OHIO:

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.

FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE DISTRICT OF COLUMBIA:

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF FLORIDA:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF NEW JERSEY:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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