

# Augusta State University

**Long Term Disability Plan – Enrollment Form**  
**Policy No. GLT-24152**



Hartford Life

- New  
 Change

## 1. Fill in the following blocks for all coverages:

Social Security Number - -		Name (last, first, middle initial)		
<input type="checkbox"/> Check if new address	Street -			
<input type="checkbox"/> Male <input type="checkbox"/> Female	City	State	Zip	
Date of Birth / /	Home Telephone ( )		Date of Hire / /	
Company/Location	Annual Salary \$	Occupation		

## 2. Please read, mark one of the boxes below, then sign and return this form to your Benefits Office:

- I REQUEST COVERAGE under the Long Term Disability Insurance Plan through my employer's group insurance contract, as now or hereafter applicable to me, and authorize the appropriate deductions from my wages.

Employees in TRS or ERS choose an elimination period:  90 days  150 days

Employees in ORP choose an elimination period:  90 days  150 days

- I DECLINE COVERAGE under the Long Term Disability Insurance Plan. I understand that if I desire to apply at a later date for the benefits that I have declined, I will have to furnish, at my own expense, proof of good health satisfactory to Hartford Life before coverage can become effective.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

## 3. To be completed by the Employer:

Effective Date of Coverage:	Effective Date of Change:
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