Tennessee Board of Regents — Exempt Enrollment Form

Long Term Disability Insurance Plan

Reset Form

☐ New ☐ Change

1. Please complete the following information:			
Social Security Number - -	Name (last, first, middle initial)		
☐ Check if new address	Street		
☐ Male ☐ 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. **PLEASE CHOOSE A PLAN OPTION BELOW:**

- ◯ Plan 1 – 50% with 6 month Elimination
- ◯ Plan 2 – 60% with 4 month Elimination
- ◯ Plan 3 – 66 2/3% with 3 month Elimination

☐ 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: