WESTERN MICHIGAN UNIVERSITY

Human Resources (269)387-3620

INS

# Long Term Disability Insurance Enrollment and Change Form

## Employee Information

| Last Name | First Name | Middle | Employee ID |
|---|---|---|---|
| | | | |

| Date of Hire | Effective Date | Department |
|---|---|---|
| / / | / / | |

| Date of Birth | Gender | Employee Group |
|---|---|---|
| / / | ☐ F ☐ M | |

## Enrollment or Changes

Refer to your Benefits and Rates Summary for coverage and premiums, as they vary per employee group

- ☐ Enroll Upon Hire
- ☐ Enroll through evidence of insurability
- ☐ Waive Upon Hire
- ☐ Cancel/Terminate
- ☐ Reinstate – RFL

## Please read, sign and date below

*****I wish to apply for the insurance indicated above, or authorize the changes above.
*****I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.
*****I understand that if I waive any of these insurance coverage's, and at a later date wish to request such, I will be required to furnish, which may be at my own expense, evidence of insurability satisfactory to the insurance carrier.
*****To the best of my knowledge and belief, the information I have provided is complete and correct.

| **Employee Signature** | **Date** / / |
|---|---|
| | |

| **HR USE ONLY** ⇒ | HRA | Deduction Begin Date / / | HRPA |
|---|---|---|---|
| | | | |