

# Short Term Disability Insurance Enrollment Form

Please print this form and complete all sections clearly using black or blue ink.

## 1. Employer Information

Employer Name:

Group Policy Number:

Division/Location:

## 2. Employee Information

Full Legal Name (Last, First, Middle):

Social Security Number:

Date of Birth (MM/DD/YYYY):

Gender (Male / Female):

Street Address:

City, State, Zip Code:

Phone Number:

Email Address:

## 3. Employment Details

Date of Hire (MM/DD/YYYY):

Job Title / Occupation:

Annual Salary:

Hours Worked Per Week:

## 4. Coverage Election

Do you wish to enroll in Short Term Disability Insurance? (Yes / No):

Plan Option (if multiple choices are offered by your employer):

## 5. Beneficiary Designation

Primary Beneficiary Name (Last, First):

Relationship to Employee:

## 6. Authorization and Signature

I authorize my employer to deduct from my earnings the necessary premium contributions (if applicable) for this coverage. I understand that the coverage will be subject to all provisions, exclusions, and limitations of the group policy.

Employee Signature (Sign after printing):

Date Signed (MM/DD/YYYY):