LONG TERM DISABILITY ENROLLMENT/CHANGE FORM

(*Please print or type*)

MSMA
MAINE SCHOOL MANAGEMENT ASSOCIATION

☐ **ENROLLMENT** ☐ **CHANGE** Effective Date of Coverage or Change _____/_____/_____

School Unit _____ Employee's Name (*Last, First, M.I.*) _____

Social Security # _____-_____-_____ Date of Birth ____/____/____ Sex (*Please Circle*) M F Occupation _____

Address _____
(*Street*) (*City*) (*State*) (Zip)

Home Telephone ( ) _____-_____ Work Telephone ( ) _____-_____ Hours Worked Weekly _____

☐ New Enrollee Date Hired _____/_____/_____
☐ Terminating Coverage Date _____/_____/_____
☐ **DECLINE COVERAGE**

☐ Single
☐ Married

To enroll, you must be full time, regularly working 17.5 hours per week.

Annual Income:
(Must be completed before enrollment can take place)
$ _____

Elimination Period (*Check One*) 60 ☐ 90 ☐ DAYS (*Check One*) ☐ With Accrued Sick Time Used ☐ Without Sick Time Used

120 ☐ 150 ☐ 180 ☐ DAYS With Accrued Sick Time Used

Request For Change

☐ Name Change To _____

☐ New Address _____

Fraud Statement *Any person who knowingly and with intent to defraud any insurance company or other person files a 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.*

I hereby authorize my employer to deduct from my earnings any payments, if applicable, for this coverage. By signing this enrollment, I hereby have read and understand the limitations that apply to Long Term Disability coverage. These limitations are listed on the back of this form.

Employee Signature _____ Date Signed _____

Employer Signature _____ Date Signed _____

Employers – For those DECLINING, keep this form for your records.

(See other side)

LIMITATIONS WHICH APPLY TO LONG TERM DISABILITY COVERAGE

Long Term Disability Coverage does not cover any disability that:

- Is due to intentionally self-inflicted injury (while sane or insane).
- Starts during the first 12 months of your current Long Term Disability Coverage, if it is caused or contributed to by a "preexisting condition". A disease or injury is a preexisting condition if, during the 3 months before the date you last became covered:
  - It was diagnosed or treated; or
  - Services were received for the disease or injury; or
  - You took drugs or medicines prescribed or recommended by a physician for that condition.

- Results from your committing, or attempting to commit, an assault, battery, or felony.
- Is due to war or any act of war (declared or not declared).
- Is due to: insurrection; rebellion; or taking part in a riot or civil commotion.
- On any day during a period of disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense:
  - The person will not be deemed to be disabled; and
  - No benefits will be payable.