

The University of Tennessee

Enrollment Form

Long Term Disability Insurance Plan

1. Fill in the following blocks for all coverages:

Social Security Number - -	Name (last, first, middle initial)	
Date of Birth / /	Coverage Effective Date: / /	Date of Hire / /
<input type="checkbox"/> Male <input type="checkbox"/> Female	Responsible Account:	Pay Cycle:

2. Choose the Desired Plan (check the block beside the desired plan number):

Plan Features	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5
Income Replacement	60%	60%	60%	60%	50%
Waiting Period	4 Months	4 Months	4 Months	4 Months	4 Months
Alcohol and Drug Abuse Treatment Limitation	2 Years	2 Years	2 Years	2 Years	2 Years
Annuity	None	None	10%	10%	None
Cost of Living Adjustment	None	3% after two years	None	3% after two years	None
Premium per \$100 of covered salary	.783	.855	1.10	1.40	.55

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

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.

Date: _____ Signature of Employee: _____