

# Voluntary Disability Enrollment Form

## Hartford Life and Accident Insurance Company

Last Name (Legal Name)	First Name	M.I.	
Duke Unique ID	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth
Street Address	City	State	Zip Code
Date of Hire or Elig.	Hours Worked Per Week	<input type="checkbox"/> Paid Biweekly	\$_____ Hourly Rate
		<input type="checkbox"/> Paid Monthly	\$_____ Monthly Salary
Email Address:	Phone Number:		

Please check the appropriate box that corresponds to your location:

- Duke University     Duke University Health System     Duke Regional Hospital     Duke Raleigh Hospital

It is easier to enroll within the first 30 days after your new hire date or first period of eligibility because the coverage is issued under “guaranteed issue” guidelines. Guaranteed issue means coverage will be issued without regard to health status. If you wait until after 30 days to apply for enrollment, you will have to answer health questions which may impact your enrollment.

## Voluntary Short Term Disability Insurance

You have the opportunity to enroll in the Voluntary Short Term Disability (STD) insurance plan. This plan provides you with income protection to replace up to 60% of your base salary, to a maximum weekly benefit of \$2,885.

- I elect to enroll in the Voluntary STD plan.

## Voluntary Long Term Disability Insurance

(for employees with less than 3 years of full time, continuous service or without the Duke Disability Waiver)

You have the opportunity to enroll in the Voluntary Long Term Disability (LTD) insurance plan. This LTD plan provides you with income protection to replace up to 60% of your base salary, to a maximum monthly benefit of \$12,500.

- I elect to enroll in the Voluntary LTD plan.

## Employee’s Acknowledgment

I have been given the opportunity to enroll in my employer’s voluntary group disability insurance plan(s). I understand that if I decline now, but later decide to enroll, I may be required to provide satisfactory evidence of insurability and understand my request for coverage may be denied.

If I opt to enroll in the plan, I authorize my employer to make the appropriate payroll deductions from my wages on a post-tax basis. I am currently not disabled, and I am performing all the duties of my occupation on a full-time basis.

MGIS will notify me in writing about my enrollment. If not notified in writing within 60 days of my enrollment form submission, it is my responsibility to contact MGIS (1-800-969-6447, ext. 139) to inquire about the status. Once confirmation of coverage is received from MGIS, it is also my responsibility to check my payroll deductions in a timely manner to confirm that premiums are deducted. Also, monthly premiums must be paid for eligible coverage to be valid.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### PLEASE RETURN THIS FORM TO:

The MGIS Companies, 95 S State St., Suite 650 Salt Lake City, UT 84111-1630  
Fax: 801-990-2401 or 800-497-8249 (toll-free) • Phone: 800-969-6447, ext. 139

# Voluntary Disability Premium Worksheet

The premium will be payroll deducted monthly. The rate depends on your current base salary and age as of January 1st of current year, calculated per \$100 of covered monthly pay. To determine your monthly payroll deduction, fill out the premium calculation worksheet.

## Premium Calculation Worksheet

Example: Employee age 35 earning \$25,000 per year.

### Voluntary STD

	Example:	You:
1. Enter your annual earnings, up to \$ 250,000:	\$ 25,000	\$ _____
2. Divide by 12:	\$ 2,083.33	\$ _____
3. Divide line 2 by 100:	\$ 20.83	\$ _____
4. Enter your rate from the table to the right:	\$ .23	\$ _____
5. Multiply line 3 by line 4. This is your monthly premium:	\$ 4.79	\$ _____

Age	Voluntary STD Rate/\$100 of covered pay
<25	\$ .27
25-29	\$ .29
30-34	\$ .23
35-39	\$ .23
40-44	\$ .23
45-49	\$ .26
50-54	\$ .31
55-59	\$ .34
60-64	\$ .36
>65	\$ .50

### Voluntary LTD

	Example:	You:
1. Enter your annual earnings, up to \$250,000:	\$ 25,000	\$ _____
2. Divide by 12:	\$ 2,083.33	\$ _____
3. Divide line 2 by 100:	\$ 20.83	\$ _____
4. Enter your rate from the table to the right:	\$ .32	\$ _____
5. Multiply line 3 by line 4. This is your monthly premium:	\$ 6.67	\$ _____

Age	Voluntary LTD Rate/\$100 of covered pay
<35	\$ .25
35-39	\$ .32
40-44	\$ .50
45-49	\$ .94
50-54	\$ 1.10
55-59	\$ 1.24
>60	\$ 1.36

## How Do I Enroll?

Complete the enrollment form included in your orientation packet and return it to our plan record keeping administrator:

Ashlie Lara  
ashlie.lara@mgis.com

Send the completed enrollment form and keep a copy of it for your records. MGIS will notify you in writing about your enrollment. Questions about plan administration, record keeping, and payroll deductions may be referred to MGIS at:

(800) 969-6447 ext. 139  
9:30 AM to 6:15 PM EST