INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Offered by Life Insurance Company of North America

Employer: Delta State University

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ **Social Security #** _____ **Birthdate** _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Gender: _____

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employee-Paid (Voluntary) Short-term Disability Insurance Policy # VDT 0960642		
Applicant	Review your available plan below before accepting or declining coverage.	
Employee	Benefit Percentage: 60% Maximum Weekly Benefit Amount: $2,500	❑ Accept Coverage ❑ Decline Coverage

Employee-Paid (Voluntary) Long-term Disability Insurance Policy # VDT 0960643		
Applicant	Review your available plan below before accepting or declining coverage.	
Employee (including the Public Employee's' Retirement System)	Benefit Percentage: 60% Maximum Monthly Benefit Amount: $10,000	❑ Accept Coverage ❑ Decline Coverage
Employee (excluding the Public Employee's' Retirement System)	Benefit Percentage: 50% Maximum Monthly Benefit Amount: $10,000	❑ Accept Coverage ❑ Decline Coverage

All coverage elected during this enrollment period will take effect on the latest of 05/01/2024, the date your election form is received by your employer, or if applicable the day your Evidence of Insurability Form is approved by the Insurance Company.

SIGN HERE TO ACCEPT YOUR DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to New York Life Group Benefit Solutions' approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by DE: Life Insurance Company of North America.

Pre-Existing Condition Limitation (applies to disability insurance): "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.

I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage.

Please Sign Here ☛ Signature _____ Date _____

Created on 10/2023.