

**The State of Connecticut
Voluntary Long-Term Disability
Benefits Enrollment Form**

A supplemental voluntary benefit available to you as an eligible employee of The State of Connecticut

Instructions

Step 1 – Make Your Coverage Election

Complete the required sections and select the coverage options available under your employer's plan.

Step 2 – Sign and Submit

Sign, date, and return this form to the contact below.

Please keep a copy for your records.

Submission Contact

SCEVLTD Program

c/o **USI Insurance**

95 Glastonbury Blvd, Suite 406

Glastonbury, CT 06033

Phone: (203) 634-2829 Toll-Free: (888) 723-8583 Fax: (866) 486-3508

Email: USICT.SCEVLTD@usi.com

Enrollment Type

New Enrollment Change to Existing Coverage

Social Security Number:		Name (last, first, middle initial):		
Check if new address	Home Address:	City:	State:	Zip Code:
Date of Birth:	Date of Hire:	Job Record Code:		
Agency Name:	Annual Base Pay:	Department ID:		
Work Address:		Position Title:		
Work Phone:	Home Phone:	Employee Number:		

Long Term Disability Insurance Enrollment Form Continued

Name: _____

Please check the box that corresponds to your pay schedule:

Bi-Weekly Semi-Monthly Monthly

Please check one box and fill in the Cost Per Pay Period box below:

Plan 1: 50% of annual salary

Plan 2: 60% of annual salary

- Option 1: 90-day elimination period.
 Option 2: 180-day elimination period.
 Option 3: 365-day elimination period.

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 Option 2: 180-day elimination period.
 Option 3: 365-day elimination period.

Cost Per Pay Period (see next two pages to calculate): _____

Confirmation: I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer. I understand and agree that if I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

If I have disability income coverage with The Hartford, I understand and agree that the maximum duration of benefits payable will be limited to a specified period which may start at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I authorize payroll deductions from my wages to cover my cost of coverage when applicable and authorize the release of any information (including salary information) as necessary for my enrollment and / or the administration exclusively for the State of Connecticut Employee Voluntary Long Term Disability plan of benefits to the Hartford Insurance Company and its appointed agents. I understand rates and benefits may be changed by the insurer.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are required by The Hartford or by law and are not met, the policy will not be implemented and the coverage I have elected will not be in force.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Name: _____

Signed: _____ Date: _____

Long Term Disability Insurance Enrollment Form Continued

Name: _____

How to Calculate the Cost of Coverage:

Use the chart and formula below to calculate the cost of your coverage:

Plan 1 – 50% of Salary (Max Monthly Benefit \$5,000)

Age	90-Day EP	180-Day EP	365-Day EP
Under 35	0.0022	0.0015	0.0014
35–39	0.0036	0.0027	0.0023
40–44	0.0052	0.0040	0.0030
45–49	0.0077	0.0058	0.0040
50+	0.0095	0.0072	0.0050

Plan 2 – 60% of Salary (Max Monthly Benefit \$5,000)

Age	90-Day EP	180-Day EP	365-Day EP
Under 35	0.0032	0.0024	0.0021
35–39	0.0054	0.0041	0.0035
40–44	0.0080	0.0060	0.0050
45–49	0.0115	0.0087	0.0070
50+	0.0144	0.0119	0.0090

Step	Bi-Weekly	Semi-Monthly	Monthly
Enter your regular earnings (from paystub)	\$ _____	\$ _____	\$ _____
Maximum earnings allowed	P1: \$4,615 P2: \$3,846	P1: \$5,000 P2: \$4,167	P1: \$10,000 P2: \$8,333
Multiply by age-based rate	× _____	× _____	× _____
Subtotal	= \$ _____	= \$ _____	= \$ _____
Add administrative fee	+ \$0.50	+ \$0.54	+ \$1.08
Total cost per pay period	\$ _____	\$ _____	\$ _____

Round to the nearest whole dollar and enter this amount in the “Cost Per Pay Period” field on page 2