



## Short-Term Disability Enrollment Form Policy#96095

Human Resources  
3640 Colonel Glenn Hwy.  
University Hall, Suite 200  
Dayton, OH 45435-0001  
Tel: (937) 775-2120 Fax: (937) 775-3299

### Reason for Enrollment:

<input type="checkbox"/> New Hire	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Life Event: _____	Effective Date: _____
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### Employee Information:

Last Name:		First Name, Middle Initial:		University ID:	
Social Security Number:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Daytime Phone:		
Address:		City:	State:	Zip Code:	
Date of Hire:		Title:			
Department:			Annual Salary:	<input type="checkbox"/> Paid Monthly <input type="checkbox"/> Paid Bi-Weekly	

### Short-Term Disability Cost Calculation:

*To calculate your monthly cost for this coverage, complete the calculations below.  
Note, final cost may vary slightly due to rounding.*

Annual Salary*	÷ 100 =	_____	X	_____	=	_____ ÷ 12	=	_____ Monthly Cost
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*\*If your salary exceeds \$200,200.00, use \$200,200.00 as your annual salary in the calculation.*

#### Rates\*\* (per \$100.00 of Covered Salary)

*\*\*Rates are based on age as of December 31st of the plan year. Rates increase as you age.*

Age	Rate
< 55	\$0.39
55 - 59	\$0.42
60 - 64	\$0.53
65 - 69	\$0.62
70+	\$0.68

**YES**, I would like to participate. I authorize Wright State University to deduct from my salary or wages the necessary premium for this coverage. My signature verifies the accuracy of information contained on this form. I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would otherwise become effective. **I have also read and understand the information in the Plan Highlights, including all statements regarding exclusions and benefit amounts and offsets.**

I understand that I'm required to submit a Statement of Health to Unum by the designated deadline using access code V3BIMYW.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Employer Use Only		
Effective Date:	Premium:	<input type="checkbox"/> PDAEDN