Short-Term Disability Election Form

Policy #96095

Human Resources
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Step 1: Reason for Enrollment or Termination

☐ Open Enrollment	☐ Qualifying Life Event	Effective Date: _____

Step 2: Employee Information:

Last Name:	First Name, Middle Initial:	University ID:
Date of Hire:	Work Email Address:	
Department:	Annual Salary:	☐ Paid Monthly ☐ Paid Bi-Weekly

Step 3: Calculate Your Monthly Premium

To calculate your monthly cost for this coverage, complete the calculations below or use the calculator located on the HR website. Note, final cost may vary slightly due to rounding.

_____	÷ 100 =	_____	X	_____	=	_____	÷ 12	_____
Annual Salary*				Your Rate		Annual Cost		Monthly Cost

**If your salary exceeds $200,000.00, use $200,000.00 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

Step 4: Submit a Statement of Health

A Statement of Health (Evidence of Insurability) is an application process in which past and present health information of an applicant is provided to Unum, the university's disability vendor, in order to determine eligibility for coverage. Applications are either approved or denied based on the information requested and received. Approval by the vendor is not guaranteed. The Statement of Health is located at https://securehealth.unum.com/generichome, use access code **V3BIMYW**. The Statement of Health must be submitted within 31 days of a qualifying event or seven days after open enrollment ends.

☐ I would like to **apply** for coverage. I understand that I must submit a Statement of Health to determine my eligibility for coverage. If approved, 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 elect to cancel my current enrollment in STD coverage during Open Enrollment or while experiencing a qualifying life event; coverage change to be effective on the first day of the new plan year or on the date the qualifying event occurs.

_____ _____

Signature Date

Employer Use Only:	Unum Decision: ☐ Approved ☐ Denied	Effective Date: