Seattle
Department of Human Resources

Supplemental Long-Term Disability Insurance Enrollment & Change Form

Employee Information: (Please print)

Last Name	First Name	Employee ID# or last 4-digits of SSN	Birth Date (mm/dd/yyyy)

Enrollment Status: (Please select one)

- ◯ New hire
- ◯ Change coverage (within 30-day enrollment period)
- ◯ Canceling coverage (mid-year change)

Select one option below (A or B):

For applicable rate amounts and to calculate your contribution refer to your Employee Benefits Guide at https://bit.ly/benguide1.

(Employees who are members of the Seattle Police Officers' Guild and Fire Fighters Local 27, disability plan enrollment is mandatory through your union.) RECRUITS ARE NOT SWORN STATUS, THIS ELECTION IS OPTIONAL

Option A:

◯ **Yes**, I am applying for Supplemental Long-Term Disability insurance according to the terms of the group policy issues to the City of Seattle. I authorize deductions from my salary for the premium amount I am required to make towards the cost of this insurance. This coverage is in addition to the Basic LTD coverage provided by the City. I understand that the policy will not cover any disabilities during the first 12 months after the effective date of insurance that is caused or contributed by any sickness or injury for which I sought treatment during the three months prior to the effective date of coverage.

Option B:

◯ **No**, I do not want to participate in the City of Seattle's Supplemental Long-Term Disability insurance plan. I understand that if I enroll later during a subsequent open enrollment period, my insurance will be subject to the pre-existing condition exclusion period described above. I also understand that Basic LTD will still be provided by the City even if I do not elect Supplemental LTD coverage.

Acknowledgement Signature:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the insurance company. Penalties may include imprisonment, fines and denial of insurance benefits.

By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge, that I have read and understand the enrollment form and descriptive material covering the options provided under this plan. I authorize the insurance carrier to obtain, examine or release information needed to process claims for myself or my family.

Employee's Signature: Date (mm/dd/yyyy):

BENEFITS ADMINISTRATION USE ONLY:		
Coverage Effective Date:	HRIS Entry:	Payroll Adjustment PPE Premiums:
Benefits Rep. Signature & Date:		