



# CLAYTON COUNTY BOARD OF COMMISSIONERS ENROLLMENT FORM

## Information About You (Please Print)

<b>Name:</b>	<b>Employee ID Number:</b>
<b>Date of Birth:</b>	<b>Date of Hire:</b>
<b>Salary:</b>	<b>Department:</b>

### Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please **enter or check** your coverage elections and details. *You may only elect – and will be covered for – levels of coverage included in your employer's contract.*
- **Step 2:** Please **sign, date and return** this form to the Risk Management Office.

The following costs should be calculated based on your age and annual salary as of the effective date.

### Voluntary Long Term Disability (LTD) Insurance

You have the opportunity to enroll in Clayton County Board of Commissioners' Voluntary Long Term Disability (LTD) insurance plan. LTD insurance helps to replace your income if you are sick or injured and cannot work and is designed to begin after you have been disabled for a predetermined waiting period, known as the elimination period, of 90 days. This plan provides you with income protection to replace up to 40%, 50% or 60% of your regular pay, **to a maximum monthly benefit of \$1,000 or \$5,000.**

Use the rate chart and calculation line below to determine your cost per pay period (24 pay periods per year).

<b>Age</b>	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
<b>Rate</b>	\$0.0010	\$0.0010	\$0.0019	\$0.0031	\$0.00495	\$0.00715	\$0.0095	\$0.01195	\$0.0129	\$0.01625	\$0.01625

#### Option 1 – 40%, 50% & 60% Benefit Max \$5,000 - You can make only one election.

I elect to **enroll** in the Voluntary LTD plan at **40%** of the **Benefit Max \$5,000** at the cost per pay period below (24 pay periods per year).

$$\begin{array}{ccccccc}
 \text{Monthly Salary} & \times & \frac{.40}{\text{Benefit Percentage}} & = & \text{This is your Maximum Monthly Benefit. Please Do Not exceed the maximum amount of \$5,000} & \times & \frac{\text{Rate Above}}{\text{Rate Above}} = \text{Your cost per pay period (24 pay periods per year)}
 \end{array}$$

I elect to **enroll** in the Voluntary LTD plan at **50%** of the **Benefit Max \$5,000** at the cost per pay period below (24 pay periods per year).

$$\begin{array}{ccccccc}
 \text{Monthly Salary} & \times & \frac{.50}{\text{Benefit Percentage}} & = & \text{This is your Maximum Monthly Benefit. Please Do Not exceed the maximum amount of \$5,000} & \times & \frac{\text{Rate Above}}{\text{Rate Above}} = \text{Your cost per pay period (24 pay periods per year)}
 \end{array}$$

I elect to **enroll** in the Voluntary LTD plan at **60%** of the **Benefit Max \$5,000** at the cost per pay period below (24 pay periods per year).

$$\begin{array}{ccccccc}
 \text{Monthly Salary} & \times & \frac{.60}{\text{Benefit Percentage}} & = & \text{This is your Maximum Monthly Benefit. Please Do Not exceed the maximum amount of \$5,000} & \times & \frac{\text{Rate Above}}{\text{Rate Above}} = \text{Your cost per pay period (24 pay periods per year)}
 \end{array}$$

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**Option 2 - 40%, 50% & 60% Benefit Max \$1,000 - You can make only one election.**

I elect to **enroll** in the Voluntary LTD plan at **40%** of the **Benefit Max \$1,000** at the cost per pay period below (24 pay periods per year).

$$\text{Monthly Salary} \times \frac{.40}{\text{Benefit Percentage}} = \text{This is your Maximum Monthly Benefit. Please Do Not exceed the maximum amount of \$1,000} \times \frac{\text{Rate Above}}{\text{Rate Above}} = \text{Your cost per pay period (24 pay periods per year)}$$

I elect to **enroll** in the Voluntary LTD plan at **50%** of the **Benefit Max \$1,000** at the cost per pay period below (24 pay periods per year).

$$\text{Monthly Salary} \times \frac{.50}{\text{Benefit Percentage}} = \text{This is your Maximum Monthly Benefit. Please Do Not exceed the maximum amount of \$1,000} \times \frac{\text{Rate Above}}{\text{Rate Above}} = \text{Your cost per pay period (24 pay periods per year)}$$

I elect to **enroll** in the Voluntary LTD plan at **60%** of the **Benefit Max \$1,000** at the cost per pay period below (24 pay periods per year).

$$\text{Monthly Salary} \times \frac{.60}{\text{Benefit Percentage}} = \text{This is your Maximum Monthly Benefit. Please Do Not exceed the maximum amount of \$1,000} \times \frac{\text{Rate Above}}{\text{Rate Above}} = \text{Your cost per pay period (24 pay periods per year)}$$

I elect to **decline** the Voluntary LTD plan.

Your cost may change on your plan anniversary.

***Employee Confirmation***

I acknowledge that I have been given the opportunity to enroll in the insurance coverage described in the Benefit Highlight Sheets and offered through Clayton County Board of Commissioners.

I understand and agree that if I decline coverage now, but later decide to enroll, I will 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 the policyholder (your employer) can fully describe the provisions, terms, conditions, limitations and exclusions of your 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 benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I authorize my employer to make the appropriate payroll deductions from my earnings.

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 not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed \_\_\_\_\_ Date \_\_\_\_\_