

## Disability Income Insurance Enrollment Form

*INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee.*

Name of Employer/Plan Sponsor Independent School District #279—Osseo Area		Group/Plan Number 63245-7	Account Number/Location 1
Class/Occupation ESP (minimum 30 hours/week)	Date of Hire	Annual Salary	Employment Status: <input type="checkbox"/> Active Full-Time <input type="checkbox"/> Retired <input type="checkbox"/> Active Part-Time
This change is due to: (check all that apply) <input type="checkbox"/> Change in Coverage Amount <input type="checkbox"/> Other: _____ <input type="checkbox"/> Initial Eligibility Following Hire <input type="checkbox"/> Late Entrant*			Effective Date of Coverage or Change:

### Employee Information

Employee Name ( <i>last, first, middle initial</i> )	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth / /	Social Security #	Employee ID #
Employee Address ( <i>street address, city, state, zip code</i> )			Telephone Work ( ) Home ( )	

### Disability Income Coverage

Monthly Income Benefits (LTD)	<input checked="" type="checkbox"/> Elect Coverage ( <i>Note: LTD coverage is employer provided.</i> )
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### READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee's Signature	Date Signed / /
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### FOR EMPLOYER/PLAN SPONSOR USE ONLY

COVERAGE	LTD
ACCOUNT	
CLASS	
AMOUNT	
EFF. DATE	