

# Saint Mary's College

## Short Term Disability Enrollment Form

Underwritten by: Hartford Life And Accident Insurance Company ("The Hartford")

Name:	Date of Birth:	Date of Hire:
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### Short Term Disability (STD) Insurance - Voluntary

You have the opportunity to enroll in Short Term Disability (STD) Insurance offered through Saint Mary's College. STD Insurance helps to replace your income if you are sick or injured and cannot work. This insurance coverage provides you with income protection to replace up to 60% of your earnings, to a maximum weekly benefit of \$1,500.00.

To calculate your Monthly Cost please locate your age and corresponding rate, from the table below. Then, complete that formula and calculate your Monthly Cost.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65 and Up
Rate	\$1.43	\$1.25	\$1.02	\$0.77	\$0.68	\$0.78	\$0.90	\$1.01	\$1.12	\$1.23

$$\frac{\text{Annual Salary}}{52} = \text{Weekly Salary} \times .60 = \text{Benefit Amount} \times \frac{\text{Rate (from table)}}{10} = \text{Monthly Cost}$$

\*If your benefit amount is greater than \$1,500 it will be capped at \$1,500. Therefore, do not calculate your monthly cost with a benefit amount higher than \$1,500.

I elect to **enroll** in Short Term Disability (STD) Insurance for a Monthly Cost of \_\_\_\_\_ (as calculated in above formula).

I elect to **decline** Short Term Disability (STD) Insurance.

\*Your cost may change on the Plan Anniversary if your age category or earnings change.

### Disability Simplified Medical Underwriting Application

#### HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Please answer the following questions by checking yes or no in the designated box. Upon completion, please sign and return this Form along with your completed Enrollment Application to The Hartford Group Benefits.

#### STD

During the past 5 years, have you been diagnosed or treated by a member of the medical profession for any of the following: heart condition; cancer; chronic/recurrent respiratory disease; diabetes; kidney or liver disease; any disease of the joints, including neck and back disorders; any mental or nervous disorder; any disorder of the brain or nervous system; or have you been absent from work due to a chronic/recurrent reproductive system disorder?

Employee  Yes  No

During the past 5 years, have you been declined for any disability insurance coverage?

Employee  Yes  No

#### STD ONLY

Are you currently pregnant?

Employee  Yes  No

#### NOTICE

I hereby certify that the above answers are complete and true to the best of my knowledge and belief concerning the past and present state of health and medical history of the person(s) to whom the answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. This information may be used by the Hartford Life and Accident Insurance Company for plan administration purposes to decide if the person(s) is/are eligible for coverage.

EMPLOYEE'S SIGNATURE (Required)

DATE SIGNED

Please sign and return this form to Human Resources by January 31, 2007.