

Eligible Employee Instructions: Please mark all boxes and complete sections A, B, and C, either online or use a ball-point pen and print clearly. Send completed form to your Agency Personnel/Payroll Office. Please keep a copy for your records.

Section A Applicant	1. Type of Enrollment <input type="checkbox"/> New – Enrolling for the first time <input type="checkbox"/> Canceling Plan <input type="checkbox"/> Changing Plan Option							
	2. Your Soc. Sec. No.		3. Your Name (First, Middle, Last)				4. Date of Birth	
	5. Your Address				6. City		7. State	8. ZIP
	9. Job Title/Occupation						10. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Section B LTD Plan Options	1. Please select your LTD Plan option below. Then complete item 2.							
	<input type="checkbox"/>	OPTION A – 65% MISCELLANEOUS/NON-SAFETY/OASDI EMPLOYEES (075-111)						
		Under Age 30	30-39	40-49	50-59	Over 60		
		.00093	.00221	.00508	.01089	.01478		
<input type="checkbox"/>	OPTION B – 65% PEACE OFFICERS/FIREFIGHTERS/SAFETY/NON-OASDI EMPLOYEES (075-112)							
	Under Age 30	30-39	40-49	50-59	Over 60			
	.00130	.00314	.00729	.01561	.02105			
<input type="checkbox"/>	OPTION C – 55% MISCELLANEOUS/NON-SAFETY/OASDI EMPLOYEES (075-119)							
	Under Age 30	30-39	40-49	50-59	Over 60			
	.00054	.00119	.00281	.00594	.00810			
<input type="checkbox"/>	OPTION D – 55% PEACE OFFICERS/FIREFIGHTERS/SAFETY/NON-OASDI EMPLOYEES (075-120)							
	Under Age 30	30-39	40-49	50-59	Over 60			
	.00076	.00173	.00400	.00853	.01156			
2. Please calculate your monthly LTD premium by using the formula below.								
Premium Computation								
	_____	×	_____	+	.80 =	_____		
	Monthly Base Salary *		Factor For Your Age From Options Above			Monthly LTD Premium		
* Not to exceed a monthly base salary of \$10,910 for the 55% plan options and \$9,231 for the 65% plan options.								
Section C Signature	I wish to make the choices indicated on this form. If electing to change coverage, I authorize deductions from my wages to cover my contribution, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. If I elect to cancel coverage in the LTD Plan, I understand I will not be able to re-enroll again until the next open enrollment period.							
	Employee Signature Required						Date (Mo/Day/Yr)	
Agency Personnel/Payroll Office: VERIFY EMPLOYEE'S PREMIUM COMPUTATION								
Section D Agency Use Only	1. Deduction Code 075	2. Organization Code	3. Deduction Amount	4. Agency Name				
	5. Effective Date		6. CBID		7. Agency Code		8. Rept. Unit	
	9. AUTHORIZED AGENCY SIGNATURE I certify that authorization for payroll deductions signed by this employee and appointing the above-named company or organization as his/her agent is on file in this office.							
	SIGNATURE _____							
	10. Remarks/Eligibility date for "newly eligible employees" (beginning and ending date)						11. Telephone number	
						12. Date received in employing office		

Agency Distribution List: Original and 1 copy TO SCO
 1 copy TO EMPLOYEE
 1 copy TO EMPLOYEE'S PERSONNEL FILE