RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Effective Date_____

Voluntary Disability Plan

Instructions: Use this form only for cases that offer the employee the ability to purchase voluntary disability coverage. Type or print with ballpoint pen. The employee and the policyholder must each receive a copy of the completed Group Disability Enrollment Form.

Group Disability Enrollment Form

All sections must be completed to ensure accurate processing.

(1) Policyholder/Employer Mississippi University for Women		(2) RSL Policy No. VPL674575
(3) Location		(4) Full-Time Employment Date
(5) Hours Per Week	(6) Annual Salary	
(7) Employee's Full Name (8)Employee's Address and Phone Number (9)Employee's Email Address		(10) Reason for Completing Form: Initial Eligibility/New Hire Late Applicant Approved Enrollment Period
(11) Social Security Number	(12) Gender (M/F)	(13) Employee's Birth Date

(14)

I request to purchase a **monthly LTD** benefit. Please check below the amount of benefit you wish to purchase.

I request to purchase a Group Disability Insurance Benefit of _____ per month

Please also select Elimination Period:

☐0/3 day EP ☐14 day EP ☐30 day EP ☐90 day EP ☐180 day EP

Monthly Premium_____

Do you have prior coverage? ☐ YES ☐NO

If YES, who was the Prior Carrier: _____

Monthly Premium:

I authorize my employer to deduct from my salary or wages the necessary premium for the coverage requested above. The signature below also verifies the accuracy of the information contained on this form.

I understand that any coverage will not become effective until and unless approved by RSL, and upon approval, any benefits payable are subject to the terms, conditions and limitations of the Group Disability Policy. I also understand that the amount of any payroll deduction may be adjusted based on underwriting changes or age changes that affect the rates charged.

_____ / _____ / _____

Employee Signature Date

Please sign, date and return enrollment form to your Plan Administrator upon completion. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Enrollment Representative_____