County of Dane Disability Insurance

FOR OFFICE USE ONLY
Effective Date

PLAN	OPTION

Standard Insurance Company: Policy 163054

Social Security No.	Applicant Name (Last, First, MI)			
Address (street number and name)		City	State	Zip Code
Date of birth	Gender ○ MALE ○ FEMALE	Marital Status	Hire Date	Actively working? (Y/N) ○ YES ○ NO
Department Name		Job Title		

REASON FOR APPLICATION:

- ○ NEW EMPLOYEE / NEWLY ELIGIBLE
- ○ OPEN ENROLLMENT
- ○ CHANGE PLAN (MEDICAL UNDERWRITING)
- ○ LATE ENROLLMENT (MEDICAL UNDERWRITING)
- ○ CHANGE PREMIUM OPTION ONLY

Plans (indicate choice in box above):

A: Short Term + Long Term: (42 day elimination period)

B: Long Term Only: (90 day elimination period)

Options (indicate choice in box above):

#1: County paid premium is tax free, Employee paid premium is pre-tax. Benefits are taxable to employee when received.**

Portion of the premium paid by County is determined by hours of sick leave used in prior payroll year:*

Sick hours used*	County Pays	Employee Pays
0.0-32.0	100%	0%
32.1-40.0	60%	40%
40.1-48.0	40%	60%
48.1-56.0	20%	80%
56.1+	0%	100%

#2: County paid premium is imputed (taxable) income to employee, employee paid premium is post-tax. Benefits are tax free when received by employee.**

Portion of the premium paid by County is determined by hours of sick leave used in prior payroll year:*

Sick hours used*	County Pays	Employee Pays
0.0-32.0	100%	0%
32.1-40.0	60%	40%
40.1-48.0	40%	60%
48.1-56.0	20%	80%
56.1+	0%	100%

#3: Employee pays entire premium, post tax. Benefits are tax free**. Wellness hours are granted:

ST-LT: Sick hours used in prior year are 48 hours or fewer = **24** wellness hours prorated by FTE
Sick hours used in prior year exceed 48 hours = **16** wellness hours prorated by FTE

LT Only: Sick hours used in prior year are 48 hours or fewer = **16** wellness hours prorated by FTE
Sick hours used in prior year exceed 48 hours = **8** wellness hours prorated by FTE

* **For new employees, sick leave analysis will begin for the disability plan year after one *full* payroll year of sick leave has been earned/used. Until then, the employee pays 100% of the premiums under each option.**

** **Taxability of benefits is based on a three year lookback at taxation of premiums paid at the time benefits are received.**

Date signed	Employee Signature

WAIVER OF DISABILITY INSURANCE:

This is to certify that I have declined the opportunity to participate in this portion of the Group Insurance Program. I further certify that I fully understand that by this refusal I will not be entitled to any benefits whatsoever under such portion of the Group Insurance program, and that if I wish to become a participant in such portion of the Group Insurance program at a future date, I may be required to go through medical underwriting.

Employee Name (please print)	Employee Signature

Revised: 2/28/2017

TERMS AND CONDITIONS

1.) I have been given the opportunity to enroll in County of Dane Disability Insurance plan. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to the insurer and understand my request for coverage may be denied.

2.) If this application is accepted by the insurer, and any covered person subsequently ceases to be eligible for coverage under the contract then in effect for such person, then the coverage for such person shall terminate in accordance with the terms of such contract.

3.) I hereby apply for the coverages I have indicated on the front of this form, and I authorize my employer to make the appropriate deductions, if any, from my wages to pay for my share of the cost.

4.) In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the Certificate of Insurance booklet issued to each insured individual.

5.) If I have disability income coverage with the County's current carrier of such insurance, I understand and agree that the maximum duration benefits are payable will be limited to a specific period starting at a specific age and that a claim for benefits may not be approved for a pre-existing condition and be subject to certain offsets.

6.) All statements and answers in this application are representations made by the Applicant to induce the issuance of the contract applied for. The contents of this application are to be solely relied upon by the insurer, exclusive of the knowledge of an agent or employee of the insurer.

7.) The applicant agrees to cooperate in providing the insurer with information needed to process this application. This might include signing a form for the release by hospitals, doctors, and other health care providers of pertinent patient health care records to the insurer or their legal representatives.