Voluntary Short Term Disability Employee Enrollment Form

TO BE COMPLETED BY EMPLOYER

Advantage RN	9021405889000
Name of Employer (Use Name from Group Billing Notice or Master Application)	Group Number

TO BE COMPLETED BY EMPLOYEE

Your Name Last	First	Middle Initial	Date of Birth / /
Social Security Number - -	Date Employed Full-Time		Coverage Effective Date / /
Occupation			
Annual Earnings $	Hours Worked Per Week		Sex Male Female
Beneficiary			Relationship

BENEFIT LEVELS

Select the Benefit Level (A-J) that meets your needs from the chart below and enter the Benefit Level letter in the box on the right.

Benefit Level	Weekly Benefit	Your Annual Salary Must be at Least
A	$150	$11,700
B	$200	$15,600
C	$250	$19,500
D	$300	$23,400
E	$350	$27,300
F	$400	$31,200
G	$450	$35,100
H	$500	$39,000
I	$550	$42,900
J	$600	$46,800

Benefit Level Selected

Weekly Benefits will Equal the Amount Selected, Not to Exceed 66⅔% of Basic Weekly Earnings

I elect the above benefits which I have selected from all those for which I am eligible. If any contribution from me is necessary to pay part of the cost of the insurance, I authorize my employer to deduct the necessary contribution from my wages.

FRAUD WARNING (Not Applicable in AZ, FL, MD, OR, VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING (FL only): 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.

Employee Signature	Date	**Do Not Write in This Box Unless Instructed To Do So.**

If you are refusing coverage, sign below and return this form to your employer.

I acknowledge that I have been offered Voluntary Short Term Disability Insurance by my employer. I hearby wish to waive my right to be insured under this plan. I am aware that I must furnish evidence of insurability satisfactory to Companion Life Insurance Company, at my own expense. If I should apply at a later date, the company shall have the right to decline coverage.

Employee Signature Date

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