Short-Term Disability Enrollment Form

UNIVERSITY OF CONNECTICUT

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Social Security Number	Name (first, middle initial, last name)		
Home Address Street	City	State	Zip Code
Date of Birth	Job Position/Department		
Email Address (If you would like a confirmation of your application being received)			

You have the opportunity to enroll in the Hartford Life Short-Term Disability (STD) Insurance Plan. STD insurance helps to replace your income if you are sick or injured and cannot work. It has been specifically designed to help fill the gap between the start of your disability and the start of your Long-Term Disability benefits, six months later. The STD Plan provides you with income protection to replace up to 70% of your regular pay, to a maximum weekly benefit of $1,000, beginning after 30 days of disability.

EMPLOYEE CONFIRMATION

I want to enroll in the Hartford Life Short-Term Disability Insurance Plan. I authorize UConn to make the appropriate payroll deductions from my wages on a post-tax basis and to provide employment information to the insurance company in the event of a claim. I am not now disabled and I am able to perform all the duties of my occupation on a full-time basis. (please check one box)

❑ **I Want to Enroll** ❑ **I Decline To Enroll**

Signature: _____ Date: _____

Mail the completed form to us at College Benefits Group, PO Box 522, Storrs, Connecticut 06268-0522. You can also fax the form to us at College Benefits Group (860) 429-9513.

Your premiums will be deducted automatically from your paycheck and will change as your age, salary and/or benefits may change. A certificate of insurance with detailed information is available on our website at: www.collegebenefitsgroup.com.

This Section to Be Completed by Employer	
Effective Date of Coverage/Change	Employee #
Salary $	UBox #