Income Protection Benefits

Lubbock Independent School District

Information About You

Name:	**Date of Birth:**
Address:	**Phone:**
Social Security Number:	**Date of Hire:**
Coverage Effective Date:	**Annual Salary:**

Instructions

Please enter all required Information clearly.

- **Step 1:** Please enter or check your coverage elections and details. *You may only elect - and will be covered for - levels of coverage included in your employer's contract.*
- **Step 2:** Please **sign, date and return** this form to your HR department.

Long-term Disability Insurance

You have the opportunity to enroll in **Lubbock Independent School District's** Long-term Disability insurance plan. Disability insurance helps to replace your income if you are sick or injured and cannot work. You have the option to determine the amount of coverage and when this coverage will begin based on the attached chart. This plan provides you with income protection to replace up to 66 2/3% of your earnings.

☐ I elect to **enroll** in the **Premium Option**
Elimination Period Selection: ☐ 0/7 ☐ 14/14 ☐ 30/30 ☐ 60/60 ☐ 90/90 ☐ 180/180
Monthly Benefit Selection: $_____ Monthly Premium: $_____

Employee Confirmation

I acknowledge that I have been given the opportunity to enroll in the insurance coverage described in the Benefit Highlight Sheet and offered through **Lubbock Independent School District.**

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the policyholder (your) employer) can fully describe the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the enrollment form and the insurance poliy, I agree to be bound by the insurance policy.

If I have disability income coverage with The Hartford, I understand and agree that the maximum duration benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I authorize my employer to make the appropriate payroll deductions from my earnings.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed _____ Date _____