DISABILITY BUY-UP INSURANCE ENROLLMENT/CANCELLATION FORM

☐ NEW ENROLLMENT ☐ QUALIFIED LIFE EVENT ☐ OPEN ENROLLMENT

		EFFECTIVE DATE
CLACKAMAS COUNTY **General County Policy #: 343201-C**		**EMPLOYEE ID**
EMPLOYEE NAME (Last, First MI)	**GENDER** ☐ Male ☐ Female ☐ Unknown	**SOCIAL SECURITY**
DATE OF HIRE	**JOB TITLE**	**DATE OF BIRTH**
HOURS PER WEEK	**DEPARTMENT/DIVISION NAME**	

COUNTY-PAID COVERAGE: Clackamas County pays the entire cost of basic non-duty disability insurance. **Benefit Level** is 60% of your base monthly salary (including longevity), up to a maximum insured salary level of $3,333.00 per month. **Maximum Benefit** is $1,999.80 per month.

EMPLOYEE-PAID COVERAGE: If you are earning more than $3333.00 per month, you may enhance your coverage by insuring your higher salary level. **Benefit Level** is 60% of your base monthly salary over $3,333.00 (including longevity), up to a total maximum insured salary level of $8,333.00 per month. **Maximum Benefit** is $3,000.00 per month. This benefit is paid in addition to the benefit from the County-paid coverage, for a maximum total benefit of $4,999.80 per month. **Employee Premium Rate** is $0.58 for each $100 of additional insured salary. Remember, each time you have a salary increase your premium will increase automatically.

☐ I WANT TO PURCHASE ADDITIONAL DISABILITY COVERAGE

I understand that I am currently enrolled in a basic long-term disability insurance program through Clackamas County. I wish to enroll in the voluntary portion of the group long-term disability insurance program. I authorize deductions from my wages to cover my contributions toward the cost of my insurance. I understand that this coverage may be terminated only at the end of a plan year or when there is a qualifying family status change. I also understand that my insurance may be subject to a Pre-Existing Condition Exclusion.

☐ I WANT TO CANCEL MY ADDITIONAL DISABILITY COVERAGE

Coverage can only be cancelled during Open Enrollment and is effective December 31st following receipt of the completed form.

Signature _____ Date _____

Premium Calculation

A.	BASE MONTHLY SALARY	**$** _____
B.	LONGEVITY	**$** _____
C.	TOTAL COVERED SALARY (LINE A PLUS LINE B)	**$** _____
D.	SALARY LEVEL COVERED BY COUNTY ($3,333.00)	**$ (3,333.00)**
E.	REMAINING SALARY (LINE C MINUS LINE D)	**$** _____
F.	MULTIPLY BY PREMIUM RATE (LINE E x 0.0058)	**$ X 0.0058**
G.	**TOTAL MONTHLY PREMIUM**	**$** _____

RETURN ENROLLMENT FORM AND STATEMENT OF HEALTH TO: THE STANDARD