DISABILITY BUY-UP INSURANCE ENROLLMENT/CANCELLATION FORM

□ NEW ENROLLMENT □ I	FAMILY STATUS CHANGE	□ OPEN EN	ROLLMENT	EFFECTIVE DATE
CLACKAMAS COUNTY			EMPLOYEE ID	
General County Policy #: 343201-C				
EMPLOYEE NAME (Last, First MI)		GENDER	□ Male □ Female	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 cathe completed form. Signature				cember 31 st following receipt of
Premium Calculation				
A. BASE MONTHLY SALA B. LONGEVITY C. TOTAL COVERED SAL		B)	\$	
D. SALARY LEVEL COVERED BY COUNTY (\$3,333.0		,	\$ \$	(3,333.00)
E. REMAINING SALARY (LINE C MINUS LINE D)		,	\$	(3,333.00)
F. MULTIPLY BY PREMIUM RATE (LINE E x 0.0058)			\$	X 0.0058
G. TOTAL MONTHLY PR	•	\$		