

POA - DISABILITY BUY-UP INSURANCE ENROLLMENT/CANCELLATION FORM

NEW ENROLLMENT FAMILY STATUS CHANGE OPEN ENROLLMENT

CLACKAMAS COUNTY General County Policy #: 343201-C		EFFECTIVE DATE
EMPLOYEE NAME (Last, First MI)		EMPLOYEE ID
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		SOCIAL SECURITY NUMBER
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. MINUS SALARY LEVEL COVERED BY COUNTY (\$3333.00)	\$	(3,333.00)
C. INSURABLE SALARY (LINE A MINUS LINE B)	\$	
D. MULTIPLY BY PREMIUM RATE (LINE C x 0.0058)	\$	X 0.0058
E. TOTAL MONTHLY PREMIUM	\$	