BN-LTD-HSA Enrollment Form

University of Michigan

Expanded Long-Term Disability Application With Health Statement

The University of Michigan Long-Term Disability (LTD) Plan

BAO Use Only

Ben Fam _____ ABBR _____ Effort _____

AAW _____ Current Option Code _____

New Option Code _____

Approved/Denied _____ Effective Date _____

SSC Use Only

Input Elections:

All pages of this application MUST be completed. Print all information in **black** ink.

Use this form when:

- More than 30 days have passed since your hire date or date of eligibility and you wish to enroll
- You have two or more years of service and wish to increase your coverage over the $62,800 of your base salary paid for by the university.

Premiums will be based on your full annual base salary for the first two years. At two years of service, the university pays for coverage on your annual base salary up to $62,800. Coverage on salary over $62,800 is elective and paid for by the faculty or staff member. You may complete an Expanded LTD Plan Notice of Withdrawal form at any time to cancel elective employee-paid coverage.

1. Faculty or Staff Member Information

Name (Last, First, Middle Initial)			UMID
Street Address	City, State, Zip		Daytime Phone Number
Title	Date of Hire	Email Address	

2. Calculating Your Cost

If you are qualified for the university contribution, subtract $5,233 ($62,800 annual limit) from your monthly salary before calculating your monthly cost.

The current cost of this benefit is $6.73 per month for each $1,000 of monthly base salary. To calculate your monthly costs, use the formula below or visit hr.umich.edu/expanded-ltd-cost-calculator.

The formula for calculating LTD cost for newly eligible staff members is:

_____ ÷ 1,000 X $6.73 = _____

monthly salary — your monthly cost

For example (less than 2 yrs), if your monthly salary is:
$2,500 ÷ 1,000 x $6.73 = $16.83 per month
$5,000 ÷ 1,000 x $6.73 = $33.65 per month
$6,250 ÷ 1,000 x $6.73 = $42.06 per month
$8,500 ÷ 1,000 x $6.73 = $57.21 per month

3. Enrollment

☐ Check here for immediate enrollment in the Plan if your request is approved by the Claims Administrator $6.73/$1,000 of Monthly Salary

☐ Also check here if you are a practicing physician at the University of Michigan
(A practicing physician is defined as a licensed physician who provides patient services at a University of Michigan medical facility or affiliated hospital.)

4. Authorization and Signature

I hereby authorize the University of Michigan to make payroll deductions, when applicable, for Expanded Long-Term Disability coverage based on the current rates and any future increases. I understand that I am responsible for contacting the SSC Contact Center at 734-615-2000 or 866-647-7657 (toll free) if coverage is not reflected on my pay stub within two months. Premiums will be based on my full salary for the first two years. At two years of service, the university pays for coverage on my annual base salary up to $62,800. Coverage on my salary over $62,800 is elective and paid for by me. I may complete an Expanded LTD Plan Notice of Withdrawal form at any time to cancel elective employee-paid coverage.

_____ _____

Signature of Faculty or Staff Member — Date Signed

Limitations

The University of Michigan in its sole discretion may modify, amend, or terminate the benefits provided with respect to any individual receiving benefits, including active employees, retirees, and their dependents. Although the university has elected to provide these benefits this year, no individual has a vested right to any of the benefits provided. Nothing in these materials gives any individual the right to continued benefits beyond the time the university modifies, amends, or terminates the benefit. Anyone seeking or accepting any of the benefits provided will be deemed to have accepted the terms of the benefits programs and the university's right to modify, amend, or terminate them.

HUMAN RESOURCES
BENEFITS OFFICE
UNIVERSITY OF MICHIGAN

Questions?

If you have any questions, view hr.umich.edu/benefits-wellness, or call the SSC Contact Center at 734-615-2000 or 866-647-7657 (toll free for off-campus long-distance calls within the U.S.) Monday through Friday from 8 a.m. to 5 p.m.

How to Return Your Signed and Completed Form

By FAX

Fax it to 734-615-2201

Keep a copy of the fax transmission report with your form in your records.

By Mail

Make a copy for your records and send the original by **Campus Mail or U.S. Mail** to:
Benefits Administration Office -- LTD Area
Wolverine Tower -- Low Rise G405
3003 South State Street
Ann Arbor, MI 48109-1278

Employee Statement of Good Health for the Expanded Long-Term Disability Plan

Please complete all questions in each section below. Omitted information will cause delays in processing your application.

SECTION 1

Name: _____ UMID: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Your height _____ feet _____ inches Your weight _____ pounds

	Yes	No
1. In the past 5 years, have you been examined by, or consulted a physician or other healthcare provider? **If No, your application cannot be processed at this time. You must obtain a current medical exam or physical before your application can be considered**.	☐	☐
2. In the past 6 months, have you been absent from work because of sickness or injury?	☐	☐
3. Are you now on a diet prescribed by a physician or other health care provider? If "yes" indicate type _____	☐	☐
4. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____	☐	☐
5. Are you now, or have you in the past 5 years, used tobacco in any form?	☐	☐
6. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐	☐
7. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?	☐	☐
8. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐	☐
9. In the past 5 years, have you been Hospitalized as defined below (not including well-baby delivery)? Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.	☐	☐
10. Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	☐	☐

11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:

	Yes	No
a. cardiac or cardiovascular disorder?	☐	☐
b. stroke or circulatory disorder?	☐	☐
c. high blood pressure?	☐	☐
d. cancer, Hodgkins disease, lymphoma or tumors? Indicate type _____	☐	☐
e. anemia, leukemia or other blood disorder? Indicate type _____	☐	☐
f. diabetes? Your age at diagnosis? _____ ☐ Check if insulin treated	☐	☐
g. asthma, COPD, emphysema or other lung disease? Indicate type _____	☐	☐
h. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____	☐	☐
i. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____	☐	☐
j. memory loss?	☐	☐
k. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Specify date of last seizure (month/year) _____ Indicate type _____	☐	☐
l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia?	☐	☐
m. multiple sclerosis, ALS or muscular dystrophy?	☐	☐
n. lupus, scleroderma, auto immune disease or connective tissue disorder?	☐	☐
o. arthritis? ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____	☐	☐
p. back, neck, knee, spinal, joint or other musculosketal disorder?	☐	☐
q. carpal tunnel syndrome?	☐	☐
r. kidney, urinary tract or prostate disorder? Indicate type _____	☐	☐
s. thyroid or other gland disorder? Indicate type _____	☐	☐
t. mental, anxiety, depression, attempted suicide or nervous disorder?	☐	☐
u. sleep apnea	☐	☐
v. migraines	☐	☐
w. traumatic brain injury (TBI)?	☐	☐
x. other(s) _____	☐	☐

For "yes" answers, please provide full details on the next page in Section 2, then complete Sections 3, 4 and 5. If all questions (except for question 1) are answered "no," you may proceed directly to Section 3 on the next page.

Employee Statement of Good Health for the Expanded Long-Term Disability Plan

SECTION 2 - Please provide full details below for each "Yes" answer to the preceding questions 1-11. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. The LTD Third-Party Claims Administrator, CMI, may contact you for additional or missing information.

Question Number	Condition/Diagnosis	Medication Prescribed
		☐ Yes __________ ☐ No
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Personal Physician's Name: __________ Telephone: __________		

Question Number	Condition/Diagnosis	Medication Prescribed
		☐ Yes __________ ☐ No
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Personal Physician's Name: __________ Telephone: __________		

Question Number	Condition/Diagnosis	Medication Prescribed
		☐ Yes __________ ☐ No
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Personal Physician's Name: __________ Telephone: __________		

SECTION 3 - Other Prescription Medications

Are you currently taking any other prescibed medications? ☐ Yes ☐ No
Medication: __________ Condition/Diagnosis: __________
Prescribing Physician's Name: __________ Telephone: __________
Address (Street, City, State, Zip Code): __________

SECTION 4 - Certification and Signatures

I declare to the best of my knowledge and belief that my answers to all of the above questions are complete and true. I agree that the benefits requested are subject to the plan terms and shall become effective on the date or dates established by the plan, provided my evidence of good health is satisfactory to the LTD Claims Administrator. I understand if, at any time in the future, it is confirmed that the answers provided on this health statement did not represent full disclosure of my medical information or medical conditions, my enrollment in the Expanded LTD Plan may be terminated and any future attempts to re-enroll in coverage on my full annual base salary will not be allowed.

__________ Signature of Faculty or Staff Member

__________ Date Signed

SECTION 5 - Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or other organization or institution, that has any records or knowledge of me or my health to provide my authorized representatives of the University of Michigan and its Third-Party Claims Administrator, CMI, any such information. A photographic copy of this authorization shall be as valid as the original.

__________ Signature of Faculty or Staff Member

__________ Date Signed