BN-LTD-Enrollment Application

University of Michigan

Expanded Long-Term Disability Application

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

BAO Use Only
Ben Fam _____ ABBR _____ Effort _____
AAW _____ Current Option Code _____
New Option Code _____
Approved/Denied _____ Effective Date _____
SSC Use Only
Input Elections:

Premiums will be based on your full salary for the first two years. At two years of service, the university pays for coverage on your annual base salary up to $64,900. Coverage on salary over $64,900 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. Print all information in **black** ink.

1. Faculty or Staff Member Information.

Name (Last, First, Middle Initial)		UMID	U.S. Social Security Number (If UMID is unknown)
Street Address	City, State, Zip		Daytime Phone Number
Title	Date of Hire (Service Date)	Email Address	

2. Calculating Your Cost

If you are qualified for the university contribution, subtract $5,408 ($64,900 annual limit) from your monthly salary before calculating your monthly cost.

The current cost of this benefit is $6.86 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 $6.86 = _____

monthly salary — your monthly cost

For example (less than 2 yrs), if your monthly salary is:
$2,500 ÷ 1,000 x $6.86 = $17.15 per month
$5,000 ÷ 1,000 x $6.86 = $34.30 per month
$6,250 ÷ 1,000 x $6.86 = $42.88 per month
$8,500 ÷ 1,000 x $6.86 = $58.31 per month

3. Enrollment.

☐ Check here for immediate enrollment in the Plan $6.86/$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 $64,900. Coverage on my salary over $64,900 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

Receipt Confirmation
A confirmation email will be sent to your UMICH email address within 72 hours of receipt of your 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