

# BN-LTD-Enrollment Application

University of Michigan

## Expanded Long-Term Disability Application

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

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 \$66,600. Coverage on salary over \$66,600 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.

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

  

SSC Use Only
Input Elections:

### 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 \$5,550 (\$66,600 annual limit) from your monthly salary before calculating your monthly cost.

The current cost of this benefit is \$7.14 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](http://hr.umich.edu/expanded-ltd-cost-calculator).

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

$$\frac{\text{monthly salary}}{1,000} \times \$7.14 = \text{your monthly cost}$$

For example (less than 2 yrs), if your monthly salary is:  
\$2,500 ÷ 1,000 x \$7.14 = \$17.85 per month  
\$5,000 ÷ 1,000 x \$7.14 = \$35.70 per month  
\$6,250 ÷ 1,000 x \$7.14 = \$44.62 per month  
\$8,500 ÷ 1,000 x \$7.14 = \$60.69 per month

### 3. Enrollment.

- Check here for immediate enrollment in the Plan \$7.14/\$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 \$66,600. Coverage on my salary over \$66,600 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.



#### Questions?

If you have any questions, view [hr.umich.edu/benefits-wellness](http://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 **734-763-0363**.

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:  
SSC Benefits Transactions  
Wolverine Tower  
3003 South State Street  
Ann Arbor, MI 48109-1276