

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

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 \$69,800 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 \$69,800. Coverage on salary over \$69,800 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 \$5,816.67 (\$69,800 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.

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:

$$\$2,500 \div 1,000 \times \$7.14 = \$17.85 \text{ per month}$$

$$\$5,000 \div 1,000 \times \$7.14 = \$35.70 \text{ per month}$$

$$\$6,250 \div 1,000 \times \$7.14 = \$44.62 \text{ per month}$$

$$\$8,500 \div 1,000 \times \$7.14 = \$60.69 \text{ per month}$$

3. Enrollment

- Check here for immediate enrollment in the Plan if your request is approved by the Claims Administrator \$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 \$69,800. Coverage on my salary over \$69,800 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.



Questions?

Visit 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 Only

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

Receipt Confirmation

A confirmation email will be sent to your UMICH email address once your form is processed.

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

Home address: _____ Phone: _____ Email: _____ SSN: _____ Date of hire: _____

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? Yes No

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? Yes No

3. In the past 6 months, have you had a claim open with Work Connections? Yes No

4. In the past 6 months, have you used extended sick time pay or used vacation, short-term sick or PTO due to an illness or injury? Yes No

5. In the past 6 months, have you been on a paid or unpaid leave of absence due to an illness or injury? Yes No

6. Are you being accommodated at your current job or working in a different capacity (job duties or hours) for which you were hired, due to an illness or injury? Yes No

7. Are you now on a diet prescribed by a physician or other health care provider? If "yes" indicate type _____ Yes No

8. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____ Yes No

9. Are you now, or have you in the past 5 years, used tobacco in any form? Yes No

10. 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? Yes No

11. 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? Yes No

12. Have you ever applied for and/or received any disability benefits, including workers' compensation? Yes No

13. In the past 5 years, have you been Hospitalized as defined below? Yes No

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.

14. 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? Yes No

15. 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. stroke or circulatory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. cancer, Hodgkins disease, lymphoma or tumors? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| e. anemia, leukemia or other blood disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| f. diabetes? Your age at diagnosis? _____ <input type="checkbox"/> Check if insulin treated | <input type="checkbox"/> | <input type="checkbox"/> |
| g. asthma, COPD, emphysema or other lung disease? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| h. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| i. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| j. memory loss? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. epilepsy, paralysis, seizures, dizziness or other neurological disorder?
Specify date of last seizure (month/year) _____ Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia | <input type="checkbox"/> | <input type="checkbox"/> |
| m. multiple sclerosis, ALS or muscular dystrophy? | <input type="checkbox"/> | <input type="checkbox"/> |
| n. lupus, scleroderma, auto immune disease or connective tissue disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| o. arthritis? <input type="checkbox"/> osteoarthritis <input type="checkbox"/> rheumatoid <input type="checkbox"/> other/type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| p. back, neck, knee, spinal, joint or other musculoskeletal disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| q. carpal tunnel syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| r. kidney, urinary tract or prostate disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| s. thyroid or other gland disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| t. mental, anxiety, depression, attempted suicide or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| u. sleep apnea | <input type="checkbox"/> | <input type="checkbox"/> |
| v. migraines | <input type="checkbox"/> | <input type="checkbox"/> |
| w. traumatic brain injury (TBI)? | <input type="checkbox"/> | <input type="checkbox"/> |
| x. other(s) _____ | <input type="checkbox"/> | <input type="checkbox"/> |

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. Please be advised that the LTD Third-Party Claims Administrator will send you a request for medical records as part of the review process.

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 1-15. 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, may contact you for additional or missing information.

Question Number	Condition/Diagnosis	Medication Prescribed
		<input type="checkbox"/> Yes, medication prescribed: _____ <input type="checkbox"/> No medication prescribed
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Physician's Name: _____		
Physician's Telephone: _____		

Question Number	Condition/Diagnosis	Medication Prescribed
		<input type="checkbox"/> Yes, medication prescribed: _____ <input type="checkbox"/> No medication prescribed
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Physician's Name: _____		
Physician's Telephone: _____		

Question Number	Condition/Diagnosis	Medication Prescribed
		<input type="checkbox"/> Yes, medication prescribed: _____ <input type="checkbox"/> No medication prescribed
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Physician's Name: _____		
Physician's Telephone: _____		

SECTION 3 - Other Prescription Medications

Are you currently taking any other prescribed medications? Yes No

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: _____

Address (Street, City, State, Zip Code): _____

SECTION 4 - Certification and Signature

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 capped or maximum coverage 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, any such information. A photographic copy of this authorization shall be as valid as the original.

Signature of Faculty or Staff Member

Date Signed