LIFE INSURANCE COMPANY OF NORTH AMERICA

POLICYHOLDER — WASHINGTON COUNTY PUBLIC SCHOOLS

POLICY NUMBER — VDT-961168

Long-Term Disability (LTD)
Enrollment Form

Name ______________________________ Sex: ❑ Male ❑ Female
Last *First* *M. I.*

Date of Birth ____________ Social Security No. ___/___/___ - ___/___ - ___/___/___/___

Address ______________________________ Home Phone (____)__________
Number and Street *City* *State* *Zip Code*

Date Hired __________ Title or Occupation __________ Annual Salary $ __________

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Please check the appropriate box.

❑ I accept the LTD insurance provided by the Company’s Group Insurance Plan and authorize the deduction from my earnings of the required contribution toward the cost of the insurance.

❑ I have been offered LTD insurance and decline to purchase it at this time. I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the Insurance Company’s approval.

Late entrants must complete an Evidence of Insurability Form. Coverage for late entrants is subject to the Insurance Company’s approval.

If you are not in active service on the date your coverage would otherwise take effect, you will be covered on the date you return to active service.

Pre-Existing Condition Limitation: A pre-existing condition is any injury or illness for which you have consulted a physician, received medical treatment, care or services (including diagnostic measures), taken prescribed drugs or medicines, or incurred expenses during the 3 months prior to the effective date of your insurance. If you become disabled due to a pre-existing condition, you will not receive benefits unless your disability begins more than 12 months after the effective date of your coverage.

Signature of Applicant______________________________ Date______________

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Return original to your employer and make a copy for your records.