LIBERTY LIFE ASSURANCE COMPANY OF BOSTON
A member of the Liberty Mutual Group

LIBERTY MUTUAL

THE UNIVERSITY OF NORTH CAROLINA
VOLUNTARY SUPPLEMENTAL DISABILITY INSURANCE
ENROLLMENT FORM

Name: _____ ☐ Male ☐ Female
(Last) (First) (MI)

Employer/Institution: _____

Social Security #: _____ Date of Birth: _____

Occupation: _____ Annual Gross Salary: _____

Date of Hire: _____ Hours Worked Per Week: _____

Participation in the State Retirement System: _____ Years _____ Months

Check the appropriate block below if you wish to enroll:

☐ I have less than 5 years of participation in the State Retirement System and I wish to participate in Liberty's Long Term Disability program. I understand that my election authorizes payroll deductions from my salary for the cost.

☐ I have 5 or more years of participation in the State Retirement System and I wish to participate in Liberty's Long Term Disability program. I understand that my election authorizes payroll deductions from my salary for the cost.

Employee Signature: _____ Date: _____

If this form is not returned during your eligibility period, you will be processed as a declination; any future application will require submission of Evidence of Insurability satisfactory to Liberty.

Check the box if you wish to decline coverage:

☐ I have reviewed the enclosed material and wish to decline coverage.

If you do not elect coverage during your initial eligibility period, but choose to at a later date, you will have to provide medical evidence of good health.

TO BE COMPLETED BY EMPLOYER

Effective Date of Insurance: MO. _____ / DAY _____ / YR. _____ Monthly Premium: _____

Policy Number: 50-273663 Division #: _____

NOTE: Please make a copy for your file. Original is to be maintained by Employer.