

OPTION D ACCEPT ☐ DECLINE ☐

**Voluntary Short
Term Disability**

Elect this option if you want both STD and LTD coverage, but want the LTD coverage to be 60% of your salary to a maximum of \$7,000.

Weekly Benefit

Monthly Cost

\$400.00

\$34.50

**Voluntary Long
Term Disability**

Benefits commence on the latter of the 239th day of disability or the end of the STD benefits.

Monthly Benefit

Monthly Cost

60% of salary to a
maximum benefit of \$7,000

\$73.88

**TOTAL
Monthly Cost**

108.38

SECTION III - ELIGIBILITY AND AUTHORIZATION

Employee Confirmation

I have been given the opportunity to enroll in SMART Union's benefit coverage. I understand that if I enroll now, I will not need to provide any evidence of insurability or good health. If I later decide to enroll, I will be required to provide evidence of good health that is satisfactory to the insurer and understand my request for coverage may be denied.

I request to be insured and authorize payroll deductions to cover the cost of such insurance. Information in this application is given to obtain insurance and the statements and answers represented, to the best of my knowledge and believe to be true and complete. I understand that (a) the insurance applied for shall not take effect until the application is approved; and (b) all insurance is subject to the eligibility provisions of the policy; and (c) must be actively at work (as defined in the group policy) to be insured. If I am not actively at work on the date my coverage would become effective, my coverage will not begin until the day I return to work.

If your answers on this application are incorrect or untrue, the carrier has the right to deny benefits or rescind your coverage.

Authorization to Release Information: I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau (MIB) or any other organization, institution or person that has any records of knowledge of me or my health to give Anthem Life Insurance Company (Anthem) or its reinsurer(s) any such information. This authorization is valid for 24 months from the date it is signed. I agree that a photocopy of this authorization shall be as valid as the original.

Employee Signature

E-Mail Address

Date

***NOTE: Each of the above costs include an administrative fee paid to the SMART Group VSTD/VLTD Plan and an insurance premium paid to Anthem.**

**RETURN THIS FORM TO: SMART, Attn: Updating Department, 24950
Country Club Blvd, Ste. 340, North Olmsted, OH 44070**