RELIANCE STANDARD
Life Insurance Company
a DELPHI company

RE-ENROLLMENT
VOLUNTARY LTD ENROLLMENT FORM

Evidence of Insurability must be completed and submitted to Human Resources along with this enrollment form. If approved, benefits will become effective the 1st of the month following approval by Reliance Standard

Re-Enrollment period: November 1, 2009 through November 30, 2009
Benefit effective: The 1st of the month following approval by Reliance Standard

All sections must be completed to ensure accurate processing.

(1) Policyholder/Employer **McHenry County College**			(2) RSL Policy No. **VPL 300226**
(3) Location/Bill Group **000001**	(4) Full-Time Employment Date		(5) Class **N/A**
(6) Hours Per Week	(7) Job Title	(8) Annual Salary	
(9) Employee's Full Name Last First MI			(10) Payroll Cycle I receive my paycheck: ☐ Weekly ☐ Monthly ☐ Bi-Weekly ☐ Other: _____ ☐ Semi-Monthly
(11) SSN/Employee ID	(12) Gender		(13) Employee's Birth Date

Choose Only One (14) or (15)

(14) **Request for Group Insurance Coverage**

☐ I request to purchase Voluntary LTD Insurance Coverage in the amount of 65% of earnings per month as described in the Policy. I authorize my employer to deduct from my salary or wages the necessary premium for the coverage requested above. The signature below also verifies the accuracy of the information contained on this form.

Use attached premium worksheet to calculate your benefit amount and your monthly payroll deduction. Write these amounts on the lines below.

65% of my covered salary = $_____

Monthly payroll deduction = $_____

(15) **Declination of Group Insurance Coverage**

☐ I have been offered and have declined to purchase the Voluntary LTD Insurance Coverage. I understand that in the event I desire such insurance at a later date: (1) I will be required to furnish evidence of insurability at my own expense; and (2) Reliance Standard Life Insurance Company (RSL) will have the right to refuse my request.

I understand that any coverage will not become effective until and unless approved by RSL, and upon approval, any benefits payable are subject to the terms, conditions and limitations of the Group Disability Policy. I also understand that the amount of any payroll deduction may be adjusted based on underwriting changes or age changes that affect the rates charged.

_____ _____ / / **Employee Signature** **Date**

Please complete, sign, date and return this enrollment form to Human Resources.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.