TOWN OF WELLESLEY
HUMAN RESOURCES DEPARTMENT

LONG TERM DISABILITY ELECTION FORM

☐ Male ☐ Female

Name

Job Title/Position | Date of Hire | Annual Salary

Date of Birth | Effective Date | Employee #

Please select level of coverage (please see Human Resources for cost of Option B and C)**:**

		Maximum Monthly Benefit	Monthly Benefit	Cost to Employee
☐	**Option A:**	40%, up to $1,250	$_____	No Cost – Paid By Town
☐	**Option B:**	60%, up to $2,500	$_____	$_____
☐	**Option C*:**	60%, up to $6,000	$_____	$_____

* Available only to employees with an annual salary of $50,000 or more

Coverage may be limited if you are disabled due to a pre-existing condition. You have a pre-existing condition when you apply for coverage when you first become eligible if: you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months prior to your effective date of coverage; **and** the disability begins in the first 12 months after your effective date of coverage.

In addition, this plan will not cover an increase in your coverage made at an annual enrollment period or change in status if you have a pre-existing condition. You have a pre-existing condition if: you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months prior to the effective date of the increase in coverage; **and** the disability begins in the first 12 months after your coverage increased.

Your disability benefit may be reduced by deductible sources of income and any earnings you have while disabled. Deductible sources of income may include but are not limited to such items as disability income or other amounts you receive or are entitled to receive under: workers compensation or similar occupational benefit laws; state compulsory benefit laws; automobile liability and no fault insurance; legal judgments and settlements; certain retirement plans; salary continuation or sick leave plans; other group or association disability programs or insurance; and amounts you or your family receive or are entitled to receive from Social Security or similar governmental programs. Please refer to your booklet and Human Resources for more details.

Delayed Effective Date: Initial coverage will be delayed if the employee is not in active employment because of an injury, sickness, leave of absence or temporary lay-off on the date insurance begins. Any increased or additional insurance will also be delayed if the employee is not in active employment on the date that insurance would otherwise be effective. Please refer to your booklet and Human Resources for more details.

Request for Signature: I understand that by signing and submitting this form to elect coverage other than Option A, I am making a binding election for the buy-up option to 60% (option B or C) and I am authorizing payroll deduction from my earnings. I understand that:

- I am requesting LTD coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates.
- If I decline Option B or Option C now and want it at a later date, I will have to provide evidence of insurability (proof of good health) acceptable to the insurance carrier.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.

Signature | Date

THIS FORM MUST BE RETURNED TO:
Town of Wellesley Human Resources
525 Washington Street, Wellesley, MA 02482