2024 LTD Change Form

Please Print– Please Complete ALL Sections

Employee Information

Name (Last, First, Initial):_____

Employee ID#:_____ Phone Number:_____

E-mail Address:_____

Long-Term Disability (LTD)

NOTE: To add/increase LTD coverage after your initial enrollment eligibility period you need to complete and submit a statement of health for approval by the insurance company. When applicable, forms can be obtained from Leave Administration.

Please Choose a Coverage Level

- ❑ I wish to apply for FULL coverage to which I am now entitled or may become entitled to in the future under the UR Long-Term Disability (LTD) Plan.
- ❑ I wish to LIMIT my coverage under the UR Long-Term Disability (LTD) Plan. I understand that the coverage to which I am now entitled or may become entitled will apply to my base salary up to $36,000 ($20,000 for SEIU), but will not protect any part of my present or future salary which is above $36,000 per year ($20,000 for SEIU).
- ❑ FOR PART-TIME FACULTY AND STAFF ONLY: I wish to WAIVE my coverage under the UR Long-Term Disability (LTD) Plan. I understand that I will have no insurance coverage under the LTD Plan if I am totally disabled longer than six months.

NOTE: To apply for a waiver of the one year service requirement for LTD coverage because you had Long Term Disability Insurance through a previous employer-sponsored group plan, please contact Leave Administration for a waiver form.

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I understand that if I am increasing my LTD coverage level, that the increase takes effect on the date the insurance company approves the increase.

I also understand that if I am decreasing my LTD coverage level, that the decrease takes effect on the first pay period following the processing of my completed, signed form.

I acknowledge and agree that by signing this change form and subsequently accepting services, I am bound by the terms and conditions of the plan documents and associated administrative documents in effect and that these documents are available to me online at www.rochester.edu/working/hr/leave or in hard copy at the University of Rochester Leave Administration Office.

I authorize the University to deduct (after-tax) from my wages or salary the amount to pay my share of the cost of being covered by plan benefits.

I understand that if I have knowingly included any false information that coverage may be cancelled, upon one month's written notice and that I may be subject to disciplinary action including termination of employment to the extent permitted by law.

_____ _____

Signature Date

If you have any questions, please contact the University of Rochester at (585) 275– 3525