University of Rochester
Long-Term Disability Plan

Prior Employer-Sponsored Group LTD Coverage Credit Form

If you have had Long-Term Disability Insurance (whether through The Standard or another company), please complete this form. You may qualify for immediate LTD participation.

I hereby certify that I was previously employed by ____ and was
(previous employer)
covered there under a group long-term disability plan providing income benefits for a minimum of 5 years for disability due to sickness.

Date my coverage ended __________________________ (not more than 3 months prior to my UR appointment).

The plan was insured by ____.
(name of insurance company)

____ ______________

Last Name First Name Initial Employee ID
(Please Print)

Signature____ Date_______________________

Please return this form to the Leave Administration Office:

Fax:	*Mail:*	*Intramural Mail:*
585-276-1361	*910 Genesee Street Suite 100* *PO Box 278955* *Rochester, NY 14611*	*Box 278955*