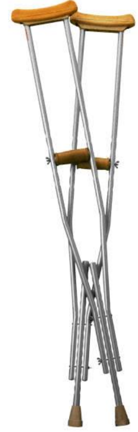
Fern Ridge School District #28J

Generic Voluntary Short Term Disability Enrollment Form



Have you considered how a **sickness, pregnancy, or accidental injury** may prevent you from working for more than a few days? Financially, how might that affect you? Could you afford to stay afloat for a few months if something were to happen?

Your Employer has provided you the opportunity to enroll in a Short Term Disability program that will provide you the financial protection you may need. This benefit replaces a portion of the income you may lose when afflicted by a disability.

Voluntary Short Term Disability

The benefit described below is one your Employer has made available for you as an Employee of Fern Ridge School District #28J.

- **Eligibility**
  All Full-Time Employees working a minimum of **30 hours** per week are eligible.

- **Benefit Payment-** Payment will be paid after the Elimination Period has been met and we have received proof that you have been disabled due to sickness or injury that requires the regular care of a Physician. You will receive a weekly payment based on your pre-disability earnings, not exceeding the maximum weekly benefit.

  - **Benefit as % of Salary - 60%**
  - **Maximum Weekly Benefit - $1,000**

- **Elimination Period**- The number of days that you must be disabled before benefits begin. Your Elimination Period begins on the first day of your disability.

  - **Injury - 7 days**
  - **Sickness - 7 days**

  Benefits will be paid while you are disabled for up to **12 weeks.**

- **Definition of Disability- You** are considered disabled if due to sickness or injury and **are unable to perform some or all of the material and substantial duties of your regular occupation. You must also have at least a 20% loss in pre-disability earnings.** You are also considered disabled if you meet the Definition of Disability above, but are working in any occupation and have at least a 20% loss in Pre-Disability earnings. A loss of a professional occupational license or certification does not, by itself, mean you are disabled. This coverage provides benefits for injury or sickness that occurs when you are off the job. **Occupational injuries and sicknesses are not covered.**

  - ***Regular Occupation***- means the occupation (as it is performed nationally) that you are routinely performing when disability begins. It does not mean the job you are performing for a specific employer or at a specific location.
  - ***Material and substantial duties***- duties that are normally required for the performance of your occupation and cannot be reasonably omitted or changed.

This form is not part of your group's policy or the Certificate of Coverage you have been provided. The policy may contain certain Limitations and Exclusions not stated here. Please see the Certificate of Coverage for specific policy information.

United Heritage Life Insurance Company (208) 493-6100 or Toll-Free 1-800-657-6351
707 E. United Heritage Ct., Meridian, Idaho 83642-3527 P.O. Box 7777, Meridian, Idaho 83680-7777
http://www.unitedheritage.com

Fern Ridge School District #28J

Generic Voluntary Short Term Disability Enrollment Form

Full Name: ______________________________

Full Address: ______________________________

Date of Birth: ________ Occupation: _____________

Male/Female: _____

Gross Weekly Earnings: $______ Hours worked/week: ______

(*Not to Exceed $1,667*)

Date of Employment __________ Social Security Number: ____-____ -_____

Calculating your payroll deduction:

Example: **Mary Smith -**

- **Age 44**
- **Gross Weekly Earnings $850**
- **Plan: 60% benefit to a maximum of $1,000 Weekly**
- **Mary's rate will be $0.36 per $10 of her weekly benefit**

***Calculation:* $850 X .60 =** $510 **X $0.36 =** $183.60 **/ 10 = $18.36**

To determine Gross Weekly Earnings, divide Gross Monthly Earnings by 4.33

1. Gross Weekly Earnings* $__________
   (*Not to Exceed $1,667*)
2. By benefit percentage X .60
3. Weekly Benefit = __________
4. Your Rate (From chart) X ____
5. Total = _______
6. Divide by 10 / 10
7. **Estimated Monthly Premium** **= $_________**

Age	Rate per $10 of Weekly Benefit
<25	.49
25-29	.47
30-34	.46
35-39	.39
40-44	.36
45-49	.39
50-54	.44
55-59	.50
60-64	.56
65+	.61

Your Pay Cycle	Pay Periods/Year
Bi-Weekly	26
Semi-Monthly	24
Weekly	52

Premium per pay period** _____________

***To determine your premium per pay period, multiply line 7 by 12 and divide by the total number of pay periods.*

NOTE: Rates will change on the policy's anniversary date. If you are moving from one age bracket to the next, your rate will not change until the anniversary date following your birth date. ***Your final payroll deductions may vary slightly pending final enrollment and payroll deduction frequency.***

Please complete this enrollment form and return it to your Human Resource Department.

❑	**I would like to ENROLL** in the Voluntary Short Term Disability Insurance offered to me and I authorize the required deduction from my wages. Signature______________________________ Date_______________
❑	**I would like to DECLINE** coverage at this time Signature______________________________ Date_______________

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