MISSISSIPPI BAND OF CHOCTAW INDIANS
GROUP INSURANCE ELECTION FORM
Policy # 426682 - 001

Name:		Social Security #:	
Date of Hire:		Annual Salary:	
Effective Date:		Date of Birth:	

IMPORTANT! ***This form must be returned to your employer prior to the end of the enrollment period.***
New hire enrollment period: If your form is not signed, dated and returned *within 31 days after the effective date of this form,* you will automatically be enrolled in the employer-funded plan.
Re-enrollment period: If your form is not signed, dated and returned *before* the effective date of the plan year for which elections are being made, you will automatically be enrolled in a plan most similar to the one you were enrolled last year.

LONG TERM DISABILITY:	
Option A - Employer Paid:	60% of your salary to a monthly maximum of $500 (You are automatically enrolled in this coverage)
Option B:	60% of your salary to a monthly maximum of $6,000 (You are paying for additional coverage)

☐ **Yes, I would like to enroll in Option B**

Calculate your cost for Option B (final cost may vary due to rounding):

_____/100 x .713 = $_____ x 12 / _____ =_____
Monthly Income to a Maximum of $10,000.00 Rate Monthly Cost Pay Periods Per Year Pay Period Cost

"*Your disability benefit may be reduced by deductible sources of income and any earnings you have while disabled. Deductible sources of income may include 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."*

Delayed Effective Date: Insurance will be delayed if an employee is not in active employment because of an injury, sickness, leave of absence or temporary lay-off on the date that insurance would otherwise be effective. Any increased or additional insurance 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 that insurance would otherwise be effective.

Request for Signature: I understand that by signing and submitting this form to elect coverage, I am making a binding election for my benefits and am authorizing payroll deductions from my earnings. I understand that if I decline any of the above coverages, I cannot later change my mind during the plan year and elect these coverage, unless I experience a family status change. If for any reason I fail to complete a new enrollment form each plan year, the elections shown on this form will remain unchanged, although the cost may change.

_____ _____
Employee Signature Date