LIBERTY LIFE ASSURANCE COMPANY OF BOSTON
A member of the Liberty Mutual Group

University of North Carolina – The School of Arts

Voluntary Supplemental Disability Insurance
Enrollment Form

☐ Male
Name: _____ ☐ Female
(Last) (First) (MI)

Social Security #: _____ Date of Birth: _____Hrs Worked Per Week:_____

Occupation: ____ Annual Gross Salary: _____Date of Hire:_____

Participation in the State Retirement System: _____ Yr's. _____ Mo's.

Check the appropriate block below if you wish to enroll:

☐ I have less than 5 years of participation in the State Retirement System and I wish to participate in Liberty Mutual's Long Term Disability program.

☐ I have 5 or more years of participation in the State Retirement System and I wish to participate in Liberty Mutual's Long Term Disability program.

I understand that my election authorizes payroll deductions from my salary.

Employee Signature: _____ Date: _____

Check the box if you wish to decline coverage:

☐ I have reviewed the enclosed material and wish to decline coverage.

If you do not elect coverage during your initial eligibility period, but chose to at a later date, you will have to provide medical evidence of good health.

Employee Signature: _____ Date: _____

TO BE COMPLETED BY EMPLOYER

MO. DAY YR.
Effective Date of Insurance: ____/ ____/ ____ Monthly Premium: _____

NOTE: Please make a copy for your file. Original is to be maintained by Employer.