POLICYHOLDER
Pennsylvania State System of Higher Education

POLICY NUMBER
LK-980005

Long-Term Disability Enrollment Form

Name____ Sex: ❑ Male ❑ Female
Last *First* *M. I.*

Date of Birth ____________________ Social Security No. ___/___/___–___/___–___/___/___/___

Address____ Home Phone (_____)____________
Number and Street *City* *State* *Zip Code*

Date Hired ________________ Title or Occupation __________________ Annual Salary $____________

Please check the appropriate box:

❑ I accept the insurance provided by the Company's Group Insurance Plan and authorize the deduction from my earnings of the required contribution toward the cost of the insurance.

❑ I have been offered LTD coverage and decline to purchase it at this time. I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the Insurance Company's approval.

In addition, please check the appropriate box to indicate which benefit waiting period you have selected:

❑ **Option 1** - Benefit Waiting Period - 180 days of continuous disability

❑ **Option 2** - Benefit Waiting Period - 90 days of continuous disability

Late entrants must complete an Evidence of Insurability Form. Coverage for late entrants is subject to the Insurance Company's approval.

If you are not in active service on the date your coverage would otherwise take effect, you will be covered on the date you return to active service.

Pre-Existing Condition Limitation: A pre-existing condition is any injury or illness for which you have consulted a physician (or for which a reasonable person would have consulted a physician), received medical treatment, care or services (including diagnostic measures), taken prescribed drugs or medicines, or incurred expenses during the 3 months prior to the effective date of your insurance. If you become disabled due to a pre-existing condition, you will not receive benefits unless your disability begins more than 12 months after the effective date of your coverage.

Signature of Applicant____ Date________________

CIGNA Group Insurance
Life • Accident • Disability

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