Underwritten by:
First Unum Life Insurance Company

NEW PALTZ UNITED TEACHERS BENEFIT TRUST FUND

Long Term Disability Insurance
Buy-Up Plan Option
Enrollment Form

Policy #118669-017

Member Name:	Annual Salary*:
Social Security Number: __ __ __ - __ __ - __ __ __ __	Date of Birth: __ __/__ __/__ __ __ __
Gender:	Date of Hire: __ __/__ __/__ __ __ __
Job Title:	

*** Annual salary is your gross annual salary, including overtime pay and additional assignments (see your New Member Portfolio or the Summary Plan Description for the Annual Salary definition).**

Monthly Rate

Buy-Up Plan Option (insures up to $171,429 of annual salary)
.21% per $100 of Covered Salary

Premiums for this Long Term Disability plan are shared between you and the New Paltz United Teachers Benefit Trust Fund. The New Paltz United Teachers Benefit Trust Fund pays $20.50 per month for your coverage. Your portion of the monthly premium can be figured below:

To calculate your per-paycheck cost for the **Buy-Up Plan Option**, complete the calculations below.

NOTE: *If your annual salary exceeds $171,429, use $171,429 as your annual salary in the following calculation.*

_____	÷ 100 =	_____	X	**.21**	=	_____	÷	**20**	=	_____
Annual Salary*				Rate		Annual Premium		# of Paychecks		Your Per Paycheck Deduction**

**** Final cost may vary slightly due to rounding.**

PLEASE CHECK YOUR CHOICE

☐ **Yes, I would like to participate in the Buy-Up Plan Option.** I authorize the NPUT Benefit Trust Fund to have my employer deduct from my wages the necessary premium for this coverage. My signature verifies the accuracy of information contained on this form. I also authorize future changes to my deduction from my wages due to salary increases.

I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would otherwise become effective. **I have also read and understand the information provided on the Plan Highlights Sheet, including all statements regarding exclusions and limitations.**

☐ **No, I do not wish to participate in the Buy-Up Plan Option.** I understand that if I elect not to participate at this time, I will not have the option to enroll in the Buy-Up Plan Option until the next Annual Enrollment.

Member Signature: _____ Date: __ __/__ __/__ __ __ __

THIS ENROLLMENT FORM MUST BE COMPLETED AND RETURNED TO RON NOELLE BY **SEPTEMBER 25, 2017** FOR THE BUY-UP PLAN OPTION COVERAGE TO BE EFFECTIVE ON **OCTOBER 1, 2016.** IF THIS ENROLLMENT FORM IS NOT RETURNED BY THE LISTED DEADLINE, YOU CANNOT ELECT TO PARTICIPATE IN THE BUY-UP PLAN OPTION UNTIL NEXT YEAR'S ANNUAL ENROLLMENT.