CLAYTON COUNTY WATER AUTHORITY
GROUP INSURANCE ENROLLMENT FORM
POLICY # 93143

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

IMPORTANT! Both the STD & LTD plans for CCWA are offered as negative elections. You will automatically be enrolled in the Employee Buy-up options if this form has not been returned to the Compensation & Benefits Coordinator prior to your eligibility effective date.

New hire enrollment period: A signed and dated form showing your elections must be returned within the eligibility period; otherwise, you will automatically be enrolled in the STD & LTD buy-up plans.
Re-enrollment period: A signed and dated form showing your elections must be returned prior to the effective date; otherwise, your elections will remain the same as the previous year.

Option A for both Short Term and Long Term Disability are Mandatory Plans paid by CCWA.

SHORT TERM DISABILITY:		
Option A:	60% of your weekly salary to a maximum benefit of $100	(Employer Paid)
Option B:	60% of your weekly salary to a maximum benefit of $1,000	(Employee Buy-up)

_____ I elect **Option A** only (core CCWA benefit)   _____ I elect **Option A&B** (Employee Buy-up + core)

Calculate your cost for Option B:

______ × .60 = ______ - $100 × .025 = $ ______ × 12 ÷ ______ = ______

Weekly Salary | Maximum of $1,000 | Monthly Cost | Pay Periods | Pay Period Cost

LONG TERM DISABILITY:		
Option A:	60% of your salary to a monthly maximum of $1,500	(Employer Paid)
Option B:	60% of your salary to a monthly maximum of $6,000	(Employee Buy-up)

_____ I elect **Option A** only (core CCWA benefit)   _____ I elect **Option A&B** (Employee Buy-up + core)

Calculate your cost for Option B:

______ - $2,500 × .0066 = $ ______ × 12 ÷ ______ = ______

Monthly Income to a Maximum of $10,000 | Monthly Cost | Pay Periods | Pay Period Cost

See your plan administrator or refer to your enrollment materials for details about pre-existing condition limitations and/or exclusions. *"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: Employee – Insurance will be delayed if an employee is not in active employment because of injury, sickness, leave of absence or temporary lay-off status on the date that the insurance would otherwise be effective. Any increased or additional insurance will be delayed if the employee is not in active employment because of injury, sickness, leave of absence or temporary lay-off status 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 coverage, I cannot later change my mind during the plan year and elect said coverage, unless I experience a family status change or eligibility change. If for any reason I fail to complete a new enrollment form for each plan year, the elections shown on this form will remain unchanged, although the cost may change.

Employee Signature: ______________   Employee Number: ______________   Date: ______________