

**STANDARD INSURANCE COMPANY**

**THE UNIVERSITY OF MISSISSIPPI  
ENHANCED LTD ENROLLMENT FORM  
(MULTI - OPTION)**

Policy Number <b>630751</b>	Suffix	Employer Name (Policyowner) <b>The University of Mississippi</b>	Social Security #
Member Name (Last, First, M.I.)		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate Mo / Day / Yr
Date Employed Mo / Day / Yr	Occupation		Eff. Date of Ins. (office use only) Mo / Day / Yr
Hours Worked Weekly for this Employer (Excl. O.T.)	Workplace Location (City, State)	Basic Earnings (From this Employer) \$	<input type="checkbox"/> MO
<p>I wish to enroll in the voluntary group long term disability insurance program. I authorize deductions from my wages to cover my contribution toward the cost of my insurance. I understand that if, after my initial selection, I wish to change Plans, my coverage under the new plan will be subject to any applicable Medical Evidence of Insurability Requirements and Pre-Existing Condition Exclusions.</p> <p>I wish to enroll in: <input type="checkbox"/> Plan 1 (90 days) <input type="checkbox"/> Plan 2 (180 days) (Plan Specifications are detailed in the Certificate of Insurance)</p> <p><input type="checkbox"/> The group insurance available to me through my employer has been explained to me. After careful consideration, I have decided that I do not want to enroll. I understand that I will be required to provide Standard Insurance Company Evidence of Insurability at my own expense if I elect to enroll at a later date, and that Standard Insurance Company will have the right to refuse my request for insurance.</p>			
Date	Signature of Employee (if enrolling in voluntary coverage)		

*Group Administrator: Please maintain form in your file. Forward to Standard in event of claim only.*