VOLUNTARY BENEFITS ELECTION FORM

Employer Name: ____

All information MUST be fully completed to be processed.

EMPLOYEE INFORMATION

Employee Name:		Social Security #:
Date of Birth: ___/___/___	Gender: Male ☐ Female ☐	Phone:
Home Address:	City:	State: Zip:
Salary:	Mode: Weekly___ Bi-weekly___	

BENEFICIARY

NAME (LAST, FIRST, M.I.)	ADDRESS (if different than above)	RELATIONSHIP	PHONE #
Primary			
Contingent			

Employee will be the beneficiary for any dependent coverage

Short Term Disability

Plan Selection: ☐ 14/14 6 mo ☐ 14/14 12 mo

Monthly Benefit Amount $______________ Premium Amount $ ______________

"I certify that I am actively at work on a full-time basis and able to perform all the duties of my occupation. (If applying for spousal and or dependent coverage) none of my dependents or spouse are currently disabled. I certify that a life insurance illustration was not used in connection with this application, only a company -provided rate sheet may have been used and no non-guaranteed values were illustrated. I authorize the carrier and HUB international to electronically enter in the data I have provided here and will send me a certificate for my review. I realize that any false statements may result in loss of coverage under the policy/certificate."

SIGNATURE____ **DATE**______________________

FORM ID: 81 ACC-CRIT-UNIV50-STD20