

St. Louis County Long-Term Disability Insurance Enrollment Form



Three Quick Steps to Protect Your Paycheck

Step One: Find your plan below and estimate your per-paycheck cost

Consult your labor contract if you are unsure which plan applies to you.

100% Employee-Paid Plan

a. Enter your annual salary:*

, .

b. Multiply your age rate from the chart below:

x

c. Annual cost:

= .

d. Divide by the number of paychecks per year:

÷

e. Your per-paycheck cost:

= .

Your Age	Rate
0-24	.00174
25-29	.00216
30-34	.00277
35-39	.00375
40-44	.00505
45-49	.00613
50-54	.00710
55-59	.00739
60-64	.00758
65+	.00594

30% Employee-Paid / 70% Employer-Paid Plan

a. Enter your annual salary:*

, .

b. Multiply by the rate:

x

c. Total cost:

= .

d. Multiply by 0.70 to determine employer contribution:

x

e. Employer contribution:

= .

f. Subtract e from c to get your annual cost:

.

g. Divide by the number of paychecks per year:

÷

h. Your per-paycheck cost:

= .

*This plan will not cover any amount of salary that exceeds \$120,000. If your annual salary exceeds this amount, do not enter your full salary. Instead, enter \$120,000 on this line.

Step Two: Fill in Your Information

Employee Information (please fill in any missing information):		
Name:	A full-time employee in my position works (check one): <input type="checkbox"/> 75 hours/pay period <input type="checkbox"/> 80 hours/pay period	
Employer: St. Louis County, MN, NIS Group #012324	Date of Hire:	
Employee of (check one): <input type="checkbox"/> St. Louis Cty 100% employee-paid plan <input type="checkbox"/> St. Louis Cty 30% employee-paid/70% employer-paid Plan <input type="checkbox"/> Arrowhead Regional Corrections		
Home Address:		
Employee ID #:	Gender:	Date of Birth:
Occupation:		
US Citizen:	Marital Status:	
Requested Coverage Date:		

Step Three: Sign and Date

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits.

By signing this Application I understand and agree that:

- I authorize my Employer to make any required deductions, if any, from my salary to pay the premium of my insurance coverage in effect.
- All statements and answers I have given are complete and true to the best of my knowledge and belief.
- Coverage is not in effect until final approval is given by Madison National Life Insurance Company, Inc.
- No person, except an officer of Madison National Life, is authorized to vary or modify a contract.

Date: _____ **Signature:** _____

For Employer Use Only:

Annual Salary: Hourly wage \$ _____ x FTE or Prorate _____ x Hours/year _____ = _____

Premium: Annual Salary \$ _____ x Age rate or fixed rate _____ / 24 = \$ _____

Date ___/___/___ Date Eligible ___/___/___ Class _____ Computed/Verified by _____