

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 or Benefit Summary if you are unsure which plan below applies to you.

100% Employee-Paid Plan

(Merit Basic and Civil Service Basic)

a. Enter your annual salary:*

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b. Multiply your age rate from the chart below:

						x						
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c. Annual cost:

=					.		
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d. Divide by the number of paychecks per year:

÷		
	2	4

e. Your per-paycheck cost:

=			.		
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Your Age	Rate
0-24	.00122
25-29	.00151
30-34	.00194
35-39	.00263
40-44	.00354
45-49	.00429
50-54	.00497
55-59	.00517
60-64	.00531
65+	.00416

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

(All Other Employees)

a. Enter your annual salary:*

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b. Multiply by the rate:

x						.	0	0	2	2
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c. Total cost:

=					.		
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d. Multiply by 0.70 to determine employer contribution:

x		
	7	0

e. Employer contribution:

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

-					.		
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g. Divide by the number of paychecks per year:

÷		
	2	4

h. Your per-paycheck cost:

=			.		
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*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.

*Your annual salary is your hourly pay rate multiplied by 1,950 (if you work 75 hours per pay period) or 2,080 (if you work 80 hours per pay period).

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 _____