



Request For Group Short Term Disability Insurance

Company Name: _____

Policy Number: _____

SHORT TERM DISABILITY BENEFITS		
Coverage Effective Date: _____	Rate Guarantee: <input type="checkbox"/> 12 months <input type="checkbox"/> 24 months	
Eligibility: PLEASE TYPE EXACTLY AS IT SHOULD APPEAR IN THE CONTRACT (Ex. All Active Full-Time Employees)		
Class 1		
Class 2		
Definition of Full-time Employment: Minimum number of hours for full-time eligibility _____ hrs/ wk	Number of Eligible Employees:	Number of Employees Enrolled:
Service Waiting Period for Employees: (Applicable to employees who have not satisfied the Service Waiting Period on or before the policy effective date) _____ <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> No Waiting Period		
Coverage begins: <input type="checkbox"/> 1st of the month following completion of waiting period <input type="checkbox"/> Immediately upon completion of waiting period <input type="checkbox"/> Other: _____		
Earnings Definition: <input type="checkbox"/> Salary Only <input type="checkbox"/> W-2 <input type="checkbox"/> K-1 <input type="checkbox"/> Salary & Commissions** <input type="checkbox"/> Salary & Bonuses** <input type="checkbox"/> Salary, Commissions & Bonuses** ** Commissions or Bonuses averaged over: <input type="checkbox"/> 12 months <input type="checkbox"/> 24 months <input type="checkbox"/> 36 months		
FMLA (Family Medical Leave Act): Include FMLA information in your policy? <input type="checkbox"/> yes <input type="checkbox"/> no		
Employer Contribution: Class 1: _____ % Class 2: _____ %	If employer contribution is less than 100%, employee contribution will be: <input type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax <input type="checkbox"/> Varies by employee	Will employee salaries be "grossed up" to pay for coverage? <input type="checkbox"/> yes <input type="checkbox"/> no
STD Quoted Rate: \$ _____ <input type="checkbox"/> per \$10 benefit unit or <input type="checkbox"/> per \$100		
Important Note: Quoted Rate(s) may be impacted based on final census rating or optional benefits chosen.		
Benefit Duration: _____ (weeks)	Elimination Period: Injury: _____ Days Sickness: _____ Days <input type="checkbox"/> Calendar or <input type="checkbox"/> Work (Days)	
Definition of Benefit Duration: <input type="checkbox"/> Includes Elimination Period (Benefits cease when LTD benefits are payable) <input type="checkbox"/> Complete Weeks (LTD benefits begin after all STD benefits have been exhausted)		
First Day Hospitalization: (Please note there is an additional cost for this provision) <input type="checkbox"/> Do not Include <input type="checkbox"/> "0" Day Inpatient Hospital Benefits OR <input type="checkbox"/> "0" Day Inpatient Hospital Benefits and "0" Day Outpatient Surgery Benefits		
Salary Extension Benefit: Do you offer a Salary Extension Benefit? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, check type of Salary Extension: <input type="checkbox"/> Sick Leave <input type="checkbox"/> Vacation <input type="checkbox"/> Salary Continuation <input type="checkbox"/> Other _____ How is your Salary Extension Benefit administered? <input type="checkbox"/> Employee is required to exhaust Salary Extension Benefit before STD benefits begin. <input type="checkbox"/> Employee is required to use a portion of the Salary Extension Benefit before STD benefits begin. Attach explanation. <input type="checkbox"/> Employee can receive both Salary Extension Benefit and STD benefits at the same time. <i>Note: Our STD benefits will be offset with any Salary Extension Benefits offered by the Employer.</i>		
Benefit Amount: Class 1 <input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> other _____ to \$ _____ Class 2 <input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> other _____ to \$ _____		
Prior Carrier Information (If applicable): <input type="checkbox"/> No Prior Coverage (A copy of prior plan certificate must accompany the Request for Insurance)		
Name of Prior Carrier	Policy Termination Date	How long was the coverage in force?