# DISABILITY BUY-UP INSURANCE ENROLLMENT FORM

☐ NEW ENROLLMENT ☐ FAMILY STATUS CHANGE ☐ OPEN ENROLLMENT

| | | | |
|---|---|---|---|
| | | | **EFFECTIVE DATE** |
| **CLACKAMAS COUNTY**<br>**General County Policy #: 343201-C** | | | **EMPLOYEE ID** |
| **EMPLOYEE NAME (Last, First MI)** | | **GENDER** ☐ Male ☐ Female | **SOCIAL SECURITY** |
| **DATE OF HIRE** | **JOB TITLE** | | **DATE OF BIRTH** |
| **HOURS PER WEEK** | **DEPARTMENT/DIVISION NAME** | | |

**COUNTY-PAID COVERAGE:** Clackamas County pays the entire cost of basic non-duty disability insurance. **Benefit Level** is 60% of your base monthly salary (including longevity), up to a maximum insured salary level of $3,333.00 per month. **Maximum Benefit** is $1,999.80 per month.

**EMPLOYEE-PAID COVERAGE:** If you are earning more than $3333.00 per month, you may enhance your coverage by insuring your higher salary level. **Benefit Level** is 60% of your base monthly salary over $3,333.00 (including longevity), up to a total maximum insured salary level of $8,333.00 per month. **Maximum Benefit** is $3,000.00 per month. This benefit is paid in addition to the benefit from the County-paid coverage, for a maximum total benefit of $4,999.80 per month. **Employee Premium Rate** is $0.56 for each $100 of additional insured salary. Remember, each time you have a salary increase, your premium will increase automatically.

## ☐ YES, I WANT TO PURCHASE ADDITIONAL DISABILITY COVERAGE.

I understand that I am currently enrolled in a basic long term disability insurance program through Clackamas County. I wish to enroll in the voluntary portion of the group long term disability insurance program. I authorize deductions from my wages to cover my contributions toward the cost of my insurance. I understand that this coverage may be terminated only at the end of a plan year or when there is a qualifying family status change. I also understand that my insurance may be subject to a Pre-Existing Condition Exclusion.

Signature _____ Date _____

***If you would like the County to calculate your monthly premium, you may leave the following section blank.***

| | | |
|---|---|---|
| A. | BASE MONTHLY SALARY | $ _____ |
| B. | LONGEVITY | $ _____ |
| C. | TOTAL COVERED SALARY (LINE A PLUS LINE B) | $ _____ |
| D. | SALARY LEVEL COVERED BY COUNTY ($3333.00) | $ **(3333.00)** |
| E. | REMAINING SALARY (LINE C MINUS LINE D) | $ _____ |
| F. | MULTIPLY BY PREMIUM RATE (LINE E x 0.0056) | $ **X 0.0056** |
| **G.** | **TOTAL MONTHLY PREMIUM** | $ _____ |