

**PEACE OFFICERS ASSOCIATION
DISABILITY BUY-UP INSURANCE ENROLLMENT FORM**

NEW ENROLLMENT FAMILY STATUS CHANGE OPEN ENROLLMENT

CLACKAMAS COUNTY Peace Officers Association Policy #: 332166D		EFFECTIVE DATE
EMPLOYEE NAME (Last, First MI)		EMPLOYEE ID
GENDER <input type="checkbox"/> Male <input type="checkbox"/> 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, 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 up to a total maximum insured salary level of \$10,000.00 per month. **Maximum Benefit** is \$4,000.20 per month. This benefit is paid in addition to the benefit from the County-paid coverage, for a maximum total benefit of \$6,000.00 per month. **Employee Premium Rate** is \$0.57 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 will 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. MINUS SALARY LEVEL COVERED BY COUNTY (\$3333.00)	\$ _____	(3333.00)
C. INSURABLE SALARY (LINE A MINUS LINE B)	\$ _____	
D. MULTIPLY BY PREMIUM RATE (LINE C x 0.0057)	\$ _____	X 0.0057
E. TOTAL MONTHLY PREMIUM	\$ _____	