

**Enrollment and Change**

**To Be Completed By Applicant**     Apply for Coverage     Change in Coverage     Name Change

Employer Name <b>University of South Florida</b>		Group Number <b>648966</b>	Date of Employment	Job Title/Occupation		
Your Name (Last, First, Middle)						
Employee ID			Your Social Security Number	Birth Date		<input type="checkbox"/> Male <input type="checkbox"/> Female
Your Address				City	State	ZIP
Hours Worked Per Week	Annual Earnings \$ _____		Choose one: I am employed on a <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 12 month contract			
<p><b>Coverage</b></p> <p><b>Short Term Disability (STD) and Long Term Disability (LTD) Insurance</b></p> <p><input type="checkbox"/> 30 Day Plan (Voluntary STD and Voluntary LTD)</p> <p><b>Long Term Disability Insurance</b></p> <p><input type="checkbox"/> 90 Day Plan (Voluntary LTD)</p> <p>The 30 Day (STD and LTD) and 90 Day (LTD) Disability Plans have a pre-existing condition limitation. If I have received medical or surgical treatment, services or advice, undergone diagnostic procedures, including self administered procedures, taken prescribed drugs or medicines, or consulted with a physician or other licensed medical professional, for any mental or physical condition which was discovered or suspected as a result of any routine or other medical examination at any time within the 90 days prior to my effective date of coverage, these conditions will not be covered unless the disability begins more than twelve (12) consecutive months after my effective date of coverage. Review your booklet for additional information about the effective date of your coverage and the pre-existing condition exclusion.</p>						
<p><b>Signature:</b> I wish to make the choices indicated on this form. I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.</p>						
Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____						

*Return completed form to your Human Resources Department.*