INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any requested information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

Life Insurance Company of North America

EMPLOYER: Snow College

ALL ABOUT YOU – THE EMPLOYEE

Your Name ______________________ SSN ______________ Date of birth ______________

Home Address ______________________ City ______________ State __________ Home Address __________

Email ______________ Home/Cell Phone ______________ Employee ID # ______________ Gender ______________

YOUR COVERAGE ELECTIONS

View the Summary of Benefits for costs and instructions for how to calculate premium.

Employee-Paid Short Term Disability – Policy # VDT0963212 Underwritten by LINA		
Review your available plan below before accepting or declining coverage.		
Who You Want to Cover	**Coverage Amount**	**Accept your desired coverage amount or decline coverage below.**
❑ Employee	60% of your weekly covered earnings to a maximum of $1,500**** per week	❑ Accept Coverage ❑ Decline Coverage

****This is the maximum coverage amount that you can choose under this plan. Coverage elected during this enrollment period will take effect on the later of 01/01/1999, the date your election form is received by your Employer, or if applicable the date your Evidence of Insurability Form is approved by the Insurance Company.

SIGN TO ACCEPT DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. I understand that coverage is subject to the insurance company's approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by Life Insurance Company of North America.

Pre-Existing Condition Limitation (applies to short-term disability insurance only): I understand that I will not receive benefits for a pre-existing condition (any injury or sickness for which medical advice, care or treatment was recommended or received during the months just prior to the coverage effective date) unless the disability begins more than **Pre-Existing Condition Limitation - 3** months after the effective date of coverage.

I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for **Pre-Existing Condition Limitation - 6** months for the Disability coverage.

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Please Sign Here Signature ______________________________________ Date ____________

Created on 10/2025.