Long-term Disability

Underwriter: Standard Insurance Company

The University of Mississippi offers long-term disability coverage through enrollment with Standard Insurance Company. Long-term disability insurance is designed to help protect you against a loss of income in the event you become disabled and are unable to work for an extended period of time. Long term disability insurance can help safeguard your family's lifestyle and provide some peace of mind. Standard Insurance Company offers two (2) plans from which to choose: a 90-day plan and a 180-day plan. The plan type designates the period of time the participant must wait, from date of injury, before receiving a disability benefit.

Coverage Options & Premiums

Benefit – Monthly benefit equals 60% of the first $8,333 of your regular earnings from the University or pre-disability earnings not to include bonuses, overtime pay, commissions, shift differential pay, your employer's contributions on your behalf to any deferred compensation arrangement or pension plan, or any other compensation.

Pre-existing Condition – A mental or physical condition for which you have done any of the following at any time during the 180 days just before your insurance becomes effective: consulted a physician; received medical treatment or services; or taken prescribed drugs or medications.

A more detailed description of benefits is available at
http://hr.wp2.olemiss.edu/wp-content/uploads/sites/93/2016/05/Long-termDisability.pdf

Premium Calculation:

Rates for Age	Plan I: 90-day waiting period	Plan II: 180-day waiting period
Under 30	.00230	.00115
30-34	.00387	.00199
35-39	.00460	.00230
40-44	.00606	.00314
45-49	.00888	.00481
50-54	.01233	.00690
55-59	.01724	.00982
60-64	.02017	.01061
Over 64	.02393	.01397

Premium:

- **Monthly income up to $8,333 x Rate Factor = Cost per month.**
- **9-Month Contract Rate up to $8,333/12) x Rate Factor = Cost per month.**

Employees electing to enroll in coverage as a new participant, change plan option, or cancel existing coverage are required to complete The University of Mississippi: Benefit Enrollment/ Change Form. Instructions are provided to guide you through the form completion process.

All coverage changes become effective January 1, 2018. Completed forms must be received in the University's Human Resources Office (108 Howry Hall) no later than November 3, 2017.

Coverage enforce on 12/31/2017 will continue at the same level for plan year 2018 in the absence of an open enrollment election/change.

IMPORTANT: PLEASE READ AS ACTION MAY BE REQUIRED.

In order to be in compliance with Form 1095-C and Affordable Care Act requirements, please verify that all names, social security numbers and dates of birth are correct for any family members who are currently enrolled or will be enrolled on an insurance plan. This information can be accessed under the 'Employee' tab and then by clicking the MyHRtools drop down box and selecting Open Enrollment Step 1: Update Beneficiaries / Dependents. If any information is incorrect, please update.

- When enrolling eligible dependents on an insurance plan, a copy of the dependent's Social Security Card **MUST** be provided to the Human Resources office. Furthermore, all listed names on insurance applications must be listed as a legal name, nicknames are not permitted.

- In order to ensure the accuracy of W-2 processing for 2017, please verify all contact information (address, phone number etc.) within myOleMiss. This can be accessed under the 'Employee' tab and then by clicking the MyHRtools drop down box and selecting Address & Communication Preferences. If any information is incorrect, please update accordingly. Please note that updating your contact information within myOleMiss will only update your address with the University, and does not update your contact information with insurance vendors. Please also complete a **Benefits Information Change** form to update your information with each respective vendor and submit the form to 108 Howry Hall. When changing your contact information within myOleMiss, a link to this form will populate on the right side of the screen. You may also access the form via the following link.
  http://hr.wp2.olemiss.edu/wp-content/uploads/sites/93/2016/05/InfoChangeForm.pdf

Enrollment Application Instructions:

Enroll as a New Participant

Employees interested in enrolling in Long-term Disability must complete **The University of Mississippi: Benefit Enrollment/Change Form**.

- Page 1 - Provide personal information in the shaded section at the top of the form.
- Page 2 – Complete the section designated for ***Long-Term Disability (LTD) – Standard Insurance Company*.** Select coverage option by marking the box that corresponds to the coverage type.
- Page 5 – Read the acknowledgement then sign and date.

Enrollees will be required to complete the **Standard Insurance Company Medical History Statement**. This form will be sent to the enrollee by the company. Failure to complete the form within 30-days will result in closure of the application and non-issuance of the policy.

Change Plan Option

Employees interested in enrolling in Long-term Disability must complete **The University of Mississippi: Benefit Enrollment/Change Form**.

- Page 1 - Provide personal information in the shaded section at the top of the form.
- Page 2 – Complete the section designated for ***Long-Term Disability (LTD) – Standard Insurance Company*.** Select coverage option by marking the box that corresponds to the coverage type.
- Page 5 – Read the acknowledgement then sign and date.

The **Standard Insurance Company Medical History Statement** must be completed only if you are changing from Plan 2 (180 days) to Plan 1 (90 days): Enrollees will be required to complete the **Standard Insurance Company Medical History Statement**. This form will be sent to the enrollee by the company. Failure to complete the form within 30-days will result in closure of the application and continuation of the 180-day plan.

Cancellation of Existing Coverage

Employees may cancel coverage via the following methods.

- After saving online Open Enrollment changes, select the option to Print Benefits Summary. Print the form and write drop next to ***Long-Term Disability (LTD)*** then sign and date.

OR

- Complete **The University of Mississippi: Benefit Enrollment/Change Form**.
  - Page 1 – Provide personal information in the shaded section at the top of the form.
  - Page 2 – Complete the section designated for ***Long-Term Disability (LTD).***
    - Mark the 'Waive/Cancel Coverage' box
  - Page 5 – Read the acknowledgement then sign and date.

The University of Mississippi: Benefit Enrollment/Change Form

Employee Name:	**Date of Hire:**
Address:	**University ID Number:**
City/State/Zip:	**Home Phone:**
SSN: **Date of Birth:**	**Work Phone:**
Email Address:	**Gender:** ☐ **Male** ☐ **Female**
Status: ☐ **9-Month** ☐ **12-Month** **Pay Mode: Semi-Monthly**	**Marital Status:**

Check One: ☐ **New Hire** ☐ **Legal Marriage/Divorce** ☐ **Birth/Adoption** ■ **Open Enrollment**

☐ **Other Status Change** _____ ☐ **Date of Qualifying Event** _____

University employees are paid twice a month. Premium deductions for 12-month employees occur over 24 pay periods while premiums for 9-month faculty are deducted over 18 pay periods.

Spouse/Dependent Information – List all dependents you wish to cover or drop from the insurance plans you have selected. Check all benefits that apply.

Name (Last, First, MI)	Social Security Number	M/F	Birth Date	Relationship	Disabled Dependent (yes/no)	Drop/Add	Dental	Vision	FSA	AD&D	LTD	UNUM Life	Am. Heritage	Life of Alabama
							☐	☐	☐	☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐	☐	☐	☐

Dental - Delta Dental (Group #1126)

Premiums are withheld 12-Month / 9-Month *Section 125 Cafeteria Plan*

	Employee Only 12-month / 9-month	Family 12-month / 9-month
Low Plan (division: 00002)	☐ $27.63 / $36.84	☐ $57.65 / $76.88
High Plan (division: 00001)	☐ $39.86 / $53.14	☐ $82.94 / $110.58

FOR HUMAN RESOURCES ONLY

Effective Date: _____

Are you or your family member(s) currently covered under another dental plan: ☐ **Yes** ☐ **No**

If yes, provide the name of the participant(s) with other coverage. _____

☐ **Waive/Cancel Coverage**

Vision – Davis Vision (Group: UMM)

Premiums are withheld 12-Month / 9-Month *Section 125 Cafeteria Plan*

	12-month / 9-month		12-month / 9-month		12-month / 9-month
Employee Only	☐ $7.80 / $10.40	**Employee + 1**	☐ $14.08 / $18.77	**Family**	☐ $21.89 / $29.19

☐ **Waive/Cancel Coverage**

FOR HUMAN RESOURCES ONLY

Effective Date: _____

The University of Mississippi: Benefit Enrollment/Change Form

Flexible Spending Accounts (FSA)

Contributions are withheld 12-Month / 9-Month *Section 125 Cafeteria Plan*

Annual Election

Dependent Care Spending Account ☐ $ _____
(annual election per family: $5,000)

Unreimbursed Medical Spending Account ☐ $ _____
(annual election per individual: $2,600)
Prescription FlexCard ☐ Yes ☐ No

FOR HUMAN RESOURCES ONLY

$_____ pay period election (D/C)
$_____ pay period election (M/R)

Effective Date: _____

☐ Waive Participation (To cancel participation in an existing plan, write '0' in the blank next to the respective plan type.)

Accidental Death and Dismemberment – National Union Fire Insurance Company of Pittsburgh #PAI9032465

Section 125 Cafeteria Plan

Amount of coverage available is a minimum of $10,000 and a maximum of $250,000 (in $10,000 increments), with amounts above $150,000 not to exceed 10x base salary. If you insure your spouse and/or dependent children under this plan, the amount of insurance applicable to the members of your family is based on the composition of your family at the time of loss and is expressed as a percentage of the employee's coverage.

☐ Employee Only ☐ Family Coverage Amount: **$**_____

☐ Waive/Cancel Coverage

FOR HUMAN RESOURCES ONLY

12-Month Cost / 9-Month Cost **$**_____

Effective Date: _____

Beneficiary Designation: Designate beneficiary(ies) for your Accidental Death & Dismemberment policy. The employee is beneficiary for dependent coverage unless otherwise indicated.

Primary %	Secondary %	Last Name, First Name, MI	Relationship	M/F	Social Security #	Birth Date	Dependent Beneficiary (if not employee) mark as 'X'	Trustee for Minor
							☐	
							☐	
							☐	
							☐	
							☐	
							☐	

Long-Term Disability (LTD) – Standard Insurance Company

You may elect disability coverage of 60% of your base salary up to $5,000 per month, until age 65. Benefits are payable after a 90 or 180 day elimination period subject to review by The Standard Insurance Company. *Pre-Existing Limitation may apply. **Guarantee Issue only applies to new hires and employees newly eligible for benefits. If you waive coverage when first eligible and wish to enroll later, Evidence of Insurability will be required and The Standard Insurance Company has the right at that time to refuse the request for coverage.

Premiums are withheld 12-Month / 9-Month

☐ Plan 1 (90-day option) ☐ Plan 2 (180-day option)

☐ Waive/Cancel Coverage

FOR HUMAN RESOURCES ONLY

Base Annual Earnings **$**_____

Position Title: _____

Hours Worked Per Week: _____

Effective Date: _____

The University of Mississippi: Benefit Enrollment/Change Form

Supplemental Term Life with AD&D – UNUM

Premiums are withheld 12-Month / 9-Month

** Guarantee Issue only applies to new hires and employees newly eligible for benefits. If you waive coverage when first eligible and wish to enroll later, Evidence of Insurability must be provided and UNUM has the right at that time to refuse the request for coverage.

Employee Coverage

☐ 1X Salary ☐ 2X Salary ☐ 3X Salary

☐ 4X Salary ☐ 5X Salary ☐ 6X Salary

Maximum coverage available is 6X your annual base salary rounded to the Next higher multiple of $1,000 to a maximum of $600,000

☐ Waive Employee Coverage

FOR HUMAN RESOURCES ONLY

Annual Salary $ _____

Coverage Amount $_____ 12-Month / 9-Month Cost $_____

Effective Date: _____

Spouse Coverage – Spouse coverage cannot exceed 50% of the employee's approved coverage.

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☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000

☐ Waive Spouse Coverage

FOR HUMAN RESOURCES ONLY

Coverage Amount $_____ 12-Month / 9-Month Cost $_____

Effective Date: _____

Dependent Child(ren) Coverage - All children are covered from birth to 6 months for $5,000 and at $10,000 from 6 months to age 19, or 25 if full-time student.

☐ Waive Dependent Child(ren) Coverage

FOR HUMAN RESOURCES ONLY

12-Month / 9-Month Cost $_____

Effective Date: _____

Primary %	Secondary %	Last Name, First Name, MI	Relationship	M/F	Social Security #	Birth Date	Trustee for Minor

Delayed Effective Date ***Employee:*** Insurance will be delayed for Employees not actively at work until the first of the month following the date they return to work. Regularly scheduled vacation time is considered active employment. ***Dependent:*** Coverage for totally disabled dependents will be delayed until the first of the month following the date the individual is no longer totally disabled.

Policy Limitations and Exclusions **I understand all the policy exclusions and Limitations listed in the certificate of coverage.** If electing to participate in any of the benefit plans mentioned above, I authorize the required payroll deductions. I understand that my payroll deduction amount will change if my coverage or costs change. I understand that if I cancel/decline participation, I may join the Plan at a specified later date; however, I will be required to provide evidence of insurability at my own expense, and the insurance company may refuse my request. In the event of any variations between this form and the Plan document, the terms of the Plan document will prevail.

The University of Mississippi: Benefit Enrollment/Change Form

Cancer/Dreaded Disease & Intensive Care - American Heritage (Underwritten by AllState)

This plan is subject to underwriting. Those electing coverage will be contacted by a representative of the William Morris Group or AllState to complete a medical health statement. Failure to complete the medical health statement in a timely manner or declination from underwriting will result in non-issuance of the policy. Premium is based upon age at time of election.

Select only one plan type. (CP12 plan) Premiums are withheld 12-Month / 9-Month *Section 125 Cafeteria Plan*

	Employee Only 12-month / 9-month	Family 12-month / 9-month
Plan 1 and 2 (Low Option)		
Base – No Intensive Care		
Age 18 - 64	☐ $11.29 / $15.06	☐ $22.71 / $30.28
Age 65 - 69	☐ $25.92 / $34.56	☐ $54.07 / $72.10
Age 70 - 74	☐ $29.91 / $39.88	☐ $62.56 / $83.42
Age 75 - 80	☐ $32.82 / $43.76	☐ $68.71 / $91.62
Plan 1+ (Low Option)		
$400 per day Intensive Care		
Age 18 - 64	☐ $12.81 / $17.08	☐ $26.56 / $ 35.42
Age 65 - 69	☐ $28.13 / $37.52	☐ $59.28 / $ 79.04
Age 70 - 74	☐ $32.23 / $42.98	☐ $67.97 / $ 90.64
Age 75 - 80	☐ $35.54 / $47.40	☐ $75.04 / $100.06
Plan 2+ (Low Option)		
$600 per day Intensive Care		
Age 18 - 64	☐ $13.57 / $18.10	☐ $28.49 / $ 38.00
Age 65 - 69	☐ $29.24 / $39.00	☐ $61.89 / $ 82.52
Age 70 - 74	☐ $33.39 / $44.52	☐ $70.68 / $ 94.24
Age 75 - 80	☐ $36.90 / $49.20	☐ $78.21 / $104.28
Plan 3 and 4 (High Option)		
Base – No Intensive Care		
Age 18 - 64	☐ $21.21 / $28.28	☐ $ 42.71 / $ 56.96
Age 65 - 69	☐ $48.90 / $65.20	☐ $102.35 / $136.48
Age 70 - 74	☐ $56.39 / $75.20	☐ $118.38 / $157.84
Age 75 - 80	☐ $61.82 / $82.44	☐ $129.89 / $173.20
Plan 3+ (High Option)		
$400 per day Intensive Care		
Age 18 - 64	☐ $22.73 / $30.32	☐ $ 46.56 / $ 62.08
Age 65 - 69	☐ $51.11 / $68.16	☐ $107.56 / $143.42
Age 70 - 74	☐ $58.71 / $78.28	☐ $123.79 / $165.06
Age 75 - 80	☐ $64.54 / $86.06	☐ $136.22 / $181.62
Plan 4+ (High Option)		
$600 per day Intensive Care		
Age 18 - 64	☐ $23.49 / $31.32	☐ $ 48.49 / $ 64.66
Age 65 - 69	☐ $52.22 / $69.64	☐ $110.17 / $146.90
Age 70 - 74	☐ $59.87 / $79.84	☐ $126.50 / $168.68
Age 75 - 80	☐ $65.90 / $87.88	☐ $139.39 / $185.86

☐ **Waive/Cancel Coverage**

FOR HUMAN RESOURCES ONLY

Effective Date: _____

The University of Mississippi: Benefit Enrollment/Change Form

Cancer/Dreaded Disease & Intensive Care – Life of Alabama

This plan is subject to underwriting. Those electing coverage will be contacted by a representative of Life of Alabama to complete a medical health statement. Failure to complete the medical health statement in a timely manner or declination from underwriting will result in non-issuance of the policy. Premiums are withheld 12-Month / 9-Month *Section 125 Cafeteria Plan*

Cancer and Dreaded Disease Options: Select only one cancer plan type.

	Employee Only 12-month / 9-month	1 Parent Family 12-month / 9-month	Employee & Spouse 12-month / 9-month	2 parent Family 12-month / 9-month
Low Option	☐ $18.67 / $24.90	☐ $21.77 / $29.03	☐ $36.17 / $48.2	☐ $37.83 / $50.44
High Option	☐ $33.76 / $45.02	☐ $39.54 / $52.72	☐ $65.52 / $87.36	☐ $68.66 / $91.55

☐ **Waive/Cancel Cancer/Dreaded Disease Coverage**

Intensive Care Options: Select only one intensive care plan type.

	Employee Only 12-month / 9-month	1 Parent Family 12-month / 9-month	Employee & Spouse 12-month / 9-month	2 parent Family 12-month / 9-month
$300 per day ICU	☐ $3.68 / $ 4.91	☐ $3.96 / $ 5.28	☐ $ 5.66 / $ 7.55	☐ $ 6.74 / $ 8.99
$600 per day ICU	☐ $7.36 / $ 9.82	☐ $7.92 / $10.56	☐ $11.32 / $15.10	☐ $13.48 / $17.98
$750 per day ICU	☐ $9.20 / $12.27	☐ $9.90 / $13.20	☐ $14.15 / $18.87	☐ $16.85 / $22.47

☐ **Waive/Cancel Intensive Care Coverage**

FOR HUMAN RESOURCES ONLY

Effective Date: _____

I acknowledge that I voluntarily and without coercion made elections/waivers as documented on this form. I understand my salary will be reduced by the amount(s) shown on this enrollment form for the eligible benefit options I have elected and since premiums are collected one month in advance, the University will collect premiums in arrears as an additional payroll deduction. If my salary reduction for the elected insurance benefit(s) are increased or decreased while this agreement remains in effect, my salary will automatically be adjusted to reflect the change.

Cafeteria Plan elections will be irrevocable for the Plan Year except for modifications due to a qualifying event (divorce, marriage, death of spouse/dependent child, birth/adoption of a child, change of employment status of me or my spouse, cost of coverage/change, HIPAA special enrollment rights, or other event specified by the IRS provided I complete enrollment paperwork with the Department of Human Resources to request the election change within 60 days after the date of the qualifying event. Prior to each Plan Year, I will be given the opportunity to change my benefit election. If I fail to complete and submit to the Department of Human Resources a new election form within the allotted enrollment period, I understand my election will remain the same.

I understand my social security benefits may be reduced due to my participation in the Cafeteria Plan. My employer may reduce or cancel the amount of my salary reduction or otherwise modify this agreement in order to satisfy certain provisions of the Internal Revenue Code.

I understand my elected benefits will cease upon my termination of employment but will be afforded an opportunity to continue coverage via COBRA for qualifying plans.

If I participate in dependent care, reimbursements cannot exceed the amount incurred during the Plan Year. If I participate in an unreimbursed medical expense plan, I may be reimbursed for qualifying out-of-pocket medical expenses. Claims must be filed with Southern Administrators and Benefit Consultants (SABC) no later than 60 day into the subsequent Plan Year. Any account balance in excess of the $500 rollover processed after the 60-day grace period will be forfeited.

I understand that privacy statements are available via the University website at http://hr.olemiss.edu/benefits/. If I do not have access to the internet, I can request a paper copy from the Department of Human Resources. As an employee, I acknowledge that I am the subscriber of coverage, and that the Privacy Policy is also applicable to my spouse and/or my dependents. I also understand I will be reissued the Privacy Statement, as a material modification is made, and every three years, via the University's email system.

This election and salary reduction agreement is subject to the terms of my employer's cafeteria plan document.

EMPLOYEE SIGNATURE _____ **DATE SIGNED** _____