



# City of Milwaukee

Policy Number <b>626556</b>	Dept. No.	Employer Name (Policyowner) <b>City of Milwaukee</b>	<input type="checkbox"/> CITY <input type="checkbox"/> HACM <input type="checkbox"/> RACM <input type="checkbox"/> MEDC	Social Security No.	
Member Name (Last, First, M.I.)			Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (Mo/Day/Yr)	
Date Employed (Mo/Day/Yr)	Occupation	Return To Work (Mo/Day/Yr)	Eff. Date of Ins. (Mo/Day/Yr)		
			<i>Office Use Only</i>		
Hours Worked Weekly for this Employer (Excluding Overtime)	Workplace Location (City, State)	Basic Earnings (Gross from this Employer) <input type="checkbox"/> Biweekly <input type="checkbox"/> Annual			
<p>I understand that I am currently enrolled in a basic long term disability insurance program through my employer and wish to enroll in the voluntary portion of the group long term disability insurance program. I authorize deductions from my wages to cover my contribution toward the cost of my insurance. I understand that if, after my initial selection, I wish to change Plan Options, my coverage under the new Option will be subject to any applicable Medical Evidence of Insurability requirements and Pre-Existing Condition Exclusions.</p> <p>I wish to enroll in:   <input type="checkbox"/> Option A (120 days)   <input type="checkbox"/> Option B (90 days)   <input type="checkbox"/> Option C (60 days)</p> <p><i>(Plan Specifications are detailed in the Certificate of Insurance)</i></p>					
Date		Signature of employee (if enrolling in voluntary coverage)			
<p><input type="checkbox"/> I am currently enrolled in the Plan 2 voluntary group long term disability insurance program, but I elect to terminate my Plan 2 coverage. I understand that if I elect to re-enroll for Plan 2 voluntary coverage, my coverage will be subject to any applicable Medical Evidence Of Insurability Requirements and Pre-Existing Condition Exclusions.</p> <p>Date: _____ Signature: _____</p>					

Group Administrator: Please maintain form in your file. Forward to Standard in the event of a claim only. (8/97)

## INSTRUCTIONS

If you intend to enroll in one of the options of Plan 2, complete the enrollment card above, cut on the dotted line and return it to **Department of Employee Relations, City Hall, Room 706, 200 East Wells Street, Milwaukee, WI 53202-3560**. If you have questions, please call Employee Benefits Division at **(414) 286-3184**, or Standard Insurance Company at **1-800-535-8465**.