

University of Louisiana at Lafayette
MetLife
Long Term Disability Benefits

Monthly Benefits: Pays 60% of your annual salary, beginning the 91st day of disability due to either illness or injury, continued up to age 65.

Maximum Monthly Benefit \$4,000.00.

Minimum Monthly Benefit 10% of the Monthly Benefit before reduction for Other Income Benefits or \$100, whichever is greater.

Premium Calculations:

10-Month Employee – Annual Salary x 60%, divided by 12 = Monthly LTD Benefit
Monthly LTD Benefit x 1.32% = Premium

12-Month Employee – Annual Salary x 60%, divided by 12 = Monthly LTD Benefit
Monthly LTD Benefit x \$1.10% = Premium

<u>Annual Salary</u>	<u>Monthly Disability Income</u>	<u>10 Month Monthly Cost</u>	<u>12 Month Monthly Cost</u>
\$10,000	\$ 500.00	\$ 6.60	\$ 5.50
\$15,000	\$ 750.00	\$ 9.90	\$ 8.25
\$20,000	\$1,000.00	\$13.20	\$11.00
\$30,000	\$1,500.00	\$19.80	\$16.50
\$60,000	\$3,000.00	\$39.60	\$33.00

Qualification: New employees may apply for coverage within 30 days from their employment date. Employees applying for the coverage after 30 days from their employment date will be required to provide proof of insurability.

Additional Information: If further information is needed, please contact the Office of Personnel Services, Martin Hall, Room 170. The telephone number is 482-6242.

TO BE COMPLETED BY THE EMPLOYEE

The Proposed Insured signing below **declares** that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief. The Proposed Insured understands that this information will be used by MetLife to determine his/her insurability.

For the Employee Proposed Insured:

I **declare** that I am actively at work on the date of this enrollment form.

For Benefit increases Requested After Initial Enrollment Period Expires

I **understand** that if I have not elected the maximum disability benefits for which I am eligible I may be required to submit evidence of good health satisfactory to MetLife if I want to increase such benefits after my initial enrollment period has expired. I **also understand** that coverage will not take effect, or it will be limited, until I receive notice that MetLife has approved the benefit increase.

For Payroll Deduction Authorization By the Employee

I **authorize** my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

Signature: The employee must sign in all cases.

Employee Signature

Date (Mo./Day/Yr.)