LIFE INSURANCE COMPANY OF NORTH AMERICA

POLICYHOLDER — **SNOQUALMIE VALLEY SCHOOL DISTRICT**

POLICY NUMBER — **VDT-961445**

Short-Term Disability (STD)
Enrollment Form

Name ____ Sex: ❑ Male ❑ Female
Last *First* *M. I.*

Date of Birth ______________________ Social Security No. ___/___/___ - ___/___ - ___/___/___/___

Address ____ Home Phone (____)__________
Number and Street *City* *State* *Zip Code*

Date Hired ______________ Title or Occupation ________________ Annual Salary $ __________

STD Amount Elected ______________. This amount is any $50 increment subject to a $100 minimum and a $1,400 maximum; not to exceed 66 2/3% of your covered weekly earnings.

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Please check the appropriate box.

❑ I accept the STD insurance provided by the Company's Group Insurance Plan and authorize the deduction from my earnings of the required contribution toward the cost of the insurance.

❑ I have been offered STD insurance and decline to purchase it at this time. I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the Insurance Company's approval.

Late entrants must complete an Evidence of Insurability Form. Coverage for late entrants is subject to the Insurance Company's approval.

If you are not in active service on the date your coverage would otherwise take effect, you will be covered on the date you return to active service.

Pre-Existing Condition Limitation: A pre-existing condition is any injury or illness for which you have consulted a physician (or for which a reasonable person would have consulted a physician), received medical treatment, care or services (including diagnostic measures), taken prescribed drugs or medicines, or incurred expenses during the 12 months prior to the effective date of your insurance. If you become disabled due to a pre-existing condition, you will not receive benefits unless your disability begins more than 12 months after the effective date of your coverage.

Signature of Applicant ____________________________________ Date______________

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Return original to your employer and make a copy for your records.