The University of North Carolina
Liberty Mutual Long-Term Disability
Enrollment/Cancel Form

☐ **Enroll** ☐ **Cancel**

Employee Information

Name: _____ ☐ Male ☐ Female
(Last) (First) (MI)

UNC Campus: _____

Social Security #: _____-____-_____ Date of Birth: _____

Occupation: _____ Annual Gross Salary: $_____

Date of Hire: _____ Hours Worked Per Week:_____

Acknowledgement and Signature

I request coverage under my employer's plan of benefits as indicated above. I understand that my election authorizes payroll deductions from my salary for the cost.

If this form is not returned during your eligibility period, coverage will be declined. If you do not elect coverage during your initial eligibility period, but choose to at a later date, you will have to provide medical evidence of good health.

Employee Signature: _____Date: _____

Directions for submission

1. Keep a copy of the form for your records.
2. Submit original form to your campus benefits office.
3. Review your pay check to make certain the deduction for coverage has begun.
4. Contact your campus benefit representative if you have any questions.

To Be Completed By Employer

Effective Date of Insurance: _____ / _____ / _____ Monthly Premium: $_____

Policy Number: 50-273663 Division #: _____