SHEET METAL | AIR | RAIL | TRANSPORTATION

SMART

TRANSPORTATION DIVISION

AL00004397

Enrollment Form - Bus

Voluntary Short Term Disability

Voluntary Long Term Disability

SECTION I - APPLICANT INFORMATION

Name/Address:	Last 4 of SSN	Annual Salary	Local #
	Date of Hire	Gender	Class: BUS	Hours Worked
	EE ID	Employer Name	

SECTION II - BENEFIT ELECTIONS (Please elect ONLY 1 option below (Option A - Option D)

OPTION A

ACCEPT ☐

For new members, If you elect no option or don't return this form, you will be automatically enrolled in Option A.

Voluntary Short Term Disability

Voluntary Short Term Disability insurance helps to replace your income if you are sick or injured and cannot work. This benefit commences on the 31st day of accident or the 31st day of sickness and is designed to continue for a period of up to 52 weeks.

Note: If you are currently enrolled in the VSTD you do not need to re-elect coverage.

Weekly Benefit	Monthly Cost	TOTAL Monthly Cost
$210.00	$26.00	$26.00

OPTION B - NEW OFFERING

Voluntary Long Term Disability

Voluntary Long Term Disability allows you to purchase coverage to protect your income should you remain disabled after a 365 day elimination period. If you elect this option, you will not have STD. See Options C and D below for both.

Part A

		Monthly Benefit	Monthly Cost
ACCEPT ☐	*DECLINE* ☐	50% of salary to a maximum benefit of $6,000	$31.50

Part B

		Monthly Benefit	Monthly Cost
ACCEPT ☐	*DECLINE* ☐	60% of salary to a maximum benefit of $6,000	$47.98

OPTION C

ACCEPT ☐ *DECLINE* ☐

Voluntary Short Term Disability

Elect this option if you want both STD and LTD coverage, but want the LTD coverage to be 50% of your salary to a maximum of $6,000.

Weekly Benefit	Monthly Cost
$210.00	$26.00

Voluntary Long Term Disability

Benefits commence on the latter of the 366th day of disability or the end of the STD benefits.

Monthly Benefit	Monthly Cost	TOTAL Monthly Cost
50% of salary to a maximum benefit of $6,000	$31.50	$57.50

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OPTION D *ACCEPT* ☐ *DECLINE* ☐

Voluntary Short Term Disability

Elect this option if you want both STD and LTD coverage, but want the LTD coverage to be 60% of your salary to a maximum of $6,000.

Weekly Benefit	Monthly Cost
$210.00	$26.00

Voluntary Long Term Disability

Benefits commence on the latter of the 366th day of disability or the end of the STD benefits.

Monthly Benefit	Monthly Cost	TOTAL Monthly Cost
60% of salary to a maximum benefit of $6,000	$47.98	$73.98

SECTION III - ELIGIBILITY AND AUTHORIZATION

Employee Confirmation

I have been given the opportunity to enroll in SMART Union's benefit coverage. I understand that if I enroll now, I will not need to provide any evidence of insurability or good health. If I later decide to enroll, I will be required to provide evidence of good health that is satisfactory to the insurer and understand my request for coverage may be denied.

I request to be insured and authorize payroll deductions to cover the cost of such insurance. Information in this application is given to obtain insurance and the statements and answers represented, to the best of my knowledge and believe to be true and complete. I understand that (a) the insurance applied for shall not take effect until the application is approved; and (b) all insurance is subject to the eligibility provisions of the policy; and (c) must be actively at work (as defined in the group policy) to be insured. If I am not actively at work on the date my coverage would become effective, my coverage will not begin until the day I return to work.

If your answers on this application are incorrect or untrue, the carrier has the right to deny benefits or rescind your coverage.

Authorization to Release Information: I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau (MIB) or any other organization, institution or person that has any records of knowledge of me or my health to give Anthem Life Insurance Company (Anthem) or its reinsurer(s) any such information. This authorization is valid for 24 months from the date it is signed. I agree that a photocopy of this authorization shall be as valid as the original.

Employee Signature _____

E-Mail Address _____

Date _____

****NOTE: Each of the above costs include an administrative fee paid to the SMART Group VSTD/VLTD Plan and an insurance premium paid to Anthem.***

RETURN THIS FORM TO: SMART, Attn: Updating Department, 24950 Country Club Blvd, Ste. 340, North Olmsted, OH 44070