Sun Life ASSURANT®

LONG TERM DISABILITY INSURANCE

1. General Information

Employer Name	Account/Policy Number	Location

2. Employee Information

Employee's Full Legal Name (First, M.I., Last)		☐ Male ☐ Female	Date of Birth (mm/dd/yy)	
Street Address	City		State	Zip Code
Eligibility Class (if applicable)	SSN#	Phone #		
Position		Occupation		
Date of Hire: ☐ Full-Time Date: ____________________ ☐ Part-Time Date: ____________________		☐ Return from Layoff Date: __________ ☐ Rehire Date: ____________		
Hours Worked: # of hours _______ ☐ Full-Time ☐ Part-Time		Salary $____________________ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually ☐ Other: ____________________		

PLAN OPTION:

☐ Plan 1 Employer Paid (Basic plan covers 50% monthly salary not to exceed $1800 per month)

☐ Plan 2 Employee Paid based on monthly salary – not to exceed $6 per month (Buy up option covers 60% monthly salary not to exceed $3000 per month)

I authorize my employer to deduct from my salary or wages, if applicable, necessary premium for the coverage requested above. This signature is also to verify the accuracy of the information contained in this form.