Madison National Life Insurance Company
Independence Holding Group

Employee Short Term Disability Enrollment Form

Check one

☐ New Employee ☐ Newly Eligible Employee, Full Time Date of Hire _____ ☐ Annual Enrollment

Name of Employer **City of Winona**	Group Number	Employee SSN
Employee Name *(last, first, initial)*	Employee Date of Birth	☐ Male ☐ Female
Employee Home Address *(street, city, state, zip)*		☐ Married ☐ Single
US Citizen? ☐ Yes ☐ No - If an enrollee is not a United States citizen, please attach a copy of his or her Visa.	Annual Salary $	Employment Date
Job Title	Job Duties	Hours Worked/Week

Short Term Disability Weekly Benefit

☐ **Change:** **$**_____ (Current STD Benefit Amount) ☐ Increase ☐ Decrease **$**_____ (Increase/Decrease) **= $**_____ (Grand Total)

☐ **Cancel**

Calculating Maximum Benefit:

Weekly Salary **$**_____ (Round to next higher $1) **x** $.60 **= $**_____ (Round to nearest $50) **This is your maximum weekly benefit Do not enter more than $1,000 above.**

Calculating Monthly Premium:

Weekly Benefit Elected **$**_____ ($50 increments) **x** Monthly Rate **$**_____ (Based on age) **/** $10 **= $**_____ monthly premium

EMPLOYEE COVERAGE AUTHORIZATION

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits.

By signing this Application I understand and agree that:

- I authorize my Employer to make any required deductions, if any, from my salary to pay the premium of my insurance coverage in effect.
- All statements and answers I have given are complete and true to the best of my knowledge and belief.
- Coverage is not in effect until final approval is given by Madison National Life Insurance Company, Inc.
- No person, except an officer of Madison National Life, is authorized to vary or modify a contract.
- I understand that if my coverage includes AD&D insurance, the AD&D coverage may have a War exclusion for benefit.

Employee Signature **Date**

EMPLOYEE WAIVER OF INSURANCE

I have been given the opportunity to apply for group insurance as presented to me, but do NOT wish to take the coverage(s). I understand that if my dependents or I decide to apply for this Group insurance plan at a later date, Evidence of Insurability will be required at my own expense, and must be approved by Madison National Life Insurance Company, Inc.

Employee Signature **Date**

FOR NATIONAL INSURANCE SERVICES USE ONLY:		
Notes:		
Date Received:	**Effective Date of Coverage:**	**Plan No.**