



**Liberty Mutual Long-Term Disability  
Enrollment/Cancel Form**

**Enroll**

**Cancel**

**Employee Information**

Name: \_\_\_\_\_  
(Last) (First) (MI)

Male  
 Female

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 #: \_\_\_\_\_