

NORTH CAROLINA STATE UNIVERSITY

Disability Employee Enrollment Form

Please type or print legibly

EMPLOYER SECTION

1. 850-279590 North Carolina State University New Hire Y ___ N ___
 Group Policy No. Employer Name
2. _____
 Location Name ID # Dept. # Class
3. _____
 Coverage Effective Date Job Title Date of Hire
- Prior State Service Y ___ N ___ (If yes) Dates of Service _____
- _____ \$ _____ per month
 HR Representative Basic Earnings

EMPLOYEE SECTION

4. _____
 Employee SS# Date of Birth
5. _____
 Employee Name Campus or Home Phone
6. _____
 Street Address (Home)
7. _____
 City State Zip Code
8. _____
 Campus or County Address
9. _____
 City State Zip Code
10. Hours worked per week _____ Male ___ Female ___

11. ACCEPT: I request coverage under my employer's plan of benefits as indicated above. If applicable, I authorize my employer to deduct from my earnings, my contributions for the coverage(s) selected. I understand that with respect to coverage's I have declined, Liberty has the right to require evidence of insurability in order to consider any later request to change this decision and that my request may be denied.

12. I am an employee in active employment working at the Employer's regular place of business.

Signature_____
Date

Please return to:
 North Carolina State University
 University Benefits Dept.
 Campus Box
 PO 7215
 Raleigh, NC 27695-7215