EMORY
FACULTY AND STAFF
LTD COLA Election

EMPLOYEE'S NAME _____
(Please Print)

SOCIAL SECURITY NUMBER _____ DATE OF HIRE _____ EFFECTIVE DATE_____

I hereby request the Optional 4% Cost of Living Adjustment (COLA) Benefit { } YES { } NO
In addition to my employer paid LTD benefit.

I authorize the proper deductions from my earnings as my contribution toward the cost of this insurance. Also, I understand that if I do not elect this coverage by the above deadline and wish to at a later date, evidence of insurability will be required.

Example of cost calculation: **(Increases or decreases based on salary)**

Annual Salary: $_____

Divide by 12 months: $_____

Multiply by 0.0011: $_____

Monthly Premium: **$**_____

Check one: **Monthly** _____**Bi-weekly**_____

For Human Resources Only

BENEFIT PLAN_____31_____

COVERAGE BEGIN DATE_____

DEDUCTION BEGIN DATE_____

HR DATA ENTRY Initial and Date _____

Signature of Employee_____

Date_____