

**Return Applications to: Harvey Watt & Company**

 P0 Box 20787 | Atlanta, GA 30320  
 Phone 1-800-241-6103  
 Fax 1-404-761-8326

**GROUP DISABILITY INCOME INSURANCE ENROLLMENT**
**TO BE COMPLETED BY THE POLICYHOLDER**

Policy Number _____			
Employer/Policyholder Name _____			
Street Address _____	City _____	State _____	Zip Code _____
Employee Occupation/Job Title _____	Employee Date of Employment _____		
Effective Date of Coverage _____	<input type="checkbox"/> Full Time Employee <input type="checkbox"/> Part Time Employee		
\$ _____ / <input type="checkbox"/> HR <input type="checkbox"/> WK <input type="checkbox"/> MO <input type="checkbox"/> YR	Class Number (if applicable) _____		
Basic Earnings			

**I. EMPLOYEE/ENROLLEE INFORMATION**

Name _____	Sex	<input type="checkbox"/> M	<input type="checkbox"/> F
Street Address _____	City _____	State _____	Zip Code _____
Home Telephone Number _____	Date of Birth _____	Marital Status _____	
Email Address _____	Are you a pilot?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**II. BENEFITS (Please check if you wish to enroll)**

	Elect	Decline
<b>Short-Term Disability Income Insurance</b>		
Short-Term Disability Income Insurance: Core Plan 60% (Employer pays 50% of the cost)	<input type="checkbox"/>	<input type="checkbox"/>
Short-Term Disability Income Insurance: Buy-Up Plan 66 2/3% (Voluntary – Check one)	<input type="checkbox"/>	<input type="checkbox"/>
	Elect	Decline
<b>Long-Term Disability Income Insurance. Evidence of Insurability is REQUIRED for VLTD.</b>		
Voluntary Long-Term Disability (VLTD) Income Insurance (Voluntary – Check one)	<input type="checkbox"/>	<input type="checkbox"/>

Group Benefits are insured by Symetra Life Insurance Company.

**III. SELECTION/WAIVER OF GROUP INSURANCE** *(Only check one box below, and sign.)*

- I, the undersigned, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance **(Not applicable if the Policyholder pays 100% of the required contribution)**.
- I, the undersigned, hereby waive my right at this time to elect the insurance coverage which I did not select above. I understand that if I do not enroll within 31 days of the date I am first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death. All information submitted by me on this form to the best of my knowledge and belief is true and complete.

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Enrollee/Employee Signature

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Date Signed

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