

Enrollment Form

The Commonwealth of Massachusetts

LONG TERM INCOME PROTECTION PLAN New Late Applicant

| | | | | |
|--|--------|------------------------------------|------------|---------------------|
| Social Security Number - - | | Name (last, first, middle initial) | | |
| <input type="checkbox"/> Check if new address | Street | | | |
| <input type="checkbox"/> Male <input type="checkbox"/> Female | City | | State | Zip Code |
| Date of Birth / / | | Home Telephone () | | Date of Hire / / |
| Agency Name & Address | | Salary \$ | Occupation | |

I REQUEST COVERAGE under the Long Term Income Protection Plan through my employer's group insurance contract, as now or hereafter applicable to me, and authorize the appropriate deductions from my wages.

Employee Signature: _____ Date: _____

Shaded area to be completed by GIC Coordinator

Effective Date of Coverage:

Agency Number:

GIC Coordinator Signature: _____ Date: _____