Madison National Life Insurance Company
Independence Holding Group

Employee Long Term Disability Enrollment Form

Please return forms to: Mail: Ochs, Inc. ● 400 Robert Street North ● Suite 1880 ● St. Paul, MN 55101
Email: ochs@ochsinc.com ● Fax: 651-665-3791

Check one

☐ New Employee ☐ Newly Eligible Employee (Status Change) ☐ Annual Enrollment

Name of Employer **Okaloosa County**	Group Number	Employee ID
Employee Name *(last, first, initial)*	Employee Date of Birth	☐ Male ☐ Female
Employee Home Address *(street, city, state, zip)*		☐ Married ☐ Single
US Citizen? ☐ Yes ☐ No - If an enrollee is not a US citizen, please attach a copy of his or her Visa.	Annual Salary $	Part Time Date of Hire / Full Time Date of Hire
Job Title	Job Duties	Hours Worked/Week

Location (check one): ☐ BCC ☐ Tax Collector ☐ Property Appraiser ☐ Clerk of Court

Long Term Disability Monthly Benefit

☐ 50% to $3,500 – Core, Employer Paid

☐ 60% to $5,000 – Buy Up, Employee Paid

☐ Cancel - Buy Up, Employee Paid

EMPLOYEE COVERAGE AUTHORIZATION

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits.

By signing this Application I understand and agree that:

- I authorize my Employer to make any required deductions, if any, from my salary to pay the premium of my insurance coverage in effect.
- All statements and answers I have given are complete and true to the best of my knowledge and belief.
- Coverage is not in effect until final approval is given by Madison National Life Insurance Company, Inc.
- No person, except an officer of Madison National Life, is authorized to vary or modify a contract.
- I understand that if my coverage includes AD&D insurance, the AD&D coverage may have a War exclusion for benefit.

Employee Signature **Date**

EMPLOYEE WAIVER OF INSURANCE

I have been given the opportunity to apply for group insurance as presented to me, but do NOT wish to take the coverage(s). I understand that if my dependents or I decide to apply for this Group insurance plan at a later date, Evidence of Insurability will be required at my own expense, and must be approved by Madison National Life Insurance Company, Inc.

Employee Signature **Date**

FOR NATIONAL INSURANCE SERVICES USE ONLY:		
Notes:		
Date Received:	**Effective Date of Coverage:**	**Plan No.**