CHARLESTON SOUTHERN UNIVERSITY
SHORT TERM DISABILITY ENROLLMENT FORM

Employee Name:_____
Last **First** **Middle Initial**

Address:_____
Street **City** **State** **Zip**

Hire Date:_____ **Sex:** ____M ____F **Married:** ____Y ____N

Birthday:_____ **Social Security Number:** _____

Earnings: _____ **Job Title/Position:**_____

_____**Hourly #Hours per week**_____ _____**Weekly** _____**Monthly** _____**Yearly**

_____**Other** _____

I represent that all of the information on this Enrollment Form is complete, true and correct. By my signature on the form, I understand and accept the following terms and conditions.

1. **If coverages have been refused, I am not insured for those coverages. If I want to apply later, I must furnish proof of good health at my own expense.**

2. **I authorize any required deductions from my earnings.**

3. **I must work the number of hours specified in the group contract or agreement to remain insured.**

_____ _____
Signature **Date**

Personnel Use Only

Date Received:_____ Effective Date: _____

Received By: _____

"Promoting Academic Excellence in a Christian Environment"