MARQUETTE UNIVERSITY

Human Resources

# MARQUETTE UNIVERSITY GROUP DISABILITY ENROLLMENT FORM

(NOTE: Completing this form does not guarantee coverage)

**All fields are mandatory, please print**

<table>
<tr><td colspan="2">Employer ID #:<br>L659624</td><td colspan="2">Employer Name:<br>Marquette University</td><td>Workplace Location:<br>Milwaukee, WI</td></tr>
<tr><td colspan="3">Employee Name: (Last, First, M.I.)</td><td>Birthdate:<br>Month / Day / Year<br>/ /</td><td>SS#:</td></tr>
<tr><td>Sex:<br>○ Male<br>○ Female</td><td colspan="2">Date of Full-time Hire:</td><td>Hours Worked Weekly</td><td>Basic Earnings<br>$_____ Per_____</td></tr>
<tr><td colspan="5">Occupation</td></tr>
<tr><td colspan="5">INSURANCE APPLIED FOR: Long Term Disability</td></tr>
<tr><td colspan="5">I authorize deductions from my wages to cover my contribution, if required, toward the cost of my insurance.</td></tr>
<tr><td>Date</td><td colspan="4">Signature of Employee (If APPLYING for coverage)</td></tr>
<tr><td colspan="5">To be completed only is WAIVING coverage</td></tr>
<tr><td colspan="5">The group disability insurance available to me through my employer has been explained to me. After careful consideration I have decided that I do not want to enroll for Long Term Disability. I understand that if I want to become insured later, I will be required to submit, and have approved, medical evidence of insurability satisfactory to Northwestern Mutual Life.</td></tr>
<tr><td>Date</td><td colspan="4">Signature of Employee (If WAIVING for coverage)</td></tr>
</table>