STATE UNIVERSITY OF NEW YORK

GROUP LONG-TERM DISABILITY INSURANCE PROGRAM

STATEMENT OF DISABILITY

INSTRUCTIONS:
If you believe that you are immediately eligible for a waiver of the one-year waiting period under the State University's Group Long Term Disability Insurance Program because you meet the qualifications below, complete this form and the attached Certification of Enrollment, and return it to hr@oswego.edu

QUALIFICATIONS:
"Within three months prior to a benefits eligible appointment to State University service, I was insured by my previous employer under a group disability insurance program providing income benefits for a period of not less than five (5) years during total disability due to sickness."

I, _____, now employed by the State University of New York, College at Oswego, do hereby certify that I believe I am eligible for immediate coverage under the State University's Group Long Term Disability Insurance Program by reason of having been insured under a similar group disability insurance program by my previous employer, which provided income benefits for a period of not less than five (5) years during total disability due to sickness.

Name of Employer: _____

Contact Name: _____

Address: _____

_____

Date of Termination: _____

Signature: _____ Date: _____

I understand that any coverage extended to me under the State University's Group Long Term Disability Insurance Program, pursuant to this certification, is subject to verification of eligibility and, in the event it is determined that I am not eligible for immediate coverage by reason of coverage with a previous employer, such coverage will be cancelled and I will be required to meet those qualifications for coverage as otherwise apply.

UP-13 (7/09)