

VINCENNES UNIVERSITY LK 8340
Long Term Disability Insurance Enrollment Card

(Please Print)

Employee Name _____ Last _____ First _____ Middle _____

Employee Address _____ Number & Street _____ City _____ State _____ Zip Code _____

Sex M F Date of Birth _____ Social Security No. _____

Location/Div _____ Date Hired _____ Mo. Day Year _____

Occupation _____

Effective date _____

I elect to participate in the Long Term Disability Plan and authorize the applicable deductions.

Signature _____ Date _____ Mo. Day Year _____

LIFE INSURANCE COMPANY OF NORTH AMERICA, A CIGNA COMPANY