

GROUP LONG TERM DISABILITY INSURANCE

LONG TERM DISABILITY ENROLLMENT FORM

The Prudential Insurance Company of America
752 Broad St.
Newark, NJ 07102
Fax: 866-764-0547

Policy Holder Name: Knox College

Group Contract Number: 04161

EMPLOYEE INFORMATION:

Employee's Last name: _____ **First Name:** _____ **MI:** ___

Social Security Number: _____ **Date of Birth:** _____

Occupation: _____ **Annual Salary:** \$ _____

Marital Status: Single: ___ Domestic Partner: ___ Married: ___ Divorced: ___ Widowed: ___

Gender: ___ Male ___ Female **Employment Date:** _____

LTD Insurance Effective date: _____ **LTD Benefit Amount (Per Month):** \$ _____