

ELECTION FORM

Professional Insurance Company

Name: _____

Address: _____

On the accompanying benefit applications and this enrollment form, I have applied for certain benefits offered through the above group. It is my decision to receive the following through allotment/payroll deduction.

DISABILITY PLAN – OCC II – 14/14 – 1 YEAR		
INITIAL ELECTION	BENEFIT AMOUNT PER MONTH	BI-WEEKLY DEDUCTION
	\$ 300	\$ 7.10
	\$ 400	\$ 9.46
	\$ 500	\$11.83
	\$ 600	\$14.19
	\$ 800	\$18.92
	\$ 900	\$21.29
	\$1,000	\$23.65
	\$1,200	\$28.39
	\$1,300	\$30.75
	\$1,400	\$33.12
	\$1,500	\$35.48
	\$1,600	\$37.85
	\$1,700	\$40.21
	\$1,800	\$42.58
	\$1,900	\$44.94
	\$2,000	\$47.31

DISABILITY PLAN – OCC II – 14/14 – 2 YEAR		
INITIAL ELECTION	BENEFIT AMOUNT PER MONTH	BI-WEEKLY DEDUCTION
	\$ 300	\$ 8.37
	\$ 400	\$11.16
	\$ 500	\$13.95
	\$ 600	\$16.74
	\$ 800	\$22.32
	\$ 900	\$25.11
	\$1,000	\$27.90
	\$1,200	\$33.49
	\$1,300	\$36.28
	\$1,400	\$39.07
	\$1,500	\$41.86
	\$1,600	\$44.65
	\$1,700	\$47.44
	\$1,800	\$50.23
	\$1,900	\$53.02
	\$2,000	\$55.81

OPTIONAL RIDERS AVAILABLE

	Employee Only	\$ 4.13
	Employee/Spouse	\$ 7.80

	Employee/Child(ren)	\$ 8.54
	Family	\$12.21

Total Bi-Weekly: \$ _____ Add \$2.00 Fee = Total Allotment: \$ _____
(Includes any Rider Cost)

EMPLOYEE ID # -

POSTAL EASE PIN # -

Authorized Signature: _____ Date: _____