Group Disability Insurance Enrollment and Change Form

Northwestern Mutual®
The Northwestern Mutual Life Insurance Company

Please Print

Policy Number	**Employer Name** (Policyowner) **Administrative Office of the Courts**			**Workplace Location** (City, State)	
Employee Name (Last, First, M.I.)	**Sex** ☐ M ☐ F	**Birthdate** Mo / Da / Yr		**Date Employed** Mo / Da / Yr	**Social Security No.**
Hours Worked Weekly (Excluding overtime for this employer)	**Basic Earnings** (From this employer) $ _____ Per _____		**Occupation**		

Insurance Applied for Under My Employer's Northwestern Mutual Life Group Policy:

☐ Long Term Disability ☐ Short Term Disability

I authorize deductions from my wages to cover my contribution, if required, toward the cost of my insurance.

Date	Signature of Employee (If applying for coverage)

To Be Completed Only If Waiving Coverage:

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 ☐ Short Term Disability

I understand that if I want to become insured later, I may be required to submit, and have approved, medical Evidence of Insurability satisfactory to Northwestern Mutual Life.

Date	Signature of Employee (If waiving coverage)
	Witnessed by

To Be Completed Only if Terminating Coverage:

Please terminate the following group insurance coverage(s) under the above group policy:

☐ Long Term Disability ☐ Short Term Disability. Please terminate this coverage on _____ (month) /_____ (day) /_____ (year).

Do not deduct any further premium contributions from my wages.

I understand that before I may become insured again, I may be required to submit, and have approved, medical Evidence of Insurability satisfactory to Northwestern Mutual Life.

Date	Signature of Employee (If terminating coverage)

To Be Completed When Insured Has Legal Name Change:

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Policy Number	**Employer Name** (Policyowner) **Administrative Office of the Courts**	**New Legal Name** (Last, First, M.I.)
Date	Signature of Insured Member	

Policyowner Use Only:

Amounts of Insurance

	Date	Class	Long Term Disability Insured Monthly Earnings	Short Term Disability Weekly Benefit Amount
Initial Data:				
Changes:				

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