Christian Schools International

INSURANCE PLAN AND TRUST FUND
SHORT TERM DISABILITY EMPLOYEE APPLICATION AND CHANGE FORM

Employee's name _____ Sex: ☐ M ☐ F Date of birth ____ / ____ / ____ ☐ Single ☐ Married

Address _____ City _____ State _____ Zip _____

School _____ Job title _____

Name of building (if different from above) _____

Grade level / subject taught _____ Work email address _____

Personal email address _____

Employee's phone number _____ Date of employment ____ / ____ / ____

Employee status: ☐ New hire ☐ Name/address change

By signing below, I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. My signature below also verifies the accuracy of the information on this form. I understand that my enrollment, and that of any of my dependents, is contingent on meeting the eligibility and enrollment rules set forth in the documents that govern the programs in which I have requested enrollment. If I have declined enrollment for myself or any dependents, I understand that I may not change my enrollment elections until the next open enrollment period without a qualifying change of status event, and that some programs may also require satisfactory evidence of insurability at my expense.

100% of eligible employees must be enrolled in the short term disability plan.

Signed _____ Date ____ / ____ / ____ SSN _____ - ____ - _____

PLEASE HAVE YOUR EMPLOYER COMPLETE.

Yearly salary _____ **School number** _____

Forms may be submitted via **email** to:
aslachter@csionline.org

(or)

Forms may be submitted via **mail** to:
Christian Schools International
Attn: US Insurance
3350 East Paris Ave SE
Grand Rapids, MI 49512

Clear Form

Revised 5/2019