Application for
Nazarene LTD Insurance Plan

This application is to request supplemental long-term disability (LTD) insurance coverage from Nazarene Benefits USA (NBUSA) and The Hartford. After downloading this form, you may complete it with your computer, but you will need to print, sign, and return it to us. This may be done via USPS mail (see address on page 2), as an attachment to an email (**benefits@nazarene.org**), or via FAX (800.334.0634). Rates can be found in our supplemental insurance guide. If you have questions, we're here to help at **888.888.4656**.

STEP 1: Complete Personal Information

Name ______________________________ ☐ M ☐ F

Address ______________________________ E-Mail ______________________

City, State, Zip ______________________ Home Phone ______________________

Date of Birth (mm/dd/yy) ________________ Social Security Number _______-________-________

Job Title ______________________ Credential ______________________

Employer ______________________ District ______________________

Employer's Address ______________________________ Hours per week __________

☐ Full-Time Service* ☐ Full-Livelihood Service* ☐ Evangelist: Sundays per year __________

*Full-time service to the local church employer is defined as no fewer than 30 hours per week for at least 30 weeks per calendar year. Full-livelihood service is defined as deriving at least 50% of compensation from such ministry. Both are required for long-term disability eligibility.

Spouse's Name ______________________________

Spouse's Date of Birth (mm/dd/yy) ______________ Spouse's SS Number ________-_______-________

STEP 2: Select Coverage Amounts

Choose your monthly benefit (3-Month Qualifying Period applies): ☐ $500 ☐ $1,000 ☐ $1,500

Annual Premium $ ______________ (A) ÷ 12 = $ ______________ (B)

To calculate your prorated premium, enter the number of FULL months until January 1. ______________ (C)

TOTAL DUE (B x C) $ ______________

Complete and sign second page

STEP 3: Date and Sign Your Application

Date ________________ Signature ____

Please sign in ink

NOTICE OF EFFECTIVE DATE: You are covered once your completed application has been approved and premium payment received.

NOTICE OF PREEXISTING CONDITIONS LIMITATIONS: Coverage is issued with a preexisting conditions limitation. If you have received treatment for a medical condition within the 6 months immediately preceding the date your coverage is effective, then you must satisfy one of the following: (1) go 6 months free of treatment on or after your effective date; or (2) be insured for 12 months even with treatment. **This preexisting conditions limitation does not apply to any other cause of disability.**

Please return completed and signed form to NBUSA.

STEP 4: Payment

Once you have submitted this signed application, we will review the information and contact you with an invoice for payment. Included will be instructions on how to make your payment using our secure online system *myNBUSA*. If you would like another payment option, phone us at **888.888.4656**.

For NBUSA Office Use Only

Received ______________________________ Effective ______________________________

Certificate No. ______________________________-05

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