STATE UNIVERSITY OF NEW YORK
GROUP LONG-TERM DISABILITY INSURANCE PROGRAM
STATEMENT OF DISABILITY

INSTRUCTIONS:

If you believe that you are immediately eligible for a waiver of the one-year waiting period under the State University's Group Long Term Disability Insurance Program because you meet the qualifications below, complete this form and the attached Certification of Enrollment, and return it to, Human Resources, Administration Building, Room 390.

Qualifications:

"Within three months prior to a benefits eligible appointment to State University service, I was insured by my previous employer under a group disability insurance program providing income benefits for a period of not less than five (5) years during total disability due to sickness."

I, _____, now employed by the State University of New York, Stony Brook University, do hereby certify that I believe I am eligible for immediate coverage under the State University's Group Long Term Disability Insurance Program by reason of having been insured under a similar group disability insurance program by my previous employer, which provided income benefits for a period of not less than five (5) years during total disability due to sickness.

I understand that any coverage extended to me under the State University's Group Long Term Disability Insurance Program, pursuant to this certification, is subject to verification of eligibility and, in the event it is determined that I am not eligible for immediate coverage by reason of coverage with a previous employer, such coverage will be cancelled and I will be required to meet those qualifications for coverage as otherwise apply.

Stony Brook University

The individual named above states that s/he left your employ on_____ and is now employed by Stony Brook University. Stony Brook provides a long-term disability insurance program that allows for immediate coverage if similar group coverage was provided during employment with a previous organization.

Employee Release:

By signing below I acknowledge that I release my current and former employers from any liability and responsibility for providing written or verbal information about me to Stony Brook University in regards to my participation in any group long term disability insurance programs.

EMPLOYEE'S SIGNATURE_____ DATE: _____

To be Completed by Recent Employer:

Previous Employer's Name:_____

Please indicate whether or not your plan provides income benefits for a period of five or more years during total disability due to sickness by checking one of the choices below:

- ❑ **Above mentioned employee participated in a similar plan**
  If so, when did group coverage end? :_____
- ❑ **Above mentioned employee did not participate in a similar plan**

Name (Print):_____ Title: _____

Signature: _____Date:_____

Phone Number:_____

This form can be mailed back to Stony Brook University, Human Resource Services- Room 390, Stony Brook, NY 11794-0751 or faxed to 631-632-1350.

Thank you for your cooperation.

Sincerely,
Human Resource Service