



**Waiver of Group Long Term Disability (LTD) Coverage -
For Employees covered under an Individual LTD plan**

Group Policy No. _____ Name of Company: _____

Name of Employee: _____

Acknowledgement and Authorization:

- I acknowledge I have been offered Long Term Disability benefits under my Employer's Group Insurance Plan with The Empire Life Insurance Company and, The Long Term Disability benefits provided by this plan have been fully explained to me.
- I further acknowledge I have waived the Group Long Term Disability coverage available to me under my Employer's plan including all my rights and privileges in respect to such benefits as I have Individual Monthly Income Disability Insurance.
- I understand my Individual Monthly Income Disability Insurance is a separate contract and may provide different coverage and benefits than my Employer's group plan with The Empire Life Insurance Company.
- I understand that if I later apply for the waived Group Long Term Disability coverage, I will be required to provide satisfactory evidence of insurability from first dollar to The Empire Life Insurance Company based on the underwriting requirements at the time of my application.

Employee's Signature _____ Date _____