STATE UNIVERSITY OF NEW YORK

GROUP LONG-TERM DISABILITY INSURANCE PROGRAM

STATEMENT OF ELIGIBILITY

INSTRUCTIONS:
If you believe that you are immediately eligible for coverage under the State University's Group Long Term Disability Insurance Program by reason of your meeting the qualification set forth below, complete this form and return it to your College Personnel Office.

QUALIFICATION:
"Within three months prior to a benefits-eligible appointment to State University service, I was insured by my previous employer under a group long term disability insurance plan providing income benefits for a period of five (5) or more years of disability."

I, _____, now employed by the State University of New York
(employee name printed)

at _____, do hereby certify that I believe I am eligible for
(name of campus)

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 in order for the waiting period to be waived, I must provide a letter from my previous employer to SUNY which verifies the period of such coverage under their group long term disability insurance plan, and include a Certificate of Coverage or Summary Plan Description for their plan.

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.

_____ XXX-XX-_____
Employee Signature Last four digits of Social Security Number

_____
Date

UP-13 (10/12)