SHORT-TERM DISABILITY INSURANCE
TAX REDUCTION AGREEMENT FORM

Name: _____
Last Name First Name Middle Initial

Address: _____

_____

Social Security No: _____

Select one of the short-term disability program options listed below.

Option A: ☐ 0 day accident/7 days sickness waiting period for benefits
Option B: ☐ 0 day accident/14 days sickness waiting period for benefits

I am applying for $_____ of monthly Short Term Disability insurance.

I elect to have $_____ deducted from payroll **Bi-Weekly** for Short Term Disability coverage.

I elect to have $_____ deducted from payroll **Monthly** for Short Term Disability coverage.

I elect to have $_____ deducted from payroll **Semi-Monthly** for Short Term Disability coverage.

My pay cycle is: **Bi-Weekly** **Monthly** **Semi- Monthly**

I elect to have this deduction on a:

☐ **Pre-tax basis** ☐ **Post-tax basis**

I understand that these benefits will remain in effect until I complete and file a new election form with the Office of Human Resources during an open enrollment period. I also understand that I cannot revoke my pre-tax election before the next open enrollment.

Employee Signature: _____ Date: _____