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 Human Resources Office.

QUALIFICATION:

"Within three months prior to full-time 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 years during total disability due to sickness."
I, _____, now employed at the State University of New York, College at Fredonia, do hereby certify that I believe that 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:
_____
_____
_____
(complete mailing address)

which provided income benefits for a period of not less than five years during total disability due to sickness, having left such employment on _____(date).

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 canceled and I will be required to meet those qualifications for coverage as otherwise apply.

Form UP-13
CPO - 10/76