

WAIVER FOR SUPPLEMENTAL DISABILITY

Employee Name

Social Security

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SUBJECT: Disability Insurance Program

<input type="checkbox"/>	Yes I applied for this coverage \$ _____ per month.
<input type="checkbox"/>	I do not want this supplemental disability coverage.

This is to authorize the University of Texas System Medical Foundation to **START / TERMINATE** my inclusion in the Voluntary Disability Insurance Program sponsored by the Foundation for residents and fellows.

I understand that such coverage is effected without medical justification and that should I wish inclusion in the Program at a later time, I can be asked to provide medical justification and I could be denied coverage based on the same.

I recognize that coverage on my life in reference to insurance noted herein is dependent on the designation checked above. I also recognize that if I chose to be covered, I have already filled an application with the provider.

Signature

Date

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PLEASE FAX OR MAIL COMPLETED FORM TO:

UT System Medical Foundation
6431 Fannin Street
Suite JLL-310
Houston, Texas 77030

(713) 500-0699 Fax