CIGNA
Short Term Disability
Enrollment Form

Please Print

Employee Name (last,first,initial)				Social Security No.
Birth Date	____ M ____ F Sex	Hire Date	Position (Title)	$ Annual Salary

I understand that Oakland Univeristy will pay the insurance premium for coverage on my behalf. However, Oakland University will not be held responsible for any decision made by CIGNA regarding my benefits.

Date	Signature
Effective Date	