

MINNESOTA ASSOCIATION OF TOWNSHIPS



Executive Director
David A. Fricke

GROUP DISABILITY ENROLLMENT FORM

The Minnesota Association of Townships endorses the Township Officers Group Disability Program sponsored by the Minnesota Benefit Association. MBA is a non-profit association of public officials and employees, whose mission is to provide fraternal and benevolent services and benefits for its member group. Minnesota Townships are permitted by Minnesota Statute 471.61 to establish group benefit programs covering their officers and employees.

HOW TO ENROLL

1. Adopt and complete this Enrollment Resolution which can be used for both officers and employees.
2. Complete the census form on the reverse side of this page. All Township Officers must elect to have the coverage.
3. Mail the Enrollment Resolution, census and a township check for the total annual premium to:



MINNESOTA BENEFIT ASSOCIATION
Township Group Disability Administrator
6701 Upper Afton Road
Woodbury, MN 55125

ENROLLMENT RESOLUTION

Be it resolved that _____ Township, located in _____ County adopts and applies for coverage to be funded for its officers under the Township Officers Group Disability Program provided under Group Policy No. 42228 and 42229 MBA, issued by Unicare Life & Health Insurance Company to the Minnesota Benefit Association.

ANNUAL PREMIUM — \$171 per officer

Benefit amount — \$150 per week

Benefit period — 52 weeks

Benefits begin — 15th day for accident
30th day for illness



**OPTIONAL — CHECK HERE IF APPLYING FOR
TOWNSHIP EMPLOYEE COVERAGE**

Eligible employees must work an average of
20 hours per week (1000 hours per year)

Name (please print) _____ Date _____

Signature of Officer _____ Position _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Email _____

TOWNSHIP BENEFIT PROGRAM

Township Name _____
County _____

TOWNSHIP OFFICERS CENSUS AND INVOICE

TOWNSHIP OFFICERS CENSUS INFORMATION

ANNUAL PREMIUM PER OFFICER

ANNUAL PREMIUM — \$171

NAME _____ Date of Birth ____/____/____ Address _____ City _____ Zip _____ Email _____
Position _____ SSN# _____

NAME _____ Date of Birth ____/____/____ Address _____ City _____ Zip _____ Email _____
Position _____ SSN# _____

NAME _____ Date of Birth ____/____/____ Address _____ City _____ Zip _____ Email _____
Position _____ SSN# _____

NAME _____ Date of Birth ____/____/____ Address _____ City _____ Zip _____ Email _____
Position _____ SSN# _____

NAME _____ Date of Birth ____/____/____ Address _____ City _____ Zip _____ Email _____
Position _____ SSN# _____

EMPLOYEE CENSUS INFORMATION

ELIGIBLE EMPLOYEES MUST WORK AN AVERAGE OF 20 HOURS PER WEEK (1000 PER YEAR)

ANNUAL PREMIUM — \$171

NAME _____ Date of Birth ____/____/____ Address _____ City _____ Zip _____ Email _____
Position _____ SSN# _____

NAME _____ Date of Birth ____/____/____ Address _____ City _____ Zip _____ Email _____
Position _____ SSN# _____

NAME _____ Date of Birth ____/____/____ Address _____ City _____ Zip _____ Email _____
Position _____ SSN# _____

Total annual premium remitted for officers \$ _____ **TOTAL PREMIUM ENCLOSED**
Total annual premium remitted for employees \$ _____ \$ _____