BENEFITS & RETIREMENT fcmm®

Long Term Disability Insurance
with Life and Accidental Death and Dismemberment Insurance

901 East 78th Street, Minneapolis, MN 55420-1300
(800) 995-5357 | Fax (952) 853-8474

Form 104: Employee Payment Method & Coverage Update

This form is given to eligible employees during the annual open enrollment period once an employer has updated its Form 120: Employer Benefit Agreement. Employees with a premium payment method change for either benefit or an Life/AD&D Insurance coverage amount change, must submit this form by December 1 for a January 1 effective date.

Employee Full Name _____

Employer Information

STOP This section must be completed by the EMPLOYER per the Form 120: Employer Benefit Agreement

Date of recently updated Form 120: Employer Benefit Agreement: _____
Changes may only be made once a year during open enrollment and submitted by November 15

Employer Name: _____

Employer Address: _____
Street City State Zip Code

Please complete for the employee named above per the Form 120: Employer Benefit Agreement:

LTD
Employee Benefit Class: #_____
☐ Staff Benefit
☐ Payroll Deduction (after-tax deduction)
☐ Conventional
☐ Tax Choice

Life\AD&D
☐ Staff Benefit
☐ Payroll Deduction (after-tax deduction)
Employee Benefit Class: #_____
☐ $10,000
☐ $50,000

_____
Signature of Employer

_____
Employer Contact Name

_____ _____
Employer Contact Email Employer Contact Phone

Only if PAYROLL DEDUCTION for either LTD or Life/AD&D premium payment methods, please affirm below:

☐ Yes, I would like to participate in the benefit plan at this time, and I authorize my employer to make the necessary deductions from my salary to pay the benefit premium when my insurance becomes effective. I understand my payroll deduction amount will change if my coverage or costs change.

☐ No, I do not wish to participate in the Long Term Disability and Life AD&D Insurance Benefit Plan at this time through payroll deduction. I understand I cannot enroll again until the Annual Open Enrollment, if I wish to elect this coverage in the future. Enrolling at a future date will include a pre-existing limitation on coverage.

Employee Signature: _____ Date: _____

For questions regarding this form, contact FCMM Client Services at (800)995-5357 or benefits@fcmmbenefits.org.

Update Form Submission:
Employer, please submit this completed form to FCMM no later than December 1 by mail, secure file exchange, or fax.

Mail:
FCMM Benefits & Retirement
901 East 78th
Street, Minneapolis, MN 55420

Secure File Exchange:
https://fcmmbenefits.leapfile.net/

Fax:
(952)853-8474

For FCMM Office Use Only

FCMM Depositor #: _____ Received Date: _____ Processed by: _____ Processed Date: _____

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