



EQUITABLE

Short Term Disability (STD) & Long Term Disability (LTD) OPT-OUT FORM

Equitable Financial Life Insurance Company of America
Employee Benefits
1290 Avenue of the Americas
New York, NY 10104

I, _____, have been offered the option to

PLEASE PRINT NAME

Disenroll/opt-out of my Short Term Disability (STD) and/or Long Term Disability (LTD) group plans. This means that I will no longer have this coverage. These policies are issued by Equitable Financial Life Insurance Company of America to insure employees of my employer, Town of Westford.

Effective 6/1/2023, I am disenrolling/opting out of the following coverage(s) that I am currently enrolled in through the Town of Westford.

Please check off the applicable selection(s) you want to opt-out of:

| Town Employees | School Employees |
|--|--|
| <input type="checkbox"/> STD Only Opt-out | <input type="checkbox"/> STD Only Opt-out |
| <input type="checkbox"/> LTD Only Opt-out | <input type="checkbox"/> LTD Only Opt-out |
| <input type="checkbox"/> STD & LTD Opt-out | <input type="checkbox"/> STD & LTD Opt-out |

Please circle one: Town Employee / School Employee

If I wish to enroll in coverage in the future, I understand that I may be required to furnish evidence of insurability (EOI) and will not be insured unless and until my application is approved by the insurance company.

Signature: _____ Date: _____