



Underwritten by:  
 Unum Life Insurance Company of America  
 2211 Congress Street, Portland, ME 04122

# Intermediate Unit 1

Short Term Disability Insurance and  
 Long Term Disability Insurance  
 Support Employees (Bargaining Unit)  
 Enrollment Form

**Policy #214977/Div #001**

Please complete this form in its entirety. Blank fields will cause significant delays in processing.

Employee Social Security Number    Gender    Date of Birth (mm/dd/yyyy)    Hours Worked Per Week

Employee First Name    M.I.    Last Name

Employee Street Address    City    State    Zip Code

Original Date of Hire    Annual Salary    Occupation

Exempt     Non-Exempt

- Date entered into an eligible class (ex: part time to full time) or
  - Rehire Date or
  - Date of promotion to an eligible class
- (If unknown, consult with your Plan Administrator to complete.)

**STD Plan: 60% of weekly earnings to a maximum benefit of \$150 per week**

**STD Cost Calculation:** To calculate your per-paycheck cost for this coverage, complete the calculations below (see rate table on the reverse side of this form). \*Final Cost may vary slightly due to rounding.

**NOTE:** If your weekly salary exceeds \$150, use \$150 as your weekly salary in the calculation.

$$\frac{\text{Annual Salary}}{52} = \text{Weekly Salary} \times \frac{\text{Benefit \%}}{100} = \text{Your Weekly Benefit}$$

$$\frac{\text{Your Weekly Benefit}}{10} = \text{Your Rate} \times .44/\$10 = \text{Your Monthly Cost}$$

$$\text{Your Monthly Cost} \times 12 = \text{Annual Cost} \div \text{\# Paychecks per year} = \text{Cost per Paycheck*}$$

**LTD Plan: 60% of monthly earnings to a maximum benefit of \$1,000 per month.**

**LTD Cost Calculation:** To calculate your per-paycheck cost for this coverage, complete the calculations below (see rate table on the reverse side of this form). \*Final Cost may vary due to rounding.

**NOTE:** If your annual salary exceeds \$1,667, use \$1,667 as your annual salary in the calculation.

$$\frac{\text{Annual Salary}}{100} = \text{Your Rate} \times .44/\$100 = \text{Annual Cost} \div \text{\# Paychecks per year} = \text{Cost per Paycheck*}$$

- Yes**, I would like to participate in the following coverage (check one or both):     **STD**     **LTD.**
- I authorize my employer to deduct from my salary or wages the necessary premium for this coverage. My signature verifies the accuracy of information contained on this form. I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would otherwise become effective. **I have also read and understand the information in the Plan Highlights, including all statements regarding exclusions and benefit amounts and offsets.**
- No**, I do not wish to participate. I understand that evidence of insurability will be required, at my own expense, if I decide to elect this coverage in the future.

Employee Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_

Return Forms To: \_\_\_\_\_ By: \_\_\_/\_\_\_/\_\_\_\_

**This section to be completed by your employer:**

Coverage Effective Date: \_\_\_/\_\_\_/\_\_\_\_