



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
 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 M F 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.

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

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

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

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.

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

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: __ __ / __ __ / __ __ __ __