



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

HRnovations

Long Term Disability Insurance
 Enrollment Form

Policy #151203/Div # _____

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

____ - ____ - _____ M F ____ / ____ / _____ _____

Employee First Name M.I. Last Name

Employee Street Address City State Zip Code

Original Date of Hire Annual Salary (Prior year's W-2) 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.)

| Rates* per \$100 of Covered Salary | | | |
|------------------------------------|--------|---------|--------|
| Age | Rate | Age | Rate |
| < 25 | \$0.12 | 50 - 54 | \$0.93 |
| 25 - 29 | \$0.15 | 55 - 59 | \$1.21 |
| 30 - 34 | \$0.23 | 60 - 64 | \$1.28 |
| 35 - 39 | \$0.34 | 65 - 69 | \$1.53 |
| 40 - 44 | \$0.45 | 70 + | \$1.62 |
| 45 - 49 | \$0.66 | | |

*LTD rates are based on five-year increments. Rates increase as you age.

To calculate the per-paycheck cost for this coverage, complete the calculations below.

Note: If your annual salary* exceeds \$200,000, use \$200,000 as your annual salary in the calculation.

_____ ÷ 100 = _____ X _____ = _____ ÷ _____ = _____

Annual Salary* Your Rate Annual Cost # Paychecks per Year **Cost per Paycheck****

* Annual salary is based on your prior year's W-2. ** Final cost may vary slightly due to rounding.

- Yes**, I would like to participate. 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: ____/____/____