



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      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\***

\* 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: \_\_\_\_/\_\_\_\_/\_\_\_\_