Underwritten by:

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

HRnovations

Short Term Disability Insurance Enrollment Form

Policy #146570/Div #_____

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**
__ / __ / ____

STD Cost Calculation: To calculate your per-paycheck cost for this coverage, complete the calculations below. *Final Cost may vary slightly due to rounding.

NOTE: *If your weekly salary exceeds $2083, use $2083 as your weekly salary in the calculation.*

_____ (Annual Salary) ÷ 52 = _____ (Weekly Salary) X 60 (Benefit %) = _____ **Your Weekly Benefit**

_____ (Your Weekly Benefit) ÷ 10 = _____ X _____ (Your Rate) = _____ **Your Monthly Cost**

_____ (Your Monthly Cost) X 12 = _____ (Annual Cost) ÷ _____ (# Paychecks per Year) = _____ **Cost per Paycheck***

Rates* per $10 of Weekly Benefit	
Age	**Rate**
<25	$0.48
25 – 29	$0.52
30 – 34	$0.47
35 – 39	$0.40
40 – 44	$0.41
45 – 49	$0.41
50 – 54	$0.49
55 – 59	$0.69
60 – 64	$0.85
65 – 69	$0.91
70+	$0.91

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

☐ **Yes,** I would like to participate. I authorize my employer to deduct from my salary or wages the necessary premium for this coverage on an after tax basis. 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: __ __/__ __/__ __ __ __

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