LONG TERM DISABILITY INSURANCE ENROLLMENT FORM

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

Employer Name:	Policy #:	
Employee Name:	Occupation:	
Social Security Number:	Date of Birth (mm/dd/yyyy):	
Hours Worked/Week:	Gender:	Location:
Date of Hire (mm/dd/yyyy):	Annual Salary:	

LTD Cost Calculation

To calculate your cost, you'll need to know the monthly benefit maximum and rates included in your enrollment materials distributed to you by your Plan Administrator. You may choose to insure 50%, 40%, or 25% of your monthly earnings, not to exceed the monthly benefit maximum.

1. Enter your monthly covered earnings (round to nearest dollar) $_____

2. Choose the percent of earnings you want to insure

___50%; ___40%; ___25% (write as decimal, such as .50) X_____

3. Multiply line 1 by line 2 to determine Monthly Benefit Amount $_____

4. Enter the monthly benefit maximum $_____

You will be insured for the lesser of the amounts in line 3 or line 4. If your monthly benefit amount (line 3) is less than the monthly benefit maximum (line 4), take your monthly earnings from line 1 and enter this amount in line 5 below.

Or,

If your monthly benefit amount is greater than the monthly benefit maximum, divide the monthly benefit maximum (line 4) by the monthly benefit percent (line 2). (_____÷_____= _____)

Monthly Benefit Maximum Monthly Benefit Percent Monthly Covered Earnings

Enter this amount (monthly covered earnings) in line 5.

5. $_____

6. To calculate your monthly premium, enter your rate and complete the calculation below:

_____ ÷ 100 X _____ = $_____

Amount from line 5 Rate Monthly Premium*

If you are not paid monthly, to calculate your cost per pay period, multiply the monthly premium by 12 and divide by the number of paychecks per year.

* Final cost may vary slightly due to rounding.

☐ **Yes,** I would like to participate. The percent of earnings I wish to insure is: _____ %.
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 as contained in the enrollment materials, including all statements regarding exclusions.**

☐ **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: _____

Please complete, sign and return this form to your Plan Administrator.

This section to be completed by your employer:

Coverage Effective Date (mm/dd/yyyy):

1336-03 (4/07)