



**DISABILITY INSURANCE ENROLLMENT FORM**

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

Policy # \_\_\_\_\_ Div # \_\_\_\_\_

Effective Date: \_\_\_\_\_

Employer Name:		Worksite Location:	
Employee Name (Format example: John M. Smith):		SSN:	
Street Address:			
City:		State:	Zip:
Date of Birth:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Hire:	Annual Earnings:	Hours Worked/Week:	
Occupation:	Phone:	<input type="checkbox"/> Home <input type="checkbox"/> Work	
E-mail Address:			

Select coverage by completing steps 1-5. The coverage amounts you indicate will replace all prior coverage amounts you have under this policy.

1) Choose a Plan:  Platinum Plan  Gold Plan

2) Choose an Elimination Period:  7 Days  14 Days  30 Days  60 Days  90 Days  180 Days

**3) Choose a Monthly Benefit Amount:**

You may not purchase more coverage than the maximum monthly benefit amount. Your "Maximum Monthly Benefit" is listed on the rate sheet next to your "Annual/Monthly Earnings". (If your earnings are not shown, use the next lower earnings and maximum benefit amounts, or refer to Plan Highlights to calculate your maximum benefit based on your earnings.) You may choose any amount up to and including your maximum in \$100 increments. Write in your benefit amount choice and corresponding cost below.

Monthly Benefit Amount: \$ \_\_\_\_\_ Your Cost: \$ \_\_\_\_\_

What portion of your premium is board paid (if any)?: \$ \_\_\_\_\_

4) Payroll Deduction Frequency:  10 times per year  12 times per year

**5) Complete Enrollment Acknowledgement and Signature:**

I would like to participate. My signature below verifies the accuracy of information contained on this form, and authorizes my employer to deduct from my salary or wages the necessary premium for this coverage.

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 limitations, exclusions, benefit amounts and offsets.**

Employee Signature: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_\_

If I choose not to participate, I understand that if I wish to apply for coverage at a later date, I must wait until the next annual enrollment to enroll. **Please remember to sign and date the form.**

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