UNUMPROVIDENT

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

Group Insurance Enrollment Form

Please print legibly and complete this form in its entirety. Blank fields will cause significant delays in processing.

Policyholder Name | **Policy No.** | **Division No.**

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** __/__/____

Spouse First Name (if coverage is selected)

Spouse Date of Birth (mm/dd/yyyy) __/__/____

COVERAGE ELECTIONS: Your employer will inform you of available coverage. Check yes to enroll; check no if you decline or coverage is not available.

Life/AD&D ☐ Yes ☐ No **Dependent Life** ☐ Yes ☐ No **LTD** ☐ Yes ☐ No **STD** ☐ Yes ☐ No

AMOUNT OF COVERAGE SELECTED FOR:

LIFE/AD&D You: $ ___,___,___ Spouse: $ ___,___,___ Child: $ ___,___

Note: If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete an Evidence of Insurability form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting and will become effective upon approval either on the first of the month coincident with or next following the date UnumProvident approves your Evidence of Insurability form. If you **DO NOT APPLY FOR** coverage for you or your dependent (s) during your or their initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage. You may complete and electronically submit an Evidence of Insurability form—please see your Plan Administrator.

Beneficiary Information:

Name (last name, first, middle initial):	**Relation to You:**	**Benefit %:**
If the beneficiary(ies) named above are not living, then pay:		

Request for Signature and Certification: I understand that my coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

_____ _____ _____ _____

Employee Signature *Date* *Work Phone* *Home Phone*

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER