## Life / Disability Enrollment Form

☐ New Hire ☐ Change ☐ Late Entrant

**To be completed by the employee**

| Name: (Last Name, First Name & M.I.) | Date of Birth (mm/dd/yyyy) |
|---|---|
| Social Security Number | Gender ☐ Male ☐ Female |
| Employee Home Address: (Street, City, State & Zip Code) | Annual Salary |
| Dependent Information (Complete only if dependent coverage is available and elected.)<br>(Last Name, First Name & M.I.) | Date of Birth (mm/dd/yyyy) |
| Spouse | |
| Child | |
| Child | |
| Child | |

Indicate type of coverage below. You may only elect coverages reflected in your Employer's contract. (You will not be covered for coverages not included in your Employer's contract.) To elect coverage check the box marked "Y". To decline coverage check the box marked "N."

| **Basic Life** | **Supplemental Life** | **Basic AD&D** | **Supplemental AD&D** | **Short Term Disability** |
|---|---|---|---|---|
| As provided by the Employer | ☐ Y ☐ N<br>☐ $___________<br>☐ ___________ X Annual Earnings | As provided by the Employer | ☐ Y ☐ N<br>☐ $___________ X Annual Earnings | ☐ Y ☐ N<br>☐ Flat Amount $___________ |

| **Dependent Life** | **LTD** | **LTD Buy-Up** |
|---|---|---|
| Spouse ☐ Y ☐ N Amount $___________<br>Child ☐ Y ☐ N Amount $___________ | ☐ Y ☐ N | Option 1 ___________%<br>Option 2 ___________% |

Note: If you have chosen coverage over the Guarantee Issue amount for you or your spouse, or apply for coverage after your initial enrollment period, you will need to complete an Evidence of Insurability form. The coverage requiring evidence of insurability will be subject to medical underwriting approval and will become effective in accordance with the terms of the policy. This applies to Life and Disability coverage.

Beneficiary Designation: Please refer to the last page of this form for important information regarding beneficiary designation.

| Full Name | Address | Social Security No. | Relationship | Date of Birth |
|---|---|---|---|---|
| **Primary:** | | | | |
| **Contingent:** | | | | |

☐ I hereby apply for the coverages I have indicated above on behalf of myself and all dependents listed, and I authorize my Employer to make the appropriate deductions, if any, from my wages for my share of the cost. I understand that any coverage I am requesting is subject to all the terms of the policy including any exclusions, any provisions requiring the submission of Evidence of Insurability and approval by Unum, and any provisions specifying a Delayed Effective Date in the event that I am absent from work or an eligible dependent is totally disabled on the date coverage would otherwise begin.

I also understand that if I submit Evidence of Insurability for additional coverage, the Effective Date for the additional coverage will be after Unum approves my submission per the terms of the policy.

☐ I hereby waive the coverages offered to me.

Request for Signature and Certification: I have read and understand the “Limitations and Exclusions” on the reverse side of this enrollment form. 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. I understand that evidence of insurability may be required, if I decide to elect coverage in the future.

Signature ______________________________ Date ______________________

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**To be completed by the employer**

| Employer Name | | Policy Number | Division Number |
|---|---|---|---|
| Employee Hire Date | Effective Date of Coverage | | |

**Limitations and Exclusions**

**Delayed Effective Date:**

**Employee:** Insurance will be delayed for employees not in active employment until the first of the month, coincident with or next, following the date they return to work. Regularly scheduled vacation time is considered active employment.

**Dependents:** Coverage for totally disabled dependents will be delayed until the first of the month, coincident with or next, following the date the individual is no longer disabled. This delay does not apply to newborn children or new hires who enroll dependent children within their initial enrollment period while dependent insurance is in effect. "Totally disabled" means that, as a result of injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; or has a life threatening condition.

**Exclusion for Suicide (applicable to Supplemental Life only):**

**Where the cause of death is suicide:**

1. No benefits will be payable for a loss occurring within 12 months after the individual's initial effective date; and
2. No increased or additional insurance will be payable for a loss occurring within 12 months after the day such increased or additional insurance is effective.

**This Suicide Exclusion does not apply to Washington residents.**

**AD&D Benefit Exclusions**

AD&D Benefits would not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders;
- Suicide, self-destruction while sane, or self-inflicted injury;
- War, declared or undeclared, or any act of war;
- Active participation in a riot;
- Attempt to commit or commission of a crime;
- The voluntary use of any prescription or non-prescription drug, poison, fume or any other chemical substance unless used according to the prescription or direction of the individual's doctor. This exclusion does not apply to the individual if the chemical substance is ethanol; or
- Intoxication. ("Intoxicated" means that the individual's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.)

***Please see your Plan Administrator [or your Policy] for a complete listing of applicable limitations and exclusions.***

# Important Information About Designation of Beneficiaries

## Beneficiary Information

- **Primary Beneficiary(ies)** means the person(s) you choose to receive your life insurance benefits. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any primary beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining primary beneficiary(ies).

- **Contingent Beneficiary(ies)** means the person(s) you choose to receive your life insurance benefits only if **all** primary beneficiaries are disqualified or die before you. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any contingent beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining contingent beneficiary(ies).

- **Minor Beneficiary(ies) –** When you designate minors as beneficiaries, it is important to understand that insurance benefits may not be released to a minor child. They may, however, be paid to a court appointed guardian of the child's estate. The regulations governing minor beneficiaries vary by state.

- **Trust –** You may designate a valid trust as a beneficiary.

## Types of Coverage Information

- **Basic Life** is life insurance provided by your employer for which they pay the premiums.

- **Supplemental Life** is life insurance elected by you for which you pay the premiums.

- **AD&D** is Accidental Death & Dismemberment coverage.

- If you wish to designate different beneficiaries for any of the above coverages, please complete a separate form.

## General Information

- **Updates to Your Beneficiary Designation –** You can change your beneficiary designation at any time. You may wish to review your designation periodically.

- **Consult an Attorney –** This information is not intended to be relied on as legal advice. You may wish to get the assistance of an attorney to help ensure your beneficiary designation correctly reflects your intentions.