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

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Policy #123456/Div 001

Term Life and AD&D Insurance Enrollment Form

Please print legibly and complete this form in its entirety. Blank fields will cause significant delays in processing.
Application Type:
☐ **Initial Enrollment:** To make initial elections; OR
☐ **Annual Enrollment:** To make changes to existing elections and/or information. The elections/information you indicate will replace your prior elections/information on file with Unum. **Note: If you do not wish to make any changes, do not complete this form. Please contact your plan administrator with any questions.**

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**

If date below unknown, consult with your Plan Administrator to complete:
☐ **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)** __ / __ / ____

HAVE ANY TOBACCO PRODUCTS BEEN USED IN THE LAST 12 MONTHS?
You: ☐ *Yes* ☐ *No **Your Spouse: ☐ *Yes* ☐ *No***

COVERAGE ELECTIONS: Please indicate below the coverage amounts you would like to select for you and your spouse and/or child, if applicable. Dependent life and/or AD&D coverage amounts cannot exceed 50% of your life and/or AD&D coverage amounts. Any coverage amounts left blank will result in a coverage amount of $0.

AMOUNT OF COVERAGE SELECTED FOR:

Life You: $ ☐ , ☐☐☐ , ☐☐☐ Your Spouse: $ ☐☐☐ , ☐☐☐ Your Child: $ ☐☐ , ☐☐☐

AD&D You: $ ☐ , ☐☐☐ , ☐☐☐ Your Spouse: $ ☐☐☐ , ☐☐☐ Your Child: $ ☐☐ , ☐☐☐

NOTE: If you have chosen Life coverage over the Guarantee Issue amount of $100,000 for you or $25,000 for your spouse, you will also need to complete an Evidence of Insurability form. The amount of Life coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective in accordance with the terms of the policy. 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. This applies to Life coverage only. You may complete and electronically submit an Evidence of Insurability form–please see your Plan Administrator.

Beneficiary Information: Please complete the beneficiary information on the reverse side of this form.

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.

_____ __ __/__ __/__ __ __ _____ _____
Employee Signature *Date* *Work Phone* *Home Phone*

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

Beneficiary Information:

NAME *(last name, first, middle initial)*:	**RELATION TO YOU:**	**BENEFIT %:**
IF THE BENEFICIARY(IES) NAMED ABOVE ARE NOT LIVING, THEN PAY:		

LIMITATIONS AND EXCLUSIONS

Delayed Effective Date:

Employee: Insurance will be delayed for employees not in active employment until 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 date the individual is no longer totally disabled. This delay does not apply to newborn children while dependent insurance is in effect. "Totally disabled" means that, as a result of sickness or injury, the dependent is unable to perform each of the usual and customary duties or activities of a person of the same age and sex in good health.

EXCLUSION FOR SUICIDE:

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date; and
2. No increased or additional insurance will be payable for a loss occurring within 24 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, mental infirmity, or diagnostic, medical or surgical treatment
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while insane;
- War, declared or undeclared, or any act of war;
- Active participation in a riot;
- Committing or attempting to commit an assault or a felony;
- Voluntary use of any controlled substance. (This is defined in Title II of the Comprehensive Drug Abuse Prevention Control Act of 1970 and all amendments.) This exclusion will not apply if the controlled substance is prescribed for the individual by a physician;
- The presence of that percentage of alcohol in the individual's blood which raises a presumption that he was under the influence of alcohol. The blood-alcohol level which raises this presumption is governed by the laws of the state in which the event occurred;
- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from it while it is being used for test or experimental purposes; you or your dependent is operating, learning to operate, or serving as a member of the crew; it is being operated by, or for, or under the direction of any military authority. (This exclusion does not apply to transport type aircraft operated by the Military Airlift Command of the United States; or similar air transport service of any other country.)
- Travel or flight in any aircraft or device for aerial navigation, including boarding or alighting from it, owned or leased by, or on behalf of your employer.
- Bacterial infection. This exclusion does not apply to you or your dependent when the bacterial infection is due directly to an accidental cut or wound.
- Service on full-time active duty in the Armed Forces of any country or international authority.