To complete this form online please go to
www.unum.com/esign/enrollment/1073-06

Underwritten by:
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122
Fax Number: 207-771-4019

Term Life and AD&D Insurance Enrollment Form Policy #_____ Div _____

THIS IS NOT AN APPLICATION FOR INSURANCE – This is an Enrollment Form.

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

Enrollment 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 employer with any questions.**

Employee Social Security Number **Gender** **Date of Birth (mm/dd/yyyy)** **Hours Worked Per Week**
M ◯ **F** ◯

Employee First Name **M.I.** **Last Name**

Employee Street Address **City** **State** **Zip Code**

Employee Email Address

Original Date of Hire **Annual Salary** **Occupation**

☐ **Exempt** ☐ **Non-Exempt**

☐ **Date entered into an eligible class** ***(ex: part time to full time or promotion date)***
☐ **Rehire Date**
Not to include waiting period. (Unum will calculate) **Spouse First Name (if coverage is selected)** **Spouse Date of Birth (mm/dd/yyyy)**

Have you used tobacco products (such as cigarettes, cigars, snuff, chew or pipe) or any nicotine delivery system in the past 12 months? You: ☐ ***Yes*** ☐ ***No*** Spouse: ☐ ***Yes*** ☐ ***No***

COVERAGE ELECTIONS: Please indicate below the coverage amounts you would like to select for you and your spouse and/or child(ren), if applicable. Spouse and child(ren) life and/or AD&D coverage amounts cannot exceed 100% of your life and/or AD&D coverage amounts.

Any coverage amounts left blank will result in a coverage amount of $0, including current coverage.

Total amount of coverage:

Life You: $	Your Spouse: $	Your Child(ren): $
AD&D You: $	Your Spouse: $	Your Child(ren): $

Note: If the amount of life coverage selected for you or your spouse is subject to medical underwriting approval, you will need to complete a Evidence of Insurability (Statement of Health). If approved, your coverage will become effective in accordance with the policy. If you DO NOT APPLY for coverage for you, your spouse or your child(ren) during your initial enrollment period, or are increasing coverage you may need to complete a Evidence of Insurability (Statement of Health) for all new amounts of coverage. You may be able to electronically submit the Evidence of Insurability (Statement of Health) - please see your employer for additional information.

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, Exclusions, Reductions and Terminations" on the reverse side of this enrollment form, including the delayed effective date warnings applicable to all coverage.* 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 (mm/dd/yyyy)* *Mobile Phone* *Work Phone*

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

Beneficiary Information:

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

Limitations, Exclusions, Reductions and Terminations

Effective Dates; Delayed Effective Date: The plan effective date is provided in your certificate. Your effective date may be later that the plan effective date. Coverage for employees who are not in active employment because of an injury, sickness, temporary layoff, or leave of absence is not effective until they have returned to active employment with the employer.

> ***Spouse and Dependent Coverage:*** If your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan.

Benefit reduction: Coverage amounts reduce as you age in accordance with your plan. Coverage may not be increased after a reduction. This is a sample reduction schedule:

Age:	Insurance Amount Reduces to:
70	65% of original amount
75	50% of original amount

If your plan has a different age reduction it will be in your certificate.

Exclusion for Suicide Life: Life insurance benefits will not be paid for deaths caused by suicide in the first 24 months after your effective date of coverage or after any increase in coverage. If your plan has a different exclusion period for suicide it will be in your certificate.

AD&D Benefit Exclusions if AD&D coverage is included with your plan:
Accidental death and dismemberment benefits are paid for loss of:

- Life
- Both hands or both feet or sight of both eyes
- One hand and one foot
- One hand and the sight of one eye
- Speech and hearing

AD&D Exclusions and Limitations, if AD&D is included with your plan*: Accidental death and dismemberment benefits are not paid for losses caused by, contributed to by, or resulting from:

- disease of the body; diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM);
- 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 a crime under state or federal law;
- operating any motorized vehicle while intoxicated; and
- the voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of your physician.

Some exclusions and limitations may not apply. Your certificate has details.

Termination of Coverage:
Your coverage and any spouse and dependent coverage will end on the earliest of:

- the date the policy or plan is cancelled;
- the date you are no longer in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in the certificate.

In addition, coverage for any spouse or dependent will end on the earliest of:

- the date your coverage under a plan ends;
- the date your dependent ceases to be an eligible dependent;
- for a spouse, the date of a divorce or annulment;
- the date of your death.

Unum will provide coverage for a payable claim that occurs while you, your spouse or dependents are coverage under the plan.

*The suicide exclusion does not apply in Washington and is limited to 12 months in Missouri and North Dakota. In New York accidental losses due to drug addiction may be excluded.

Certificate issued under policy form controls: This information is not a complete description of the insurance coverage offered. The policy or its provision may vary or be unavailable in some states. For complete details of coverage please refer to policy form C.FP-1, except in MD please refer to policy form C.FP-1D. Your certificate of coverage controls your benefits and rights.