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

# Select Short Term Income Protection Insurance Enrollment Form

## Policy #604532 /Div #001

| **Employer Name:** | **Worksite Location:** |
|---|---|
| Employee Name *(Format example: John M. Smith)*: | SSN: |
| Date of Birth: | Gender: ☐Male ☐Female |
| Date of Hire: | Annual Earnings: |
| Occupation: | Hours Worked/Week: |

**Select coverage by completing steps 1-4. The coverage amounts you indicate will replace all prior coverage amounts you have under this policy.**

**1) Calculate Your Maximum Weekly Benefit:**

| $_____ | ÷ 52 = | $_____ | X | 60% | = | $_____ |
|---|---|---|---|---|---|---|
| Annual Earnings | | Weekly Earnings | | Benefit % | | Weekly Benefit |

Your maximum benefit is the lesser of $1,500 or the "Weekly Benefit" calculated above, rounded to the nearest $50. The maximum benefit shown here is the highest amount for which you can apply.

**2) Choose a Weekly Benefit Amount:**

You may not purchase more coverage than the maximum weekly benefit amount. You may choose any amount up to and including your maximum in $50 increments. Write in your benefit amount choice below.

Weekly Benefit Amount: **$**_____

**3) Calculate Your Cost:** Enter your chosen Weekly Benefit Amount and the rate from the rate sheet corresponding to your age and Elimination Period chosen above.

| $_____ | ÷ 50 = | $_____ | X | $_____ | = | $_____ |
|---|---|---|---|---|---|---|
| Weekly Benefit | | | | Your Rate | | Monthly Cost* |

* Final cost may vary due to rounding.

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

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: __ __/__ __/__ __ __ __

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 and that evidence of insurability will be required, at my own expense.

**Please remember to sign and date the form.**