First Unum Life Insurance Company

unum

GROUP TERM LIFE, AD&D, STD AND LTD INSURANCE ENROLLMENT FORM

Underwritten by:

First Unum Life Insurance Company

2211 Congress Street, Portland, ME 04122

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** **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**

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: 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

Note: Coverage amounts for your spouse will never exceed the amount for which you are eligible.

Coverage amounts for your child will never exceed the lesser of $25,000 or the amount for which you are eligible

AMOUNT OF COVERAGE ELECTED 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 for you or 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 on the date Unum 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. 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.

Beneficiary Information:

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

Please see your Plan Administrator (or your Policy) for a complete listing of applicable limitations and exclusions.

Request for Signature: 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. 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.

For AD&D, STD and LTD insurance: We may have the right to deny benefits or rescind insurance if any of the information provided on this enrollment form is incorrect.

Caution for AD&D, STD and LTD insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____	_____	_____	_____	_____
Employee Signature	*Date*	*Work Phone*	*Home Phone*	*E-Mail*

First Unum Life Insurance Company
Provident Life and Casualty Insurance Company
The Paul Revere Life Insurance Company

As part of your enrollment for insurance with Unum, please complete this form and provide it to your Plan Administrator. Also, in order to effectively identify and locate beneficiaries and help ensure that benefits are distributed appropriately upon the death of an insured or additional named insured, we request information in writing from time-to-time, including when we become aware of a change regarding you, your beneficiary(ies) or additional named insured of your life insurance coverage. Please fill in the requested information below.

SECTION 1: Employee Information

Name (Last Name, Suffix, First Name, MI)		Social Security Number
Mailing Address	Telephone Number	Date of Birth

SECTION 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

Name & Mailing Address (Last Name, Suffix, First Name, MI)	Telephone Number	Relationship to You	Social Security Number	Date of Birth	Percentage
					Total Must Equal 100%

SECTION 3: Contingent Beneficiary (ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

Name & Mailing Address (Last Name, Suffix, First Name, MI)	Telephone Number	Relationship to You	Social Security Number	Date of Birth	Percentage
					Total Must Equal 100%

SECTION 4: Additional Named Insured/Spouse

Name (Last Name, Suffix, First Name, MI)		Social Security Number
Mailing Address	Telephone Number	Date of Birth

SECTION 5: Additional Named Insured/Spouse Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

Name & Mailing Address (Last Name, Suffix, First Name, MI)	Telephone Number	Relationship to You	Social Security Number	Date of Birth	Percentage
					Total Must Equal 100%

SECTION 6: Additional Named Insured/Spouse Contingent Beneficiary (ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

Name & Mailing Address (Last Name, Suffix, First Name, MI)	Telephone Number	Relationship to You	Social Security Number	Date of Birth	Percentage
					Total Must Equal 100%

SECTION 7: Signature

X _____ _____

Employee Signature **Date**