UNUMPROVIDENT

GROUP INSURANCE ENROLLMENT FORM

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

Policy # 0499471-001

Employee Name (last name, first, middle initial)			Policyholder Name	
Employee Address (street, city, state, zip code)			Social Security Number	Date of Birth
Sex ❑ Male ❑ Female	Salary $ ■ Weekly ■ Monthly ❑ Annually		Hours Worked per Week	Occupation/Title
Full Time Date of Hire or Date you enter an eligible class		Class Description (if applicable)		

Coverage Elections: Both plans are employer-paid for full-time employees at the amounts below:

Employer-Paid Basic Life $50,000

Employer-Paid Basic AD&D $50,000

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 coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective on the first of the month coincident with or next following the date UnumProvident approves your Evidence of Insurability form. If you **do not apply for** any of the above coverage during your initial enrollment period and choose to enroll at a later date, you will need to complete an Evidence of Insurability form for all amounts of coverage.

Beneficiary Information (complete only if Life Coverage is selected)

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

Request for Signature and Certification:

I **understand that my insurance 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.** 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 ____________