University of Dayton Life Enrollment Form

Name of Employer (Please Print) UNIVERSITY OF DAYTON	Group Policy 123359	Sub Division		Branch
Employer's Street Address	City	State	Zip Code	Employee Work Location

Date of Hire (Mo./Day/Year) __ __/__ __/__ __ __ __	Employee Base Annual Salary (BAS) $	Employee's Occupation	Coverage Effective Date (Mo./Day/Yr.): __ __/__ __/__ __ __ __
Work Status: ☐ New Hire ☐ Active ☐ Retired ☐ Disabled ☐ Rehire ☐ On Layoff/Leave of Absence	Hours Worked per Week:	☐ Hourly Paid ☐ Salaried	☐ Full-Time ☐ Part-Time

Reason for Enrollment: ☐ New Coverage ☐ New Hire First Time Eligible ☐ Late Enrollee **Evidence of Insurability Form**
☐ Change in Coverage Amount Requested ☐ Change in Enrollment Other than Coverage Amount
☐ Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) __ __/__ __/__ __ __ __

SECTION TO BE COMPLETED BY EMPLOYEE

Employee Name (last name, first, middle initial)		Social Security Number __ __ __-__ __-__ __ __ __
Salary	Date of Employment __ __/__ __/__ __ __ __	Date of Birth __ __/__ __/__ __ __ __

Address	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Gender ☐ M ☐ F
City	State	Zip
Home Phone: (__ __ __) __ __ __ - __ __ __ __ Work Phone: (__ __ __) __ __ __ - __ __ __ __	E-Mail	

COVERAGE REQUEST DATA:
I have received and read a copy of my employer's current announcement of the group plan. I want to be covered under the group plan for the benefits that I am or may become eligible for, requested below:

I request the following coverage:
Employee Coverage
☐ Basic Life (Employer Paid)
☐ Optional Life (You may elect coverage 1x to 4x Base Annual Salary up to a maximum of $750,000.
NOTE: Coverage amounts exceeding 3x Base Annual Salary or $375,000 require an Evidence of Insurability Form.
☐ 1x ☐ 2x ☐ 3x ☐ 4x Base Annual Salary

Dependent Spouse Life Coverage
☐ Dependent Spouse Life* ☐ $10,000 ☐ $20,000

Dependent Child Life Coverage
☐ Dependent Child Life* (Select One) ☐ $2,000 ☐ $5,000 ☐ $10,000

*Amounts will be subject to state limits, if applicable.

IF APPLYING FOR DEPENDENT COVERAGE (SPOUSE AND CHILD), COMPLETE SECTION BELOW:

	NAME: (LAST, FIRST, MI)	DATE OF BIRTH	GENDER (M/F)
SPOIUSE:	________________	__ __/__ __/__ __ __ __	______
CHILD(REN):	________________	__ __/__ __/__ __ __ __	______
	________________	__ __/__ __/__ __ __ __	______
	________________	__ __/__ __/__ __ __ __	______
	________________	__ __/__ __/__ __ __ __	______
	________________	__ __/__ __/__ __ __ __	______

IF DEPENDENT CHILDREN ARE FULL-TIME STUDENTS IN COLLEGE, VOCATIONAL OR TRADE SCHOOL, PLEASE COMPLETE THE FOLLOWING:

CHILD(REN)	NAME OF SCHOOL
________________	________________
________________	________________
________________	________________
________________	________________
________________	________________

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE (Dependent Insurance is Payable to the Employee)

The Employee signing below names the following person(s) as primary beneficiary(ies) for any UnumProvident payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from your employer. Unless designated otherwise, payments will be made in equal shares or all to the survivor. The Employee understands that he or she has the right to change this designation form at any time.

☐ I Designate as my Primary Beneficiary: ☐ My Designation of Beneficiary is on a separate form, which is signed, dated and attached.

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Address (Street, City, State, Zip)	Share %
		__ __/__ __/__ __ __ __		
		__ __/__ __/__ __ __ __		
		__ __/__ __/__ __ __ __		
		__ __/__ __/__ __ __ __		
			TOTAL:	100%

If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Address (Street, City, State, Zip)	Share %
		__ __/__ __/__ __ __ __		
		__ __/__ __/__ __ __ __		
		__ __/__ __/__ __ __ __		
		__ __/__ __/__ __ __ __		
			TOTAL:	100%

Unless designated otherwise, payment will be made in equal shares or all to the survivor.

DECLARATION SECTION: EACH PERSON SIGNING BELOW DECLARES THAT ALL THE INFORMATION GIVEN IN THIS ENROLLMENT FORM IS TRUE AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF. EACH PERSON UNDERSTANDS THAT THIS INFORMATION WILL BE USED BY UNUMPROVIDENT TO DETERMINE HIS OR HER INSURABILITY.
THE EMPLOYEE DECLARES THAT HE OR SHE IS ACTIVELY AT WORK ON THE DATE OF THIS ENROLLMENT FORM.
FOR CHANGES REQUESTED AFTER INITIAL ENROLLMENT PERIOD EXPIRES
I UNDERSTAND THAT IF DISABILITY COVERAGE IS NOT ELECTED, OR IF THE MAXIMUM COVERAGE IS NOT ELECTED, EVIDENCE OF GOOD HEALTH SATISFACTORY TO UNUMPROVIDENT MAY BE REQUIRED TO ELECT OR INCREASE SUCH COVERAGE AFTER THE INITIAL ENROLLMENT PERIOD HAS EXPIRED. COVERAGE WILL NOT TAKE EFFECT TO IT WILL BE LIMITED, UNTIL NOTICE IS RECEIVED THAT UNUMPROVIDENT HAS APPROVED THE COVERAGE INCREASE.

FOR PAYROLL DEDUCTION AUTHORIZATION BY THE EMPLOYEE
I AUTHORIZE MY EMPLOYER TO DEDUCT THE REQUIRED CONTRIBUTIONS FROM MY PAY FOR THE COVERAGE REQUESTED IN THIS ENROLLMENT FORM. THIS AUTHORIZATION APPLIES TO SUCH COVERAGE UNTIL I RESCIND IT IN WRITING.

Signature(s): The employee must sign in all cases. Each person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

______________________________	______________________________	__ __/__ __/__ __ __ __
Employee Signature	Print Name	Date (Mo./Day/Year)

LIMITATIONS AND EXCLUSIONS

DELAYED EFFECTIVE DATE

EMPLOYEE:

INSURANCE WILL BE DELAYED FOR EMPLOYEES NOT IN ACTIVE EMPLOYMENT UNTIL THE FIRST OF THE MONTH, COINCIDENT WITH OR NEXT, FOLLOWING 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 FIRST OF THE MONTH, COINCIDENT WITH OR NEXT, FOLLOWING 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 AN INJURY, A SICKNESS OR A DISORDER, YOUR DEPENDENT IS CONFINED IN A HOSPITAL OR SIMILAR INSTITUTION; IS UNABLE TO PERFORM TWO OR MORE ACTIVITIES OF DAILY LIVING (ADLS) BECAUSE OF A PHYSICAL OR MENTAL INCAPACITY RESULTING FROM AN INJURY OR A SICKNESS; IS COGNITIVELY IMPAIRED; OR HAS A LIFE THREATENING CONDITION.

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 OF INSURANCE; 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.