GROUP LTD INSURANCE ENROLLMENT FORM

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

Enrollment for LTD Section to be completed by the Employer

Employer Name (Please print) University of Dayton		Policy Number **335731-104**	
Employer's Street Address		City, State, Zip	
Branch/Employee Work Location		Date of Hire	
Employee's Base Annual Salary (BAS)		Employee's Occupation	
Coverage Effective Date (Mo./Day/Yr)		Marital Status: ☐S ☐M ☐W ☐D	
Employee Address (street, city, state, zip code)		Social Security Number	Date of Birth
Gender ☐ M ☐ F	Salary $ ____________ ☐ Weekly ☐ Monthly ☐ Annually	Hours Worked Per Week______ ☐Hourly ☐Full-Time ☐Salaried ☐Part-Time	
Reason for Enrollment:: ☐New Coverage ☐New Hire First Time Eligible ☐Change in Coverage ☐Late Enrollee Evidence of Insurability Form			

Section to be completed by employee

Name (print)

First Middle Last

Address City State Zip 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 which I am or may become eligible, requested below

POLICY NUMBER 335731-104

Long Term Disability ☐ Core 40% ☐ Buy Up 60%

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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, or it will be limited, until notice is received that UnumProvident has approved the coverage or 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.

____ __ __/__ __/__ __ __

Employee Signature Date

Print Name

(_________) __ __ __ - __ __ __ __
Work Phone

(_________) __ __ __ - __ __ __ __
Home Phone

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.