



**SMALL CASE OFFERING (2-9 LIVES)
GROUP INSURANCE ENROLLMENT FORM**

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

Policy # _____

Division # _____

Employee Name (last name, first, middle initial)		Policyholder Name	
Employee Address (street, city, state, zip code)		Social Security Number	Date of Birth
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Salary \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	Hours Worked per Week	Occupation/Title
Full Time Date of Hire or Date you enter an eligible class			

Coverage Elections: Your employer will inform you of available coverage. Coverage amounts may be subject to medical underwriting approval based on satisfactory Evidence of Insurability. Check yes to enroll; check no if you decline or coverage is not available.

LTD <input type="checkbox"/> Yes <input type="checkbox"/> No	Life/AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No
STD <input type="checkbox"/> Yes <input type="checkbox"/> No	Life Amount Requested \$ _____
	AD&D Amount \$ _____*

*Note: AD&D coverage amount requested will equal the amount of approved Life Insurance requested. If any amount of Life coverage requiring medical underwriting is not approved, the AD&D coverage amount may be subject to adjustment.

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:		

*Note: Benefits cannot be sent directly to a minor. Please consult your policy for additional information.

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