



UNUM[®]

Unum Life Insurance Company of America
Portland, Maine 04122-1670

Group Enrollment Form

1. Policy		2. Division #		3. Policyholder's Name			
4. Employees's Last Name			First	Middle Initial	5. Social Security Number ____/____/____		
6. Birthdate ____/____/____		7. Employment Date ____/____/____		8. Sex <input type="checkbox"/> F <input type="checkbox"/> M	9. Salary \$	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	10. Hours Worked Weekly
11. Occupation/Title		12. Your employer will inform you of available coverages. Check yes to enroll. Check no if you decline or coverage is not available.					
		Life/AD&D		<input type="checkbox"/> Yes <input type="checkbox"/> No	LTD	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		STD		<input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Beneficiary(ies) Last Name			First	Middle Initial	14. Relationship		

• To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for instructions.

15. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that Unum may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense.

Employee's Signature _____ Date: ____/____/____

16. For Unum Use:

Class	Effective Date of Coverage	Class	Effective Date of Coverage
____ Life/AD&D	____/____/____	____ STD	____/____/____
____ Dep Life	____/____/____	____ LTD	____/____/____

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.