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

IIANC Member Services, Inc.
Policy #530465/Div _____

Term Life and AD&D Insurance Enrollment Form

Plan Chosen for Agency: A, B, C, D _____

Please print legibly and complete this form in its entirety. Blank fields will cause significant delays in processing.

Application Type:
☐ **Initial Enrollment:** To make initial elections; OR
☐ **Annual Enrollment:** To make changes to existing elections and/or information. The elections/information you indicate will replace your prior elections/information on file with Unum. **Note: If you do not wish to make any changes, do not complete this form. Please contact your plan administrator with any questions.**

Employee Social Security Number ___ - ___ - ____ **Gender** M ☐ F ☐ **Date of Birth (mm/dd/yyyy)** __ / __ / ____ **Hours Worked Per Week** __

Employee First Name _____ **M.I.** _ **Last Name** _____

Employee Street Address _____ **City** _____ **State** __ **Zip Code** _____

Original Date of Hire __ / __ / ____ **Annual Salary** _ , ___ , ___ **Occupation** _____

☐ **Exempt** ☐ **Non-Exempt**

If date below unknown, consult with your Plan Administrator to complete:
☐ **Date entered into an eligible class (*ex: part time to full time*) or**
☐ **Rehire Date or**
☐ **Date of promotion to an eligible class** __ / __ / ____

Spouse First Name (if coverage is selected) _____ **Spouse Date of Birth (mm/dd/yyyy)** __ / __ / ____

COVERAGE ELECTIONS: Please indicate below the coverage amounts you would like to select for you and your spouse and/or child, if applicable. Dependent life and/or AD&D coverage amounts cannot exceed 100% of your life and/or AD&D coverage amounts. Any coverage amounts left blank will result in a coverage amount of $0.

Amount of coverage selected for:

Life You: $ _ , ___ , ___ Your Spouse: $ ___ , ___ Your Child: $ __ , ___

AD&D You: $ _ , ___ , ___ Your Spouse: $ ___ , ___ Your Child: $ __ , ___

Beneficiary Information: Please complete the beneficiary information on the reverse side of this form.

Request for Signature and Certification: *I have read and understand the "Limitations and Exclusions" on the reverse side of this enrollment form.* 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*

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER

Beneficiary Information

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

Please be aware that your coverage may be impacted by certain limitations and exclusions including, but not limited to, the following:

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 disabled. This delay does not apply to newborn children while dependent insurance is in effect. "Totally disabled" means that, as a result of 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; is receiving or is entitled to receive any disability income from any source due to any sickness or injury; is receiving chemotherapy radiation therapy or dialysis treatment; or has a life threatening condition. Disabled children over the maximum child age may be eligible for benefits, please see your plan administer for more details.

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; 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.

This Suicide Exclusion does not apply to Washington residents.

AD&D Benefit Exclusions

AD&D Benefits would not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders;
- Suicide, self-destruction while sane, or self-inflicted injury;
- War, declared or undeclared, or any act of war;
- Active participation in a riot;
- Attempt to commit or commission of a crime;
- The voluntary use of any prescription or non-prescription drug, poison, fume or any other chemical substance unless used according to the prescription or direction of the individual's doctor. This exclusion does not apply to the individual if the chemical substance is ethanol; or
- Intoxication. ("Intoxicated" means that the individual's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.)

Please see your Plan Administrator [or your Policy] for a complete listing of applicable limitations and exclusions.

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