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

IIANC Member Services, Inc.
Long Term Disability Insurance
Enrollment Form
Policy #530465/Div #_____

USE THIS FORM IF AGENCY HAS MORE THAN 10 LIVES

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**

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

60% to a maximum monthly benefit of $6,000

To calculate the per-paycheck cost for this coverage, complete the calculations below.
Note: *If your annual salary exceeds $120,000, use $120,000 as your annual salary in the calculation.*

Annual Salary	÷ 100 =		Your Rate	X .66 =	Annual Cost	÷	# Paychecks per Year	=	**Cost per Paycheck***
_____		_____		_____		_____			_____

* Final cost may vary slightly due to rounding.

☐ **Yes,** I would like to participate. I authorize my employer to deduct from my salary or wages the necessary premium for this coverage. My signature verifies the accuracy of information contained on this form.

I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would otherwise become effective. **I have also read and understand the information in the Plan Highlights, including all statements regarding exclusions and benefit amounts and offsets.**

☐ **No,** I do not wish to participate. I understand that evidence of insurability will be required, at my own expense, if I decide to elect this coverage in the future.

Employee Signature: _____ Date: __ __/__ __/__ __ __ __

Return Forms To: _____ By: __ __/__ __/__ __ __ __

This section to be completed by your employer:

Coverage Effective Date: __ __/__ __/__ __ __ __