



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

- Initial Enrollment:** To make initial elections;
- Qualified Life Event:** If allowed, to make initial elections or changes to existing elections and/or information. The elections/information you indicate will not replace your prior elections/information on file with Unum; OR
- Scheduled Enrollment:** To make changes to existing elections and/or information. The elections/information you indicate will not 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 employer with any questions.**

Employer Name		Identification No.	Division No	Class
Employee Social Security Number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)	Hours Worked Per Week	
Employee Legal First Name		M.I.	Last Name	
Employee Street Address		City	State	Zip Code
Original Date of Hire	Occupation			

- Date entered into an eligible class (ex: part time to full time) or Rehire Date or
- Date of promotion to an eligible class or Date of Qualified Life Event (mm/dd/yyyy): _____

Have you used tobacco products (such as cigarettes, cigars, snuff, chew, or pipe) or any nicotine delivery system in the past 12 months
 Yes No

COVERAGE ELECTIONS: Your employer will inform you of available coverage. Check yes to enroll in coverage you are required to pay for; check no if you decline or coverage is not available.

Employee Whole Life <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount of Coverage Selected: \$ _____	
Spouse name (if coverage is selected)	Spouse DOB (mm/dd/yyyy)	Spouse Whole Life <input type="checkbox"/> Yes <input type="checkbox"/> No Amount of Coverage Selected: \$ _____

Children's Term Insurance Rider Yes No

Amount of Coverage Selected: \$ _____

Note: If you have chosen coverage over the Evidence of Insurability amount for you or your spouse as described in the Certificate of Coverage, you will also need to complete a Statement of Health form. The amount of coverage over the Evidence of Insurability amount will be subject to medical underwriting and will become effective on the first of the month coincident with or next following the date Unum approves your Statement of Health form. If you **DO NOT APPLY FOR** coverage for you or your spouse during your or their initial enrollment period, you may need to complete a Statement of Health form for all amounts of coverage. You may complete and electronically submit a Statement of Health form—please see your Plan Administrator.

Accelerated Death Benefit for Long-Term Care Rider Questions:

- 1. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)? Yes No
- 2. Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months? Yes No
 - (a) If so, with which company? _____
 - (b) If that policy lapsed, when did it lapse? _____
- 3. Are you covered by Medicaid? Yes No
- 4. Do you intend to replace any of your long-term care or medical or health insurance coverage with this certificate?
 Yes No

Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this certificate for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Name _____

Address _____

I elect NOT to designate a person to receive this notice.

Producer Information:

If a producer/agent assists with this enrollment, they must complete the following:

Have you sold any other health insurance policies to the applicant that cover the proposed insured in the past 5 years?

Yes No

If "Yes," provide the following:

Policy Number	Company	Coverage Type	In Force	Lapse Date
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Request for Signature and Certification: I understand that my coverage may be subject to exclusions, limitations, delayed effective dates and benefit reductions, as described in the enrollment materials or Certificate of Coverage that has 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

Mobile Phone

Work Phone

Beneficiary Information:

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