unum

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

**FCMM Benefits & Retirement**
901 East 78th Street, Minneapolis, MN 55420
Group Short and Long Term Disability Insurance
with Term Life/AD&D
Enrollment Form
Policy #930391/Div #001

# Form 101: Enrollment Application

**Employee Social Security Number** _____ - _____ - _____

**Gender** ☐ M ☐ F

**Date of Birth (mm/dd/yyyy)** ____ / ____ / _____

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

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

**Occupation / Job Title** _____ **Phone Number** _____ **Email Address** _____

**Eligible Class Full-time Hire Date** _____ **Total Annual Salary** $ _____ **Salaried** ☐ **Hourly** ☐ **Hours Worked Per Week** _____

## Employer Completion REQUIRED

This section must be completed by the employer.
Complete one of the employer pre-determined plan options for the employee listed above.

☐ **Option 1: Standard Plan (LTD & Life/AD&D)**

Long Term Disability Payment Method:
☐ Staff Benefit
☐ Payroll Deduction (after-tax deduction)

Life/AD&D Payment Method
☐ Staff Benefit
☐ Payroll Deduction (after-tax deduction)

☐ **Option 2: Plus Plan (STD, LTD & Life/AD&D)**

Short Term & Long Term Disability Payment Method:
☐ Staff Benefit
☐ Payroll Deduction (after-tax deduction)

Life/AD&D Payment Method:
☐ Staff Benefit
☐ Payroll Deduction (after-tax deduction)

**If payroll deduction for any benefit (STD, LTD, and/or Life/AD&D) OR declining all benefits, employee affirm below:**

☐ Yes, I would like to participate in the FCMM Benefit Plan (Disability and Life/AD&D) at this time, and I authorize my employer to make the necessary deductions from my salary to pay the benefit premiums when my insurance becomes effective. I understand my payroll deduction amount will change if my coverage or costs change.

☐ No, I do not wish to participate in the FCMM Benefit Plan (Disability and Life/AD&D) at this time through payroll deduction. I understand I cannot enroll again until the annual open enrollment, if I wish to elect this coverage in the future. Enrolling at a future date will include a pre-existing limitation on coverage.

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*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 read and understand the information in Form 138 - Coverage Overview, Limitations & Exclusions, benefit amounts, and offsets. My signature verifies the accuracy of information contained on this form.*

**Employee Signature:** _____ **Date:** _____

**Coverage Effective Date: __ __/ 0 1 /__ __ __ __** **Authorized Employer Signature:** _____