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** _____

Phone Number _____ **Email Address** _____ **Job Title** _____ **Pastor or Non-Pastor** ☐ ☐

Hire Date/Eligibility Date _____ **Total Annual Salary** $ _____ **Salary or 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

Life/AD&D Payment Method
☐ Staff Benefit
☐ Payroll Deduction

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

Short Term & Long Term Disability Payment Method:
☐ Staff Benefit
☐ Payroll Deduction

Life/AD&D Payment Method:
☐ Staff Benefit
☐ Payroll Deduction

If payroll deduction for one benefit (STD, LTD, and/or Life/AD&D), employee must 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:** _____