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

Rutgers University

Long Term Disability Insurance
Enrollment Form

Policy #313789/Div #001

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

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** _____

☐ **Date entered into an eligible class**

__ / __ / ____ **(If unknown, consult with your Plan Administrator to complete.)**

Rate per $100 of Covered Salary = $0.79

To calculate the per-paycheck cost for this coverage, complete the calculations below.

Note: *If your annual salary exceeds _____, use _____ as your annual salary in the calculation.*

Annual Salary	÷ 100 =		X	Your Rate	=	Annual Cost	÷	# Paychecks per Year	=	**Cost per Paycheck***
_____		_____		____.79_____		_____		_____		_____

* 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: __ __/__ __/__ __ __ __