

Group Enrollment Form for Educator Disability

Underwritten By: UNUM Life Insurance Company of America
2211 Congress Street, Portland, Maine 04122

Employer Information

Employer Name: **NORTH EAST INDEPENDENT SCHOOL DISTRICT** Insurance Effective Date:
School Location: Policy/I.D. Number: **572505** Division Number: **MG0814**

Employee Information

Employee Name: Social Security Number:
Address: City State Zip
Phone: Home: Business: Date of Birth:
Sex: Birthplace: Marital Status: Single Married Widowed Divorced/Separated
Date of Hire: Occupation Basic Annual Earnings: \$
Are you actively performing all the duties of your occupation or profession? Yes No (If no, explain): Hours per week worked:

Beneficiary Information

Name of Primary Beneficiary: Relationship: Age:

Disability Benefit Information

	<u>Benefit Amount</u>	<u>Monthly Premium</u>
Plan: <input type="checkbox"/> Gold Plan '02 <input type="checkbox"/> Platinum Plan '02	\$	\$
Elimination Period (Injury/Sickness): <input type="checkbox"/> 0/3 <input type="checkbox"/> 14/14 <input type="checkbox"/> 30/30 <input type="checkbox"/> 60/60 <input type="checkbox"/> 90/90 <input type="checkbox"/> 180/180 <input type="checkbox"/> Other:		
Payroll Deduction Mode: <input type="checkbox"/> 12 Months <input type="checkbox"/> 10 Months <input type="checkbox"/> Other		

WAIVER OF COVERAGE: I elect not to enroll for Disability Insurance for me by Unum Life Insurance Company of America. I understand that proof of good health will be required if I decide to apply for coverage at a later date.

Date Signature of Employee

I HEREBY AUTHORIZE my employer to deduct the applicable premium from my earnings each month as consideration for Disability Insurance for me issued by Unum Life Insurance Company of America. I understand that all insurance coverages will become effective according to the terms of the Contract.

✘ Date ✘ Signature of Employee

Date Signature of Agent