



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

Educator Select Income Protection
 Insurance Enrollment Form
Policy # 146726

Employer Name: North East Independent School District		Worksite Location:
Employee Name <i>(Format example: John M. Smith):</i>		SSN:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Hire:	Annual Earnings:	
Occupation:	Hours Worked/Week:	
Payroll Cycle: <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly		

Select coverage by completing steps 1-4. The coverage amounts you indicate will replace all prior coverage amounts you have under this policy.

1) Choose a Plan: Plan A: ADEA II Plan B: ADEA II/3 YR ADEA

2) Choose an Elimination Period: 0/7 14/14 30/30 60/60 90/90 180/180
 (Injury/Sickness)

3) Choose a Monthly Benefit Amount:

You may not purchase more coverage than the maximum monthly benefit amount. Your "Maximum Monthly Benefit" is listed on the rate sheet next to your "Annual/Monthly Earnings". (If your earnings are not shown, use the next lower earnings and maximum benefit amounts, or refer to Plan Highlights to calculate your maximum benefit based on your earnings.) You may choose any amount up to and including your maximum in \$100 increments. Write in your benefit amount choice and corresponding cost below.

Monthly Benefit Amount: \$ _____ Your Cost: \$ _____ *

*Based on premium mode and/or payroll cycle selected above, if applicable. Final cost may vary due to rounding.

4) Complete Enrollment Acknowledgement and Signature:

I would like to participate. My signature below verifies the accuracy of information contained on this form, and authorizes my employer to deduct from my salary or wages the necessary premium for this coverage.

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 limitations, exclusions, benefit amounts and offsets.**

Employee Signature: _____ Date: __/__/____

If I choose not to participate, I understand that if I wish to apply for coverage at a later date, I must wait until the next annual enrollment to enroll.

Please remember to sign and date the form.

If you should have any questions about your coverage or how to enroll, please contact your Plan Administrator or your broker, Highlander Financial Services, LLC at 800-992-9642.

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