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

Archdiocese of Dubuque

Long Term Disability Insurance
Enrollment Form

Policy #285940/Div #_____

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** _____

☐ **Exempt** ☐ **Non-Exempt**

☐ **Date entered into an eligible class (*ex: part time to full time*) *or***
☐ **Rehire Date *or*** ☐ **Date of promotion to an eligible class**

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

Long Term Disability Rates* per $100 of Covered Salary

Age	Option 1 – 50% Rate	Option 2 – 40% Rate	Option 3 – 25% Rate
< 25	$0.30	$0.26	$0.20
25 - 29	$0.36	$0.31	$0.24
30 - 34	$0.48	$0.41	$0.31
35 - 39	$0.67	$0.56	$0.39
40 - 44	$0.99	$0.81	$0.56
45 - 49	$1.52	$1.23	$0.84
50 - 54	$2.36	$1.91	$1.28
55 – 59	$3.03	$2.43	$1.62
60+	$4.54	$3.64	$2.41

*LTD rates are based on five-year increments. Rates increase as you age.

LTD Cost Calculation: To calculate the per-paycheck cost complete the calculations belows. **Note: If your annual salary exceeds:**
50% Plan: $120,000, use $120,000 as your annual salary in the calculation.
40% Plan: $150,000, use $150,000 as your annual salary in the calculation.
25% Plan: $240,000, use $240,000 as your annual salary in the calculation.

_____ ÷ 100 = _____ X _____ = _____ ÷ _____ = _____

Annual Salary | Your Rate | Annual Cost | # Paychecks per Year | Cost per Paycheck*

* Final cost may vary slightly due to rounding.

☐ **Yes,** I would like to participate. The precent of earnings I wish to insure is: _____%. 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: __ __/__ __/__ __ __ __