Instructions For Card Completion
Please Type or Print – Press Pen Firmly

UnumProvident®

First Unum Life Insurance Company
Portland, Maine

LTD Enrollment Card

Employer must complete sections 1, 2 and 3.

1. Policy #

2. Div. #

3. Policyholder's Name and Address

4. Employee's **Last** Name

First

Middle Initial

Employee's Address

Employee must complete sections 4, 5, 6, and 7.

5. Social Security Number

6. Employee's Birthdate
Month Day Year
__ __ /__ __ /__ __ __ __

7. Sex
☐ Male ☐ Female

Employer must complete sections 8, 9, 11 and 12. Complete section 10 only if working less than your normal work week, less than 30 hours per week or salary is based on an hourly schedule. Section 11 must be exact salary.

8. Employment Date
Month Day Year
__ __ /__ __ /__ __ __ __

9. Employee's Occupation and/or Title

10. Hours Worked Wkly.

11. Salary
$
☐ Weekly
☐ Monthly
☐ Annually

12. Insurance Effective Date
Month Day Year
__ __ /__ __ /__ __ __ __

This is to authorize applicable deductions and to verify card accuracy.

13. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature is also to verify the accuracy of the information contained on this card.

Signature

Date __ __ /__ __ /__ __ __ __

See Reverse Side For Declination

Employer: Retain this card in your files. Do not forward to UnumProvident Home Office.
Be sure to issue certificate of coverage to your new employees.

NY 930-78 (2/03)

Printed in U.S.A.

For Employer's Use

Date of Salary Change	New Salary Amount	Date of Salary Change	New Salary Amount
__ __ /__ __ /__ __ __ __		__ __ /__ __ /__ __ __ __	
__ __ /__ __ /__ __ __ __		__ __ /__ __ /__ __ __ __	
__ __ /__ __ /__ __ __ __		__ __ /__ __ /__ __ __ __	

Employee's **Last** Name First Middle Initial

Declination of Long Term Disability Insurance

This coverage can be declined only if you pay part or all premiums.
I have been offered this LTD Insurance coverage and decline to purchase it at this time.
I understand that in the event I desire such Insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse my request.

	__ __ /__ __ /__ __ __ __	
Signature	Date	Witness' Signature

Employer: Declinations are to be retained in your files.