TERM LIFE INSURANCE ELECTION OF PORTABILITY COVERAGE

Important Information When Considering Portability Coverage

When your group term life insurance coverage ends, either because your employment has terminated or you no longer are eligible to participate in your employer's group life policy, you have two choices for continuing your life insurance coverage: Portability or Conversion. There are many differences between portability and conversion, some key considerations are:

- **Portability** allows you, your spouse or child(ren) to continue (or "port") Life and/or AD&D coverage at group rates. The ported coverage will be subject to the same provisions contained in your employer's group life insurance policy. **Eligibility to port coverage may be limited by restrictions per the terms in your Group Life certificate and Group Life Portability rider. Refer to your certificate or rider for details. Restrictions may include but are not limited to:**
    - **your age at the time of application;**
    - **either confinement to a home or hospital confinement or injury or sickness which has a material effect on life expectancy.**
- **Conversion** allows you and your dependents to purchase individual life insurance policies (but not AD&D) at rates that may be higher than portability rates. The policy you convert to will be different from the coverage you had under your employer's group life insurance policy. **Conversion does not have the same restrictions noted above for Portability**

If your Group Life Certificate and Group Life Portability rider restricts individuals with an INJURY OR SICKNESS WHICH HAS A MATERIAL EFFECT ON LIFE EXPECTANCY, please read the following to determine if you can elect coverage. Individuals diagnosed with, or having received medical advice or sought treatment for, any of the following injuries or sicknesses in the past 10 years cannot elect this coverage. Your Group Life Certificate and Group Life Portability Rider outlines the restrictions and limitations applicable to you:

• Acquired immune deficiency syndrome (AIDS) • Amyotrophic lateral sclerosis (ALS) • Cerebral palsy with cognitive impairment • Chronic renal disease • Chronic lung disease, including emphysema • Cirrhosis of the liver • Congestive heart failure • Coronary artery disease, heart surgery, or transient ischemic attack (TIA) • Cystic fibrosis • Dementia, including Alzheimer's disease • Diabetes other than gestational or diet controlled • Drug or alcohol abuse • Hepatitis B or C • High blood pressure concurrently treated with three or more medications	• Leukemia, lymphoma or any cancer other than basal or squamous cell carcinoma of the skin • Morbid obesity defined as a Body Mass Index (BMI) greater than 40 *Calculate a BMI using the Center for Disease Control's BMI Calculator online at https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html or call us with height/ weight information and we'll calculate it for you.* • Muscular dystrophy • Psychiatric hospitalization • Quadriplegia • Stroke • Systemic lupus erythematosus or any other

If you are not sure whether anyone applying for this coverage has an injury or sickness in the list above, then attach to this election form the name of the individual with the injury/sickness, his/her relationship to you, a description of the condition, and any current medications. Unum will review the information provided and let you know whether portable coverage is an option.

Important: When a life insurance claim is submitted to Unum on an individual who died within two years of the date that portability coverage became effective, Unum reviews medical records to determine whether the deceased individual was eligible for portability. If Unum determines the deceased individual wasn't eligible for portability due to any of the restrictions outlined in your Group Life certificate and Group Life Portability rider, the beneficiary will not receive the portability amount elected. Instead, the beneficiary will receive a significantly reduced benefit (or possibly no benefit at all). Please see the Portability section of your employer's group policy for an explanation of how the benefit may be reduced.

If after reading the information on this page you believe you and/or your dependents aren't eligible to elect portability coverage, remember that you and your dependents may qualify for conversion coverage. Contact your employer for the conversion application form and rates.

Important Information

What type of coverage can be ported?

- **Basic Life** is insurance that your employer provided for you when you were in active employment.
- **Voluntary Life** is insurance elected by you for which you paid the premiums when you were in active employment.
- **AD&D** is Accidental Death & Dismemberment coverage and may not exceed Life coverage.

What are your employer's responsibilities?

- Fully complete Section 1 on page 3 of this election form and provide it to the employee. Incomplete election forms may result in a denial of coverage.
- Provide the portability rate table to the employee.

What are your responsibilities as the employee?

- Complete Section 2 on page 3 and the Beneficiary Designation Form on page 4. Incomplete forms may be denied.
- Determine the amount of coverage you want to port. You may port an amount less than or equal to the amount you, your spouse or child(ren) had inforce with your Employer. Ported coverage cannot exceed the lesser of 5x your earnings, the maximum allowed under your plan or $750,000 across all Unum Life and AD&D coverages combined.
- If you wish to elect coverage in an amount other than your current coverage amount, provide the requested amounts. Coverage is subject to the minimum and maximum limits provided in the employer's policy. Contact your employer for a copy of the group life insurance policy.
- Please remember to (1) include your ACH form; (2) sign and date page 3 of this election form; (3) designate a beneficiary on page 4; and (4) retain a copy of this entire form for your records.
- Mail pages 3 and 4 of this election form to the address listed at the top of page 3.

What should you know when completing your Beneficiary Designation Form?

- **Primary Beneficiary(ies)** means the person(s) you choose to receive your insurance benefits. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any primary beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining primary beneficiary(ies).
- **Contingent Beneficiary(ies)** means the person(s) you choose to receive your insurance benefits only if all primary beneficiaries are disqualified or die before you. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any contingent beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining contingent beneficiary(ies).
- **Minor Beneficiary(ies)** – When you designate minors as beneficiaries, it is important to understand that insurance benefits may not be released to a minor child. They may, however, be paid to a child's court-appointed financial guardian. The regulations governing minor beneficiaries vary by state.
- **Trust** – You may designate a valid trust as a beneficiary.
- **Updates to Your Beneficiary Designation** – You can change your beneficiary designation at any time. You may wish to review your designation periodically.
- **Consult an Attorney** – This information is not intended to be relied on as legal advice. You may wish to get the assistance of an attorney to help ensure your beneficiary designation correctly reflects your intentions.

TERM LIFE INSURANCE APPLICATION FOR PORTABILITY COVERAGE

Submit to: Unum Life Insurance Company of America (Unum) Portability Unit
2211 Congress Street, Portland, ME 04122 • 1-800-421-0344 • Fax 207-575-2993

EMPLOYER COMPLETES SECTION 1

Company Name:	Policy Number(s) Division Class
Employee Legal Name (Last, First, MI):	Employee Preferred Name:
Date Coverage Ends (mm/dd/yyyy): _____ Current Annual Earnings:	Insured on disability or sick leave when terminated? ☐ Yes* ☐ No *If Yes, date premium paid to: _____	Reason for Loss of Coverage: ☐ Terminated Employment ☐ Retired ☐ Reduced Hours (must be working) ☐ Other, Explain _____

Fill in Current Coverage Amounts for Each Insured and Insurance Type

Insured Type	Basic Life	Supplemental Life	Basic AD&D	Supplemental AD&D
Employee				
Spouse				
Child				

Plan Administrator Name:	Plan Administrator Signature:
Plan Administrator Telephone Number:	Plan Administrator Email:

EMPLOYEE COMPLETES SECTION 2

Insured Mailing Address (Street, PO Box, City, State, Zip):			Home Telephone: Alternate Telephone:
Insured Social Security Number:	Insured Date of Birth (mm/dd/yyyy):		Sex: ☐ Male ☐ Female
Spouse Name:	Spouse Date of Birth (mm/dd/yyyy):		Spouse Social Security Number:
Child Name:	Date of Birth: *	Child Name:	Date of Birth: *
Child Name:	Date of Birth: *	Child Name:	Date of Birth: *

* Check the policy or your certificate. Child eligibility may be subject to age, student and/or marriage status.

Have you used tobacco products in the past twelve months? ☐ Yes ☐ No

Has your spouse used tobacco products in the past twelve months? ☐ Yes ☐ No

Fill in Requested Coverage Amounts for Each Insured and Insurance Type - coverages left blank will result in a coverage amount of $0. Coverage reduces according to your Employer's group insurance policy.

Insured Type	Basic Life	Supplemental Life	Basic AD&D	Supplemental AD&D
Employee				
Spouse				
Child				

ALL PREMIUMS TO BE PAID MONTHLY VIA AUTOMATIC PAYMENT. Please complete and send in the enclosed Authorization and Agreement for Automatic Payments form with your application.

☐ I am opting out of monthly payments and want to pay:
☐ Quarterly (Every three months) ☐ Semi-Annually (Every six months) ☐ Annually (One time per year)

I understand and agree to the following:
Any coverage chosen on this election form will be issued in accordance with the portability provision contained in the Employer's Unum Group Life policy and Portability rider, if any, and/or Accidental Death and Dismemberment provisions under which this coverage is being offered, and is subject to satisfaction of the conditions provided therein.

Once an application for portability has been received and approved, portable coverage will be effective the day after coverage would have otherwise ended under the Employer's policy.

I certify that neither I nor my Spouse or Children are ineligible to port coverage per the terms of the portability restrictions in my Group Life certificate and Group Life Portability rider, if any. Restrictions may include, but not be limited to: home or Hospital Confinement; loss of 2 or more Activities of Daily Living; injury or sickness which has a material effect on life expectancy; duration of coverage under the Group Life Insurance certificate; or Spouse age. Please refer to your Group Life Insurance certificate and Portability rider for definitions and restrictions.

If Unum determines an applicant is ineligible to port coverage per the terms of the portability restrictions in the Group Life certificate and Group Life Portability rider, as of the date portable coverage was elected, benefits may be reduced to the amount of coverage available under the current policy's Conversion provision.

Insured Signature:	Today's Date (mm/dd/yyyy):	Insured's Email Address

Please remember to complete and send in your beneficiary designation with this application. Please retain a copy for your records.

PORTABILITY BENEFICIARY DESIGNATION FORM
2211 Congress Street
Portland, Maine 04122
Phone: 1-800-421-0344
Fax: 207-575-2993

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper.

PART 1: Information About You

Name (Last Name, Suffix, First Name, MI)

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Policy Number ☐☐☐☐☐☐ Division ☐

PART 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

Name & Address	Telephone Number	Relationship	Social Security Number	Date of Birth	Percent
					Total Must Equal 100%

PART 3: Contingent Beneficiary (ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

Name & Address	Telephone Number	Relationship	Social Security Number	Date of Birth	Percent
					Total Must Equal 100%

PART 4: Signature

X

Signature **Date**

HOW TO CALCULATE YOUR PORTABILITY PREMIUM PAYMENT

Calculate Your Premium Payment	
1. Find your rate on the rate table under appropriate tobacco use, if applicable. The rate is based on your age at the time your coverage terminates or is reduced. **Note:** You will qualify for non-tobacco premium rates if you have not used any tobacco products within the last 12 months. Your life insurance rates will continue to increase with age, every 5 years (for example, at age 50, 55, 60 etc.).	Base Rate Per $1,000 of Coverage _____
2. Determine the amount of insurance you want. You may have any amount up to and including the amount you had under the group plan. **Note:** You may be eligible to increase your coverage which would require Evidence of Insurability subject to maximums outlined in your former group insurance policy.	Amount of Coverage _____

3. a. Base Rate Per thousand dollars of coverage:	Base Rate	_____
b. Number of thousand dollars you want:	# of $1,000 Units	x_____
c. Multiply a. by b.:	Base Rate X # of Units	_____
d. Mode you would like to pay	Mode	x_____
Monthly = 1		
Quarterly = 3		
Semi-annual = 6		
Annual = 12		
e. TOTAL c. and d. This is your premium	*TOTAL	_____

*This is the estimated amount due per payment, actual billed amount may vary slightly due to rounding

Example:

1. A 44 year old person decides to continue $25,000 of coverage
2. The person wishes to pay premiums annually
3. The monthly rate for a 44 year old is $.510 per $1,000 of coverage
4. Calculate premiums:

a. Base rate per thousand dollars of coverage:	$.510
b. Number of thousand dollar units you want:	x 25
c. Multiply a. by b.:	$12.75 (Monthly)
d. Multiply c. by 12 for annual	x 12
e. TOTAL. This is your premium.	$153.00 (Annually)

Your actual coverage is subject to the terms, conditions, limitations and restrictions set forth in your certificate of coverage and the Summary of Benefits or Policy.

Unum Life Insurance Company of America
Authorization and Agreement for Automatic Payments
Drawn By and Payable To:
Unum Life Insurance Company of America (hereinafter referred to as "the Company")
2211 Congress Street, Portland, Maine 04122
1-800-421-0344 Fax number: 207-575-2993
email to: PortabilityConversion@unum.com

PLEASE PRINT

BL#/POLICY NUMBER	INSURED NAME	SOCIAL SECURITY NUMBER

☐ Please apply this to all my policies

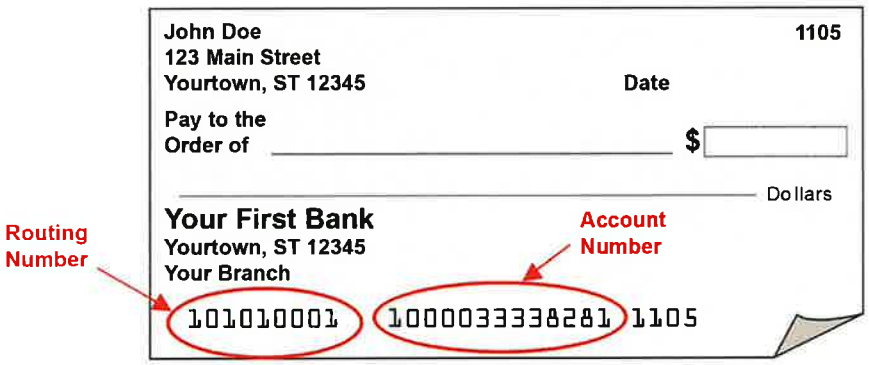
1. Purpose for submitting this authorization form:
   ☐ New Preauthorized payment plan ☐ Change in bank
   ☐ Addition of new policy to plan ☐ Change in account number

   Type of Account:
   ☐ Checking
   ☐ Savings

2. Current Address: _____
3. Name of Banking Institution: _____
4. Name on Bank Account: _____
5. Routing Number (9 digits): ___ ___ ___ ___ ___ ___ ___ ___ ___
6. Account Number: _____

   Refer to the sample check for help locating the Routing Number and Account Number. Attach or scan a Voided Check (optional).

Sample Check



APPLICANT INFORMATION FOR BANK:

You are hereby authorized, as a convenience to me, to pay and charge to my account any check or electronic fund transfer drawn on this account on the first of the month by and payable to the order of the company(s) indicated above for itself (themselves), provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or transfer shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice and you have had a reasonable time to act on it. I agree that you shall be fully protected in honoring any such check or transfer.

I further agree that if any such check or transfer be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Signature of Depositor	Date
Please print name as signed above	

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

THIRD PARTY AUTHORIZATION
PORTABILITY PROTECTION PLAN
Unum Life Insurance Company of America
Unum Insurance Company
2211 Congress Street
Portland, ME 04122
Attention: Portability/Conversion Unit
Fax: 207-575-2993

For toll-free assistance call: 1-800-421-0344

POLICY OWNER NAME	BL#							
	BL#							

AUTHORIZED INDIVIDUAL(S) NAME	Relationship to the Policy Owner	PHONE NUMBER

I authorize Unum Group, its subsidiaries and affiliates* and duly authorized representatives ("Unum") to disclose the following insurance plan, policy billing and beneficiary information to the person(s) or organization(s) listed above, for the purpose of assisting me with my insurance coverage:

- Information regarding my coverage, including policy provisions and riders;
- Information regarding premium calculation, invoicing and payments; and
- Name(s) of designated beneficiaries (if applicable).

This authorization does not alter any prior designation made under any law protecting against unintentional lapse of coverage.

This authorization does not allow the authorized individual(s) or organization(s) to make any changes to my coverage, policy, riders, beneficiary designations, or assignments under my policy.

This Authorization does not allow Unum to share claim or health information including, but not limited to, my medical condition, diagnosis, treatment, or pre-existing condition information; the names of my physicians and other medical providers; or benefit amounts paid to me or on my behalf.

Unum will rely on this authorization until I revoke it in writing.

Unum may provide information in writing, electronically, or by telephone (including voice mail messages).

CERTIFICATION

- **I understand that once information is disclosed to the named authorized Individuals or Organizations, it may no longer be protected by federal privacy regulations.**
- I am not required to sign this authorization and Unum may not condition payment of claims on whether I sign this authorization.
- I am entitled to receive a copy of this authorization.
- I may revoke this authorization in writing at any time, except to the extent that Unum has relied on the authorization prior to notice of revocation.

_____ _____

Policy Owner Signature Date Signed

_____

Print Name

*This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life Accident Insurance Company and Provident Life and Casualty Insurance Company.

APPLICATION FOR CONVERSION OF GROUP LIFE INSURANCE TO AN INDIVIDUAL LIFE INSURANCE POLICY

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

1. Employer Completes this Section

Company Name	Group Policy and Division Numbers		
Employee's Legal Name (Last, First, MI)	Employee's Preferred Name	Social Security Number	Date of Birth
Spouse or Child Name (if converting spouse or child coverage)		Social Security Number	Date of Birth

Group life insurance benefits were: ☐ Terminated ☐ Reduced	Reason for Termination	Date of Termination or Reduction	Amount of Coverage Lost $

Was the employee disabled on date of termination or reduction? ☐ Yes ☐ No	Date of Disability (Date last worked)
If yes, see Waiver of Premium provision, if available, in the Group Life Insurance certificate.	Premium Paid through Date

Has Employee submitted a claim for extension of group benefit? ☐ Yes ☐ No	Was the group life coverage previously assigned? (collateral/absolute) ☐ Yes ☐ No
Employer Signature	Date

2. Employee Information

A. Print Insured's Name (Last, First, Mid. Int.)	Sex ☐ Male ☐ Female	Date of Birth
B. Applicant's/Spouse or Child Name (if other than insured)	Sex ☐ Male ☐ Female	Date of Birth

C. Insured's Address (No. & Street, City, State, Zip Code and Phone Number)

3. I elect the following life insurance:
☐ Whole Life Only
Note: The individual policy that you convert to will not contain waiver of premium or accidental death benefits.

4. What is the amount of insurance you wish to convert? $_____
Note: The amount may not exceed the amount of coverage lost as shown in section 1.

5. Check premium payment mode
☐ Annually
☐ Semi-Annually
☐ Quarterly

6. Do you wish to elect automatic premium loan?
☐ Yes
☐ No

7. Whom do you wish as beneficiary(ies) of proceeds under the individual policy?
Primary: _____
If beneficiary(ies) named above not living, then pay:
Contingent: _____

I UNDERSTAND AND AGREE THAT: (1) The statements and answers in the above application are true, complete and correctly recorded to the best of my knowledge and belief. (2) Any policy issued on this application will be issued in accordance with the conversion privilege contained in the Group Policy. (3) The policy will become effective on the day following the last day of the conversion period prescribed under the Group Policy. (4) The beneficiary designation above has no effect on the beneficiary designation for any death benefits payable under the Group Policy. (5) If any death benefit paid under the Group Policy includes an amount representing the coverage shown in item 4 above, the individual policy will be void from the beginning. In this case, we, Unum Life Insurance Company of America, will refund to the beneficiary any premium paid. **See reverse side for fraud notices.**

8. Insured's Signature Date	Applicant's/Additional Applicant's Signature Date	Witness Signature (if other than insured) Date

FRAUD NOTICE

For Residents of California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For Residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For Residents of Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For Residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Residents of Kansas: Anyone who knowingly, and with intent to injure, defraud, or deceive us may be guilty of fraud as determined by a court of law. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.

For Residents of Kentucky and Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For Residents of Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Minnesota: Any person who knowingly or willfully makes a false or fraudulent statement in, or relative to, any application for insurance or membership for any purpose shall be guilty of a gross misdemeanor.

For Residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For Residents of New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

For Residents of Puerto Rico: Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

For Residents of Arkansas, the District of Columbia and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Ohio: Any person who, knowingly and with intent to defraud or deceive any insurance company, submits an insurance application or files a claim containing any false or deceptive statements is guilty of insurance fraud.

For Residents of Virginia: Any person who, with the intent to defraud or knowingly facilitates fraud against the insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

For Residents of All Other States: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

APPLICATION FOR GROUP INSURANCE
Unum Life Insurance Company of America
2211 Congress Street • Portland, Maine 04122

Name of Applicant _____

Address: _____
(Street)

_____
(City) (State) (Zip)

applies to the Unum Life Insurance Company of America, for:

- ☐ Group Life Benefits
- ☐ Group Accidental Death and Dismemberment Benefits
- ☐ Group Critical Illness Benefits
- ☐ Group Cancer Benefits
- ☐ Group Hospital Confinement Indemnity Benefits
- ☐ Group Short Term Disability Benefits
- ☐ Group Long Term Disability Benefits
- ☐ Group Accident Benefits

Policy Effective Date:_____
(mm/dd/yyyy)

Is there any group life insurance plan in force or being applied for on some or all employees? ☐ Yes ☐ No
If yes, complete the following or list the prior carriers:

Employee Class	Maximum Amounts	Name of Carrier	Effective Dates (mm/dd/yyyy)	Termination Dates (mm/dd/yyyy)

If the Insurance Company approves this application, a policy will be issued. The applicant agrees that acceptance of the policy will be an approval of the policy terms. The policy specifications will be made a part of the policy along with a copy of this form.

By signing this Group Master Application, you acknowledge that you have received a copy of Unum's Disclosure Notice.

Signed at not required _____ _____
(City and State) (Applicant)

on_____ By: _____
(mm/dd/yyyy) (Signature and Title)

Broker Name: _____ Broker Signature: _____
(Please Print)

SS# / Tax ID# (last 4 digits): _____

GROUP INSURANCE ENROLLMENT FORM
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

Please print legibly and complete this form in its entirety. Blank fields will cause delays in processing.

☐ **Initial Enrollment:** To make initial elections; OR

☐ **Annual Enrollment:** To make changes to existing elections and/or information. The elections/information you indicate will replace your prior elections/information on file with Unum. **Note: If you do not wish to make any changes, do not complete this form. Please contact your employer with any questions**

Policyholder Name | **Policy No.** | **Division No.**

Employee Social Security Number ___ - ___ - ___ | **Sex** Male ☐ Female ☐ | **Date of Birth** (mm/dd/yyyy) | **Hours Worked Per Week**

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

☐ **Exempt** ☐ **Non-Exempt**

Employee Preferred Name | **Spouse First Name** (if coverage is selected) | **Spouse Date of Birth** (mm/dd/yyyy)

COVERAGE ELECTIONS: Your employer will inform you of available coverage. Check yes to enroll; check no if you decline or coverage is not available.

Life/AD&D ☐ Yes ☐ No **Spouse or Child** ☐ Yes ☐ No **LTD** ☐ Yes ☐ No **STD** ☐ Yes ☐ No

AMOUNT OF COVERAGE SELECTED FOR:

LIFE/AD&D You: $___,___,___ Spouse: $___,___,___ Child: $___,___

Note: If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete a Statement of Health form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting and will become effective on the first of the month coincident with or next following the date Unum approves your Statement of Health form. If you **DO NOT APPLY FOR** coverage for you or your spouse or children during your or their initial enrollment period, you will need to complete a Statement of Health form for all amounts of coverage. You may complete and electronically submit a Statement of Health form—please see your Plan Administrator.

Beneficiary Information: Please complete the beneficiary information on the reverse side of this form.

Request for Signature and Certification: I understand that my coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

Employee Signature _____ Date _____ Mobile Phone _____ Work Phone _____

This is NOT an application for insurance – this is an Enrollment Form

Beneficiary Information:

Name (last name, first, middle initial):	Relation to You:	Benefit %:
If the beneficiary(ies) named above are not living, then pay:		

Conversion Rates

Age	Annual Rate One-Year Term	Rates for Individual Whole Life Annual	Semiannual	Quarterly	Age	Annual Rate One-Year Term	Rates for Individual Whole Life Annual	Semiannual	Quarterly
0	5.05	2.06	1.07	0.57	46	8.92	22.08	11.48	6.07
1	5.05	2.16	1.12	0.59	47	9.66	22.62	11.76	6.22
2	5.05	2.27	1.18	0.62	48	10.41	23.44	12.19	6.45
3	5.05	2.39	1.24	0.66	49	11.15	24.52	12.75	6.74
4	5.05	2.51	1.31	0.69	50	11.89	25.87	13.45	7.11
5	5.05	2.63	1.37	0.72	51	13.47	27.95	14.53	7.69
6	5.05	2.77	1.44	0.76	52	15.05	29.88	15.54	8.22
7	5.05	2.91	1.51	0.80	53	16.62	32.08	16.68	8.82
8	5.05	3.05	1.59	0.84	54	18.20	34.56	17.97	9.50
9	5.05	3.21	1.67	0.88	55	19.78	38.69	20.12	10.64
10	5.05	3.37	1.75	0.93	56	21.73	39.23	20.40	10.79
11	5.05	3.54	1.84	0.97	57	23.69	40.31	20.96	11.09
12	5.05	3.72	1.93	1.02	58	25.64	41.94	21.81	11.53
13	5.05	3.91	2.03	1.08	59	27.60	44.10	22.93	12.13
14	5.05	4.11	2.14	1.13	60	29.55	46.81	24.34	12.87
15	5.05	5.29	2.75	1.45	61	32.82	51.32	26.69	14.11
16	5.10	5.56	2.89	1.53	62	36.08	55.21	28.71	15.18
17	5.15	5.83	3.03	1.60	63	39.35	59.65	31.02	16.40
18	5.29	6.10	3.17	1.68	64	42.61	64.64	33.61	17.78
19	5.43	6.36	3.31	1.75	65	45.88	72.96	37.94	20.06
20	5.74	6.99	3.63	1.92	66	49.74	76.31	39.68	20.99
21	5.49	7.27	3.78	2.00	67	53.61	79.66	41.42	21.91
22	5.24	7.55	3.93	2.08	68	57.47	83.01	43.17	22.83
23	5.00	7.84	4.08	2.16	69	61.34	86.36	44.91	23.75
24	4.75	8.12	4.22	2.23	70	65.20	93.06	48.39	25.59
25	4.50	8.40	4.37	2.31	71	73.41	105.19	54.70	28.93
26	4.35	8.65	4.50	2.38	72	81.63	112.26	58.38	30.87
27	4.20	8.90	4.63	2.45	73	89.84	119.32	62.05	32.81
28	4.06	9.15	4.76	2.52	74	98.06	126.38	65.72	34.75
29	3.91	9.40	4.89	2.59	75	106.27	147.58	76.74	40.58
30	3.76	9.65	5.02	2.65	76	114.77	156.43	81.34	43.02
31	3.82	11.55	6.01	3.18	77	123.95	165.82	86.23	45.60
32	3.88	11.84	6.16	3.26	78	133.87	175.77	91.40	48.34
33	3.94	12.13	6.31	3.34	79	144.58	186.31	96.88	51.24
34	4.00	12.42	6.46	3.42	80	156.15	197.49	102.69	54.31
35	4.06	12.85	6.68	3.53	81	168.64	209.34	108.86	57.57
36	4.30	12.98	6.75	3.57	82	182.13	221.90	115.39	61.02
37	4.53	13.25	6.89	3.64	83	196.70	235.22	122.31	64.69
38	4.77	13.64	7.09	3.75	84	212.43	249.33	129.65	68.57
39	5.00	14.16	7.36	3.89	85	229.43	264.29	137.43	72.68
40	5.24	15.61	8.12	4.29	86	247.78	280.15	145.68	77.04
41	5.83	16.43	8.54	4.52	87	260.17	296.95	154.41	81.66
42	6.42	17.40	9.05	4.79	88	273.18	314.77	163.68	86.56
43	7.00	18.50	9.62	5.09	89	286.84	333.66	173.50	91.76
44	7.59	19.74	10.26	5.43	90	301.18	353.68	183.91	97.26
45	8.18	21.81	11.34	6.00					

Please note: Rates are per $1,000 of coverage

Policy Fee is as follows:
$90.00 per annual payment
$46.80 per semi annual payment
$24.75 per quarterly payment

AE-1260

How to Calculate Your Premium Payment

Calculate Your Premium Payment	Check Your Elections Below
1. Determine if you want the whole life or the One-Year Term coverage. The One-Year Term will be renewed next year at your attained age to Whole Life coverage assuming premiums are paid in full. If you elect the One-Year Term, you must submit an annual premium payment. Note that the One-Year Term coverage is not available in all states.	Whole Life ☐ One-Year Term ☐
2. If you have selected whole life, determine whether you want to pay your whole life premiums annually, semi-annually, or quarterly.	Annual ☐ Semi-Annual ☐ Quarterly ☐
3. Find your rate on the rate table. The rate is based on the type of coverage you want and your age at the time your conversion coverage begins, which is 31 days from the time your group coverage terminates or is reduced.	Base Rate per $1,000 of Coverage _____
4. Determine the amount of insurance you want. You may have any amount up to and including the amount you had under the group plan.	Amount of Coverage _____

5.

	Calculate Your Premiums		
a. Base rate per thousand dollars of coverage:	Base Rate		_____
b. Number of thousand dollar units you want:	# of $1,000 Units	x	_____
c. Multiply a. by b.:	Base Rate X # of Units		_____
d. If you selected whole life, add the policy fee:	Policy Fee	+	_____
No policy fee for One-Year Term			
Annual $90.00 per payment			
Semi-annual $46.80 per payment			
Quarterly $24.75 per payment			
e. TOTAL c. and d. This is your premium.	* TOTAL		_____

Please make your check payable to Unum

* This is the estimated amount due per payment, actual billed amount may vary slightly due to rounding.

Example

1. A 44 year old person decides to convert to a whole life policy
2. The person wants to convert $25,000 of coverage
3. The person wants to pay premiums semi-annually
4. The semi-annual rate for a 44 year old is $10.26 per $1,000 of insurance
5. Calculate premiums:

a. Base rate per thousand dollars of coverage:		$10.26
b. Number of thousand dollar units you want:	X	25
c. Multiply a. by b.:		$256.50
d. If you selected whole life, add the policy fee:		
No policy fee for One-Year Term		$0.00
Annual $90.00 per payment		-
Semi-annual $46.80 per payment		$46.80
Quarterly $24.75 per payment		-
e. TOTAL c. and d. This is your premium.		$303.30

Your actual coverage is subject to the terms, conditions, limitations and restrictions set forth in your certificate of coverage and/or Policy.