



**SMALL CASE OFFERING (2-9 LIVES)  
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 significant delays in processing.

**Policyholder Name** \_\_\_\_\_ **Policy No.** \_\_\_\_\_ **Division No.** \_\_\_\_\_

**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

**Spouse First Name (if coverage is selected)** \_\_\_\_\_ **Spouse Date of Birth (mm/dd/yyyy)** \_\_\_\_/\_\_\_\_/\_\_\_\_

**COVERAGE ELECTIONS:** Your employer will inform you of available coverage. Coverage amounts may be subject to medical underwriting approval based on satisfactory Evidence of Insurability. Check yes to enroll; check no if you decline or coverage is not available.

**Life/AD&D**  Yes  No **LTD**  Yes  No **STD**  Yes  No

**AMOUNT OF COVERAGE SELECTED FOR:**

**LIFE Amount:** \$ \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ **AD&D Amount:** \$ \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

\*Note: AD&D coverage amount will not exceed the amount of approved Life insurance.\* If any amount of Life coverage requiring medical underwriting is not approved, the Life coverage amount will be subject to adjustment.

**Beneficiary Information:**

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

**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 Work Phone Home Phone

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1275-03 (4/07) **RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER**