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

Multnomah County Oregon
Policy #285369/Div 001

Term Life Insurance Enrollment Form

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

Application Type:
☐ **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 plan administrator with any questions.**

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**

If date below unknown, consult with your Plan Administrator to complete:
☐ **Date entered into an eligible class (*ex: part time to full time*) or**
☐ **Rehire Date or**
☐ **Date of promotion to an eligible class** **Spouse Name (if coverage is selected)** **Spouse Date of Birth (mm/dd/yyyy)**

COVERAGE ELECTIONS: Please indicate below the coverage amounts you would like to select for you and your spouse, if applicable. Any coverage amounts left blank will result in a coverage amount of $0.

Amount of coverage selected for:

Life You: $ _____ Min: $30,000 Max: $500,000

Your Spouse: $ _____ Min: $30,000 Max: $500,000
or Domestic Partner

Note: If you have chosen Life coverage over the Guarantee Issue amount of $150,000 for you or $50,000 for your spouse / domestic partner, you will also need to complete an Evidence of Insurability form. The amount of Life coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective in accordance with the terms of the policy. If you DO NOT APPLY FOR coverage for you or your dependent(s) during your or their initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage. You may complete and submit an Evidence of Insurability 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 have read and understand the "Limitations and Exclusions" on the reverse side of this enrollment form.* 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*

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER

Please be aware that your coverage may be impacted by certain limitations and exclusions including, but not limited to, the following:

Limitations and Exclusions

Delayed Effective Date:

Employee: Insurance will be delayed for employees not in active employment until the first of the month, coincident with or next, following the date they return to work. Regularly scheduled vacation time is considered active employment.

Dependents: Coverage for totally disabled dependents will be delayed until the first of the month, coincident with or next, following the date the individual is no longer disabled. "Totally disabled" means that, as a result of injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; is receiving or is entitled to receive any disability income from any source due to any sickness or injury; is receiving chemotherapy radiation therapy or dialysis treatment; or has a life threatening condition.

Exclusion for Suicide:

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

This Suicide Exclusion does not apply to Washington residents.

Please see your Plan Administrator [or your Policy] for a complete listing of applicable limitations and exclusions.

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