Short Term Disability Enrollment Form

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: Diocese of Owensboro
Policy No.: 693003
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. Check yes to enroll; check no if you decline or coverage is not available.

STD ☐ Yes ☐ No

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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