



ENROLLMENT FORM: UNUM GROUP LIFE INSURANCE PLAN

Underwritten by: Unum Life Insurance Company of America 2211 Congress St. Portland ME 04122

Employer Name: Diocese of Fort Wayne-South Bend Plan # 551767 Div 005 Location # _____

I choose to additional Group Life Insurance

Male
 Last Name _____ First Name _____ Female

Date of Birth _____ Social Security Number _____

Street Address _____ Phone _____

City _____ State _____ Zip _____ Email _____

Job Title _____ Date of Hire _____

Hours Worked per Week _____ Annual Salary _____

Have you used any tobacco products in the last 12 months? YES NO

I additional life insurance coverage

Signature: _____

This form should only be completed if you are electing the Additional Life Insurance Coverage. To calculate your benefit, take your annual salary, multiply by .000153, take that amount, multiply by 12 and divide by 24. This amount will be taken pre-tax every pay period. By signing this form, you allow the Diocese of Fort Wayne-South Bend to make the necessary deductions from your salary to pay the premium when this insurance becomes effective. Should your salary or the cost change, this will also change your payroll deduction.

Signature: _____

V	k ti) " "	ooV	" "

If the beneficiaries named above are not living, then pay:

V	k ti) " "	ooV	" "

I understand that my coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials 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.

Signature: _____

Date: _____