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

Core Medical Group

Short Term Disability Insurance
Enrollment Form
Policy #145294/Div #001

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

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

☐☐ / ☐☐ / ☐☐☐☐ **(If unknown, consult with your Plan Administrator to complete.)**

Rate* per $10 of Weekly Benefit:
$0.71

STD Cost Calculation: To calculate your per-paycheck cost for this coverage, complete the calculations below. *Final Cost may vary slightly due to rounding.

NOTE: *If your weekly salary exceeds $1428, use $1428 as your weekly salary in the calculation.*

_____ (Annual Salary) ÷ 52 = _____ (Weekly Salary) X 0.70 (Benefit %) = _____ **Your Weekly Benefit**

_____ (Your Weekly Benefit) ÷ 10 = _____ X $0.71 (Your Rate) = _____ **Your Monthly Cost**

_____ (Your Monthly Cost) X 12 = _____ (Annual Cost) ÷ _____ (# Paychecks per Year) = _____ **Cost per Paycheck***

☐ **Yes,** I would like to participate. I authorize my employer to deduct from my salary or wages the necessary premium for this coverage. My signature verifies the accuracy of information contained on this form.

I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would otherwise become effective. **I have also read and understand the information in the Plan Highlights, including all statements regarding exclusions and benefit amounts and offsets.**

☐ **No,** I do not wish to participate. I understand that evidence of insurability will be required, at my own expense, if I decide to elect this coverage in the future.

Employee Signature: _____ Date: __ __/__ __/__ __ __ __

Return Forms To: _____ By: __ __/__ __/__ __ __ __

This section to be completed by your employer:
Coverage Effective Date: __ __/__ __/__ __ __ __

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