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

George Mason University

Long Term Disability Insurance
Enrollment Form
Policy #292539/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.)**

Long Term Disability Rates per $100 of Covered Salary			
Age	**50% Rate**	**40% Rate**	**25% Rate**
< 25 Years	$0.22	$0.18	$0.13
25 – 29	$0.26	$0.22	$0.16
30 – 34	$0.35	$0.29	$0.21
35 – 39	$0.48	$0.40	$0.28
40 – 44	$0.69	$0.57	$0.38
45 – 49	$1.03	$0.84	$0.55
50 – 54	$1.53	$1.24	$0.81
55 – 59	$1.92	$1.56	$1.00
60 – 64	$2.78	$2.25	$1.43
65 – 69	$2.78	$2.25	$1.43
70 +	$2.78	$2.25	$1.43
*LTD rates are based on five-year increments. Rates increase as you age.			

LTD Cost Calculation

To calculate the per-paycheck cost complete the calculations below. **NOTE: *If your annual salary exceeds:***

***50% Plan**: If your annual salary exceeds $144,000 use $144,000 as your annual salary in the calculation*

***40% Plan**: If your annual salary exceeds $180,000 use $180,000 as your annual salary in the calculation*

***25% Plan**: If your annual salary exceeds $288,000 use $288,000 as your annual salary in the calculation*

_____ ÷ 100 = _____ X _____ = _____ ÷ _____ = _____
Annual Salary | Your Rate | Annual Cost | # Paychecks per Year | Cost per Paycheck*

*Final cost may vary slightly due to rounding.

☐ **Yes,** I would like to participate. The percent of earning I wish to insure is: _____ %. 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 Enrollment Kit, including all statements regarding exclusions.**

☐ **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: __ __/__ __/__ __ __ __

Please complete, sign and return this form to your plan administrator, no later than __ __/__ __/__ __ __ __

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