unum[sm]

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

VA Community College System
Long Term Disability Insurance
Enrollment Form
Policy #532552/Div #____

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	25% Rate	40% Rate	50% Rate
< 25 years	$0.19	$0.25	$0.30
25 - 29	$0.21	$0.29	$0.34
30 - 34	$0.26	$0.38	$0.45
35 - 39	$0.35	$0.51	$0.61
40 - 44	$0.48	$0.71	$0.88
45 - 49	$0.70	$1.08	$1.33
50 – 54	$1.06	$1.66	$2.05
55 – 59	$1.34	$2.10	$2.61
60 – 64	$1.93	$3.04	$3.79
65 – 69	$1.93	$3.04	$3.79
70 +	$1.93	$3.04	$3.79

*LTD rates are based on five-year increments. Rates increase as you age.

To calculate the per-paycheck cost for this coverage, complete the calculations below.

Note: for the 50% benefit- *If your annual salary exceeds _$144,000__, use _$144,000_ as your annual salary in the calculation.*

Note: for the 40% benefit- *If your annual salary exceeds _$180,000__, use _$180,000_ as your annual salary in the calculation.*

Note: for the 25% benefit- *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. 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: __ __/__ __/__ __ __ __