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

# *Archdiocese of Dubuque*

Long Term Disability Insurance
Enrollment Form

**Policy #285940 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 | Option 1 – 50% Rate | Option 2 – 40% Rate | Option 3 – 25% Rate |
|---|---|---|---|
| <25 | $0.30 | $0.26 | $0.20 |
| 25 – 29 | $0.35 | $0.30 | $0.22 |
| 30 – 34 | $0.47 | $0.39 | $0.29 |
| 35 – 39 | $0.65 | $0.54 | $0.38 |
| 40 – 44 | $0.96 | $0.78 | $0.54 |
| 45 – 49 | $1.46 | $1.19 | $0.80 |
| 50 – 54 | $2.27 | $1.84 | $1.23 |
| 55 – 59 | $2.89 | $2.34 | $1.55 |
| 60 – 64 | $4.29 | $3.47 | $2.28 |

**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:** $120,000 use $120,000 as your annual salary in the calculation
**40% Plan:** $150,000 use $150,000 as your annual salary in the calculation
**25% Plan:** $240,000 use $240,000 as your annual salary in the calculation

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

☐ **Yes,** I would like to participate. The percent of earnings 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 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: __ __/__ __/__ __ __ __**