GROUP INSURANCE ENROLLMENT FORM
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

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

Policyholder Name DIOCESE FORT WAYNE - SOUTH BEND | Location # | **Policy No.** 551767 | **Division No.** 0005

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**

Beneficiary Information: SS# DATE OF BIRTH

Name (last name, first, middle initial):	Relation to You:	Benefit %:
If the beneficiary(ies) named above are not living, then pay:		

Request for Signature and Certification: I understand that my coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) 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. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

Employee Signature _____ *Date* _____ *Work Phone* _____ *Home Phone* _____

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RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER