

# ADDITIONAL LIFE INSURANCE



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

## Term Life Insurance Enrollment Form

FOR EMPLOYEE TO COMPLETE

GROUP PLAN #: 551767

DIVISION: 005

EMPLOYEE NAME (last name, first, middle initial)		EMPLOYER NAME DIOCESE OF FORT WAYNE – SOUTH BEND, INC.	
EMPLOYEE ADDRESS (street, city, state, zip code)		SOCIAL SECURITY NUMBER	DATE OF BIRTH
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF EMPLOYMENT	HOURS WORKED PER WEEK	OCCUPATION
ANNUAL EARNINGS	HAVE YOU USED ANY TOBACCO PRODUCTS IN THE LAST 12 MONTHS? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**COVERAGE ELECTIONS – THIS FORM SHOULD ONLY BE COMPLETED IF YOU ARE ELECTING THE ADDITIONAL LIFE INSURANCE COVERAGE. TO CALCULATE YOUR BENEFIT, TAKE YOUR ANNUAL SALARY, MULTIPLY BY .000153, TAKE THAT AMOUNT, MULTIPLY BY 12 AND DIVIDE THAT BY 24. THIS AMOUNT WILL BE TAKEN PRE-TAX EVERY PAY PERIOD. BY SIGNING THIS FORM, YOU ALLOW THE DIOCESE OF FORT WAYNE-SOUTH BEND TO MAKE THE NECESSARY DEDUCTIONS FROM YOUR SALARY TO PAY THE PREMIUM WHEN THIS INSURANCE BECOMES EFFECTIVE. SHOULD YOUR SALARY OR THE COST CHANGE, THIS WILL ALSO CHANGE YOUR PAYROLL DEDUCTION.**

### Beneficiary Information

NAME (last name, first, middle initial):	RELATION TO YOU:	BENEFIT %:
IF THE BENEFICIARY(IES) NAMED ABOVE ARE NOT LIVING, THEN PAY:		

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