

UNUMPROVIDENTUnum Life Insurance Company of America
Portland, Maine 04122-1670**Group
Enrollment
Form**

1. Policy #	2. Division # LOC #	3. Policyholder's Name and Address Diocese of Fort Wayne-South Bend		
4. Employee's Last Name		First	Middle Initial	5. Social Security Number

Employee's Address

6. Birthdate ____/____/____	7. Employment Date ____/____/____	8. Sex <input type="checkbox"/> F <input type="checkbox"/> M	9. Salary \$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually
11. Occupation/Title				
13. Beneficiary(ies) Last Name		First	Middle Initial	14. Relationship

* To name more than one beneficiary or to name a contingent beneficiary, ask your plan administrator for instructions.

15. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that Unum may not approve my request to change this decision unless I provide satisfactory evidence of insurability at my expense.

Employee's Signature

Date: ____/____/____

16. For Unum Use:

Class	Effective Date of Coverage	Class	Effective Date of Coverage
___ Life/AD&D	____/____/____	___ STD	____/____/____
___ Dep Life	____/____/____	___ LTD	____/____/____

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

1005-01 (10/02)