



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

Rutgers University
 Long Term Disability Insurance
 Enrollment Form
Policy # 313789

Employee Name: _____		Occupation: _____	
Social Security Number: ____ - ____ - _____		Date of Birth: ____/____/_____	
Hours Worked/Week: _____	Gender: _____	Location: _____	
Date of Hire: ____/____/_____		Annual Salary: _____	

Rates per \$100 of Covered Salary = \$0.79

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

Note: If your annual salary exceeds \$90,000 , use \$90,000 as your annual salary in the calculation.

_____	÷	100	=	_____	X	0.79	=	_____	÷	_____	=	_____
Annual Salary						Rate		Your Annual Cost		# of 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: ____/____/_____