Disability Insurance Enrollment Form

THIS IS NOT AN APPLICATION FOR INSURANCE: This is an enrollment form.

Please be aware that any new benefit elections on this form will replace all existing elections. If you do not wish to make changes, you do not need to complete this form. Please contact your plan administrator for assistance.

ALTERNATIVE CORRECTIONAL HEALTHCARE

Complete your personal information and choose your coverage amount

First name (please print) | M. initial | Last name

Social Security Number | Gender | Date of birth (mm-dd-yyyy) | Original hire date (mm-dd-yyyy)

Annual salary | Hours worked per week | Occupation

Did you recently become eligible for benefits? (Y/N)

Have you been rehired by your company? (Y/N)

If so, please provide a date (mm-dd-yyyy)

Short Term Disability Insurance

714418-001

Choose your coverage

This plan provides a 60% benefit.

To calculate your cost per paycheck, refer to the disability worksheet under 'Calculate your costs'.

If you were previously eligible and didn't purchase coverage, please complete Evidence of Insurability. Ask your plan administrator for details.

Your actual billed amount may vary slightly.

714418-001

Short Term Disability Insurance — SIGN AND CERTIFY

YES — I want **Short Term Disability Coverage**

☐ YES, I have read and understand the exclusions, limitations, delayed effective date, benefit reduction and offset features of my coverage as described in the enrollment materials. 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.

Signature _____ Date ___/___/_____

NO — I do not want **Short Term Disability Coverage**

☐ I DO NOT want **Short Term Disability Insurance**

I understand that if I elect coverage in the future, I may need to complete evidence of insurability relative to my health status in order for Unum to determine my eligibility for coverage.

Signature _____ Date ___/___/_____

Required:

First name (please print) | M. initial | Last name

Email: _____

Note: Your email will only be used if you need to answer health questions to get this coverage. You will receive a link to answer health questions online.

Return forms to: plan administrator

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Underwritten by: Unum Life Insurance Company of America, Portland, Maine

DETACH AND RETURN THIS FORM