



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

Please complete the entire form to ensure a smooth enrollment. If you already have Unum coverage, 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 the form. If you need assistance, please contact your plan administrator.

Ansell Grimm & Aaron, P.C.

994729

Step 1: Personal Information

Employee legal first name (please print) M. initial Last name

Social Security Number Gender Date of birth (mm-dd-yyyy) Have you used tobacco products (such as cigarettes, cigars, snuff, chew, or pipe) or any nicotine delivery system in the past 12 months? (Y/N)

Street address Apartment #

City State ZIP code

Original hire date Annual salary \$ Occupation Hours worked per week

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)

*Spouse first name (please print) M. initial Last name

Date of birth (mm/dd/yyyy)

*All references to Spouse shall include Civil Union Partner

Name your beneficiaries

Your primary beneficiary is the person (or persons) who will receive the benefit payment from your life insurance policy if you were to die. The total percent of benefit must not exceed 100%.

| | | | | |
|---------------------------|----------------------|----------------------|--|----------------------|
| First name (please print) | M. initial | Last name | Relationship (parent, child, friend, etc.) | % of benefit |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| First name (please print) | M. initial | Last name | Relationship (parent, child, friend, etc.) | % of benefit |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Your secondary beneficiary would receive the benefit payment from your life insurance policy if a primary beneficiary is no longer living.

| | | | | |
|---------------------------|----------------------|----------------------|--|----------------------|
| First name (please print) | M. initial | Last name | Relationship (parent, child, friend, etc.) | % of benefit |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| First name (please print) | M. initial | Last name | Relationship (parent, child, friend, etc.) | % of benefit |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Step 2: Coverage Amount

Employer-provided Life coverage

- Your employer is providing you with 5 times your earnings, to a maximum of \$500,000 of life insurance coverage.
- Your employer is providing your spouse with \$5,000 of life and AD&D insurance coverage.
- Your employer is providing your child with \$10,000 of life and AD&D insurance coverage.

Employee-purchased Term Life Insurance

The maximum amount of life insurance coverage you may have is: \$500,000

| Employee | | Spouse | | Child | |
|--------------------------|-------------|--------------------------|------------|--------------------------|----------|
| Coverage amount | | Coverage amount | | Coverage amount | |
| <input type="checkbox"/> | \$10,000 | <input type="checkbox"/> | \$5,000 | <input type="checkbox"/> | \$2,000 |
| <input type="checkbox"/> | \$20,000 | <input type="checkbox"/> | \$10,000 | <input type="checkbox"/> | \$4,000 |
| <input type="checkbox"/> | \$30,000 | <input type="checkbox"/> | \$15,000 | <input type="checkbox"/> | \$6,000 |
| <input type="checkbox"/> | \$40,000 | <input type="checkbox"/> | \$20,000 | <input type="checkbox"/> | \$8,000 |
| <input type="checkbox"/> | \$50,000 | <input type="checkbox"/> | \$25,000 * | <input type="checkbox"/> | \$10,000 |
| <input type="checkbox"/> | \$70,000 | <input type="checkbox"/> | \$30,000 | | |
| <input type="checkbox"/> | \$100,000 * | <input type="checkbox"/> | \$35,000 | | |
| <input type="checkbox"/> | \$150,000 | <input type="checkbox"/> | \$40,000 | | |

Want a different amount?

\$ _____ \$ _____

| Employee | | Spouse | | Child | | | | |
|--------------------------|--------------|-----------------|--------------------------|-----------------|--------------|--------------------------|----------|--------|
| Coverage amount | Monthly cost | Coverage amount | Monthly cost | Coverage amount | Monthly cost | | | |
| <input type="checkbox"/> | \$10,000 | \$0.25 | <input type="checkbox"/> | \$5,000 | \$0.34 | <input type="checkbox"/> | \$2,000 | \$0.00 |
| <input type="checkbox"/> | \$20,000 | \$0.50 | <input type="checkbox"/> | \$10,000 | \$0.68 | <input type="checkbox"/> | \$4,000 | \$0.00 |
| <input type="checkbox"/> | \$30,000 | \$0.75 | <input type="checkbox"/> | \$15,000 | \$1.02 | <input type="checkbox"/> | \$6,000 | \$0.00 |
| <input type="checkbox"/> | \$40,000 | \$1.00 | <input type="checkbox"/> | \$20,000 | \$1.36 | <input type="checkbox"/> | \$8,000 | \$0.00 |
| <input type="checkbox"/> | \$50,000 | \$1.25 | <input type="checkbox"/> | \$25,000 | \$1.70 | <input type="checkbox"/> | \$10,000 | \$0.00 |
| <input type="checkbox"/> | \$70,000 | \$1.75 | <input type="checkbox"/> | \$30,000 | \$2.04 | | | |
| <input type="checkbox"/> | \$100,000 | \$2.50 | <input type="checkbox"/> | \$35,000 | \$2.38 | | | |
| <input type="checkbox"/> | \$150,000 | \$3.75 | <input type="checkbox"/> | \$40,000 | \$2.72 | | | |

Want a different amount?

\$ _____ \$ _____

If you have chosen coverage over the amount of \$100,000 for you, or \$25,000 for your spouse, as described in the Certificate of Coverage, you will also need to complete a Statement of Health form. The amount of coverage over \$100,000 will be subject to medical underwriting and will become effective on the first of the month coincident with or next following the date Unum approves your Statement of Health form. If you DO NOT APPLY FOR coverage for you or your spouse or children during your or their initial enrollment period, you will need to complete a Statement of Health form for all amounts of coverage. You may complete and electronically submit a Statement of Health form - please see your Plan Administrator. The coverage amounts you choose for your spouse or child(ren) cannot exceed 100% of the coverage amount you purchase for yourself.

Step 3: 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.

No, I do not want Term Life Insurance coverage.

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

_____/_____/_____
Signature Date

_____/_____/_____
Signature Date

Email: _____

Note: Your email will only be used if you request a level of coverage that requires you to answer questions about your health status. You will receive a link to answer health questions online.

Return forms to: plan administrator