UnumProvident

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

Term Life and AD&D Insurance Enrollment Form

FOR EMPLOYEE TO COMPLETE

GROUP PLAN #: 596126 DIVISION: _____

EMPLOYEE NAME *(last name, first, middle initial)*	EMPLOYER NAME FOOTHILL-DEANZA COMMUNITY COLLEGE DISTRICT	
EMPLOYEE ADDRESS *(street, city, state, zip code)*	SOCIAL SECURITY NUMBER	DATE OF BIRTH
SEX ☐ *Male* ☐ *Female* / DATE OF EMPLOYMENT	HOURS WORKED PER WEEK	OCCUPATION
ANNUAL EARNINGS	HAVE YOU USED ANY TOBACCO PRODUCTS IN THE LAST 12 MONTHS? ☐ *Yes* ☐ *No*	

COVERAGE ELECTIONS

AMOUNT OF COVERAGE SELECTED FOR:

Life YOU: $_____ YOUR SPOUSE: $_____ EACH CHILD: $_____
AD&D YOU: $_____ YOUR SPOUSE: N/A EACH CHILD: N/A

NOTE: If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete an Evidence of Insurability form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective on the first of the month coincident with or next following the date UnumProvident approves your Evidence of Insurability form. If you DO NOT APPLY FOR coverage for you or your dependent(s) during your initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage. This applies to Life coverage only.

Spouse Information *(complete only if spouse coverage is selected)*

NAME:	SOCIAL SECURITY #:	DATE OF BIRTH:

Beneficiary Information

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

REQUEST FOR SIGNATURE *Please read the back of this form carefully before signing below.*

CERTIFICATION: 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 at my request. I have read and understand the INFORMATION ABOUT DELAYED EFFECTIVE DATES and EXCLUSIONS on the reverse side of this enrollment form. 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.

_____ __/__/____ _____ _____

Employee Signature *Date* *Work Phone* *Home Phone*