

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

City of Green Bay
 Long Term Disability Insurance
 Enrollment Form
Policy #580906

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

Age	90 Day EP	180 Day EP
< 25 Years	\$0.22	\$0.13
25 – 29	\$0.27	\$0.18
30 – 34	\$0.39	\$0.28
35 – 39	\$0.55	\$0.41
40 – 44	\$0.72	\$0.55
45 – 49	\$1.03	\$0.79
50 – 54	\$1.41	\$1.07
55 – 59	\$1.82	\$1.40
60 – 64	\$1.86	\$1.44
65 – 69	\$2.36	\$1.98
70 +	\$3.04	\$2.40

*LTD rates are based on five-year increments. Rates increase as you age.

LTD Cost Calculation					
To calculate the per-paycheck cost complete the calculations below.					
NOTE: If your annual salary exceeds: \$120,000 use \$120,000 as your annual salary in the calculation					
* Final cost may vary slightly due to rounding.					
_____	÷ 100 = _____	X _____	= _____	X 12 = _____	90 DAY
Monthly Salary		Your Rate	Monthly Premium	Annual Premium	
_____	÷ 100 = _____	X _____	= _____	X 12 = _____	180 DAY
Monthly Salary		Your Rate	Monthly Premium	Annual Premium	

- Yes**, I would like to participate. The elimination period option I wish to elect is: _____ days.
 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 Enrollment Kit, 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: __/__/_____
This section to be completed by your employer:	Coverage Effective Date: __/__/_____