

Want a different amount?

□ \$



2211 Congress Street Portland, Maine 04122

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

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 this form. Please contact your plan administrator for assistance.

					Trumbull	Industries,Inc.	
Step 1: Complete your personal in	nformation						
First name (please print)		M. initial Last n	ame			645391	
Social Security Number G	ender Date of b	irth (mm-dd-yyyy)					
		1					
Street address			l		Apartme	nt #	
City			State	ZIP code			
					-		
Original hire date Annu	ual salary	Occupation		<u> </u>		s worked	
\$,				per	week	
Did you recently become eligible for benefits? (Y/N)	Have you been by your compar	rehired (Y/N)	If so, please a date (mm				
Spouse first name (please print)		M. initial Last n	ame				
Date of birth (mm/dd/yyyy)							
Step 2: Choose a coverage amou	nt (you may use th	e worksheet to calo	culate your cos	st)			
Remember: The coverage amounts you c yourself.	hoose for your spouse	or child(ren) cannot ex	ceed 100% of the	e coverage am	nount you purcha	se for	
Term Life Insurance	Employee		Spouse		Child		
* If you previously purchased coverage and are now electing an	Coverage		Coverage		Coverage		
amount over \$100,000 for you or		amount		amount		amount	
\$25,000 for your spouse or if you were previously offered coverage	\$10,000		\$5,000		□ \$2,000		
during your initial eligibility period	\$20,000 \$30,000		□ \$10,000 □ \$15,000		\$4,000 \$6,000		
and declined to enroll, please complete Evidence of Insurability. Ask	□ \$70,000		\$20,000		\$8,000		
your Plan Administrator for details.				\$25,000 *		\$10,000	
Want a different amount?	□ \$		□ \$				
want a different amount:			ν				
AD&D Insurance	Employee		Spouse		Child		
	Coverage amount	Monthly cost	Coverage amount	Monthly cost	Coverage amount	Monthly cost	
	□ \$10,000	\$0.35	\$5,000	\$0.18	\$2,000	\$0.06	
	\$20,000	\$0.70	\$10,000	\$0.37	\$4,000	\$0.12	
	□ \$30,000	\$1.06	\$15,000	\$0.55	\$6,000	\$0.19	
	□ \$70,000 □ \$100,000	\$2.46 \$3.52	□ \$20,000 □ \$25,000	\$0.74 \$0.93	□ \$8,000 □ \$10,000	\$0.25 \$0.31	
	000,000 د	۷۵.۵۲	\$25,000	50.75	\$10,000	۱ د.۷ډ	

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Step 3: 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
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
Your secondary beneficiary would receive the	benefit pay	ment from your life insurance policy if a p	orimary beneficiary is no longer living.	
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
Step 4: Sign and certify				
I have read and understand the "Exclusion Brochure. All statements are true to the bunderstand that a copy of this form will bauthorize my employer to make the nece to pay the premium when my insurance be payroll deduction amount will change if made an error completing this form.	est of my k e made ava ssary deduc pecomes ef	nowledge and belief. I pilable to me at my request. I ctions from my salary or wages fective. I understand that my e or costs change, or if I've I to	o, I do not want coverage under the Tesurance. o, I do not want coverage under Accide eath & Dismemberment. understand that if I elect coverage in the may need to complete evidence of insulative to my health status in order for the etermine my eligibility for coverage.	e ntal ne future, nrability
Signature Date				
		-	/	/ Date
		•	gnature	Date
	eturn forms to: plan administrator			
Email:				

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.

Delayed Effective Date: if your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan. Exception: Infants are insured from live birth.

