

This section to be completed by your employer:

Coverage Effective Date: __ _/_ _/_ __ __ __

Underwritten by:
First Unum Life Insurance Company
99 Park Avenue, 6th Floor, New York, NY 10016

Health Research, Inc.

Long Term Disability Insurance Enrollment Form

Policy #461192/Div ___04___ Please complete this form in its entirety. Blank fields will cause significant delays in processing. **Employee Social Security Number** Date of Birth (mm/dd/yyyy) **Hours Worked Per Week** Gender **Employee First Name Last Name** M.I. **Employee Street Address** City State Zip Code Original Date of Hire **Annual Salary** Occupation □ Exempt □ Non-Exempt ☐ Date entered into an eligible class (ex: part time to full time) or ☐ Rehire Date or ☐ Date of promotion to an eligible class (If unknown, consult with your Plan Administrator to complete.) Rate .57 per \$100 of Covered Salary To calculate the per-paycheck cost for this coverage, complete the calculations below. Note: If your annual salary exceeds \$120,000, use \$120,000 as your annual salary in the calculation. ry ÷ 100 = ____ X ___ = __ Annual Cost ÷ ___ # Paychecks per Year = ___ Cost per Paycheck* Annual Salary * Final cost may vary slightly due to rounding. ☐ Yes, I would like to participate. 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 Plan Highlights, 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. Date: / / Employee Signature: Return Forms To: _____