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 _____

Please complete this form in its entirety. Blank fields will cause significant delays in processing.

Employee Social Security Number ___ - ___ - ____ **Gender** M ☐ F ☐ **Date of Birth (mm/dd/yyyy)** __ / __ / ____ **Hours Worked Per Week** __

Employee First Name _____ **M.I.** _ **Last Name** _____

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.*

_____ ÷ 100 = _____ X _____ = _____ ÷ _____ = _____
Annual Salary | Your Rate | Annual Cost | # Paychecks per Year | **Cost per Paycheck***

* 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.

Employee Signature: _____ Date: __ __/__ __/__ __ __ __

Return Forms To: _____ By: __ __/__ __/__ __ __ __

This section to be completed by your employer:

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