



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 #: _____ DIVISION: _____

EMPLOYEE NAME (last name, first, middle initial)		EMPLOYER NAME	
EMPLOYEE ADDRESS (street, city, state, zip code)		SOCIAL SECURITY NUMBER	DATE OF BIRTH
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF EMPLOYMENT	HOURS WORKED PER WEEK	OCCUPATION
ANNUAL EARNINGS	HAVE YOU USED ANY TOBACCO PRODUCTS IN THE LAST 12 MONTHS? <input type="checkbox"/> Yes <input type="checkbox"/> No		

COVERAGE ELECTIONS Please indicate below the coverage amounts you would like to select for you and your spouse and/or child, if applicable. The coverage amounts you indicate will replace all prior coverage amounts you have on file with UnumProvident. Any items left blank will result in a coverage amount equal to \$0.

AMOUNT OF COVERAGE SELECTED FOR:

Life You: \$ _____ YOUR SPOUSE: \$ _____ EACH CHILD: \$ _____
AD&D \$ _____ \$ _____ \$ _____

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:
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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

LIMITATIONS AND EXCLUSIONS

DELAYED EFFECTIVE DATE

Employee:

Insurance will be delayed for employees not in active employment until the date they return to work. Regularly scheduled vacation time is considered active employment.

Dependents:

Coverage for totally disabled dependents will be delayed until the date the individual is no longer totally disabled. This delay does not apply to newborn children while dependent insurance is in effect. "Totally disabled" means that, as a result of sickness or injury, the dependent is unable to perform each of the usual and customary duties or activities of a person of the same age and sex in good health.

EXCLUSION FOR SUICIDE

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date of insurance; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

AD&D BENEFIT EXCLUSIONS

AD&D Benefits would not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body, mental infirmity, or diagnostic, medical or surgical treatment
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while insane;
- War, declared or undeclared, or any act of war;
- Active participation in a riot;
- Committing or attempting to commit an assault or a felony;
- Voluntary use of any controlled substance. (This is defined in Title II of the Comprehensive Drug Abuse Prevention Control Act of 1970 and all amendments.) This exclusion will not apply if the controlled substance is prescribed for the individual by a physician;
- The presence of that percentage of alcohol in the individual's blood which raises a presumption that he was under the influence of alcohol. The blood-alcohol level which raises this presumption is governed by the laws of the state in which the event occurred;
- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from it while it is being used for test or experimental purposes; you or your dependent is operating, learning to operate, or serving as a member of the crew; it is being operated by, or for, or under the direction of any military authority. (This exclusion does not apply to transport type aircraft operated by the Military Airlift Command of the United States; or similar air transport service of any other country.)
- Travel or flight in any aircraft or device for aerial navigation, including boarding or alighting from it, owned or leased by, or on behalf of your employer.
- Bacterial infection. This exclusion does not apply to you or your dependent when the bacterial infection is due directly to an accidental cut or wound.
- Service on full-time active duty in the Armed Forces of any country or international authority.