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

Unitarian Universalist Association of Congregations

Policy #142968/Div 002

Long Term Disability Insurance Enrollment Form

Ministers (including Community Ministers) and Employees of Congregations, Districts, and UUA-Related Organizations

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

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

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

Employee (Home) Street Address **City** **State** **Zip Code**

Original Date of Hire __ / __ / ____ **Annual Salary (sal+housing for clergy)** $ ___ , ___ **Occupation**

If date below unknown, consult with your Plan Administrator to complete:

☐ **Date entered into an eligible class (*ex: increased from 600 hours worked/year to 750 hours worked/year*) or**
☐ **Rehire Date**

__ / __ / ____

Your Employer's name (church/congregation):____________________________________

Worksite Zip Code: : __ __ __ __ __ **UUA Group I.D. Number/church/congregation number:** __ __ __ __ __ __

The annual premium for this long-term disability coverage is 1% of the amount insured.

If you would like to calculate the per-paycheck cost for this coverage, complete the calculation below:
Annual Salary divided by 100 = ____________ x $1.00 = ____________Annual Cost.
Divide Annual Cost by # paychecks/year = _________Cost per Paycheck (final cost may vary slightly due to rounding).

Example: The annual LTD premium for a minister with a combined salary and housing allowance of $57,000 will be $570. To obtain the per paycheck cost, divide the annual premium by the number of paychecks/year. **Divide the annual cost by 12 to obtain the monthly premium – in this example $47.50/mo. Congregational employers will receive a monthly bill for their employees' coverage.**

☐ **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* *Work Phone* *Home Phone*

Employee email for enrollment confirmation: ____________________________________

This section to be completed by your UUA group insurance plan administrator:

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

RETAIN COPIES OF THIS FORM: 1 for yourself, 1 for your congregational employer. Fax completed, signed form to: UU – GIP 617-742-2875 for review. Then mail the signed <u>ORIGINAL</u> to UU-GIP, 25 Beacon St., Boston, MA 02108