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

# *City of Fort Worth*

Voluntary Long Term Disability Insurance
Enrollment Form

**Policy #631800/Div #0001**

**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.)**

| **LTD Cost Calculation:** To calculate your per-paycheck cost for this coverage, complete the calculations below (see rate table on the reverse side of this form). *Final cost may vary slightly due to rounding. |
|---|
| **NOTE:** *If your annual salary exceeds $180,000, use $180,000 as your annual salary in the calculation.* |
| _____ ÷ 100 = _____ X _____ = _____ ÷ _____ = _____<br>Annual Salary Your Rate Annual Cost # Paychecks per Year **Cost per Paycheck*** |

☐ **Yes,** I would like to participate in the following coverage (check one)

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.**

☐ **Group 1 - 40% & 90 day elimination period**
☐ **Group 2 - 40% & 180 day elimination period**
☐ **Group 3 - 60% & 90 day elimination period**
☐ **Group 4 - 60% & 180 day elimination period**

☐ **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:** __ __/__ __/__ __ __ __

**Group 1:**
**Monthly Benefit % and Maximum Monthly Benefit $**:
The lesser of:

40% of monthly earnings to a maximum benefit of $6,000 per month; or 70% of monthly earnings less any deductible sources of income.

**Elimination Period:** 90 days

**Group 2:**
**Monthly Benefit % and Maximum Monthly Benefit $**:
The lesser of:

40% of monthly earnings to a maximum benefit of $6,000 per month; or 70% of monthly earnings less any deductible sources of income.

**Elimination Period:** 180 days

**Group 3:**
**Monthly Benefit % and Maximum Monthly Benefit $**:
The lesser of:

60% of monthly earnings to a maximum benefit of $9,000 per month; or 70% of monthly earnings less any deductible sources of income.

**Elimination Period:** 90 days

**Group 4:**
**Monthly Benefit % and Maximum Monthly Benefit $**:
The lesser of:

60% of monthly earnings to a maximum benefit of $9,000 per month; or 70% of monthly earnings less any deductible sources of income.

**Elimination Period:** 180 days

**Period:** 180 days

| | **Plan 1** 40% to $6,000 90 Day EP | **Plan 2** 40% to $6,000 180 Day EP | **Plan 3** 60% to $9,000 90 Day EP | **Plan 4** 60% to $9,000 180 Day EP |
|---|---|---|---|---|
| **Age** | **Rate** | **Rate** | **Rate** | **Rate** |
| 15-24 | $0.22 | $0.15 | $0.40 | $0.25 |
| 25-29 | $0.22 | $0.15 | $0.40 | $0.25 |
| 30-34 | $0.25 | $0.17 | $0.45 | $0.30 |
| 35-39 | $0.30 | $0.22 | $0.54 | $0.38 |
| 40-44 | $0.41 | $0.32 | $0.74 | $0.54 |
| 45-49 | $0.63 | $0.49 | $1.10 | $0.84 |
| 50-54 | $0.88 | $0.73 | $1.58 | $1.22 |
| 55-59 | $1.22 | $1.00 | $2.19 | $1.70 |
| 60-64 | $1.38 | $1.10 | $2.45 | $1.86 |
| 65-69 | $1.48 | $1.10 | $2.63 | $1.98 |
| 70+ | $1.69 | $1.47 | $3.02 | $2.47 |