UNUMPROVIDENT

GROUP INSURANCE ENROLLMENT FORM

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

Policy # 868843 **Division #** _____

Employee Name (last name, first, middle initial)		Policyholder Name Nothside Medical Professional PC	
Employee Address (street, city, state, zip code)		Social Security Number	Date of Birth
Sex ☐ Male ☐ Female	Salary $ _____ ☐ Weekly ☐ Monthly ☐ Annually	Hours Worked per Week	Occupation/Title
Full Time Date of Hire or Date you enter an eligible class	Class Description (if applicable)		

Coverage Elections: Your employer will inform you of available coverage. Check yes to enroll; check no if you decline or coverage is not available.

Life ☒ **Yes**
AD&D ☒ **Yes**

Beneficiary Information (complete only if Life Coverage is selected)

Name (last name, first, middle initial):	Relation to You:	Benefit %:
If the Beneficiary(ies) named above are not living, then pay:		

Request for Signature and Certification:

I understand that my insurance coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. 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 to me at my request. 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