

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

DISABILITY INCOME PROTECTION INSURANCE ENROLLMENT FORM

for
The George Washington University
STD & LTD: #205262

Applicant Name: _____

Social Security #: _____

Occupation: _____

Date of Birth: _____

Date of Hire: _____

Gender: _____

Hours Worked per Week: _____

Annual Earnings: _____

Short Term Disability Income Protection Insurance Plan Highlights

Benefit: 60% of basic weekly earnings to maximum of \$3,000/Wk.

Benefits Begin: after 30 days injury or 30 days sickness

Benefits End: Maximum is 22 Weeks. (Then Long Term Disability Begins)

Your Weekly Benefit if Disabled: Annual Salary / 52 x .60

(A) Your Monthly Cost: Your Weekly Benefit x Your Age Banded Rate (see reverse side for rates)

Yes, I choose to elect Short Term Disability. 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.

No, I do not wish to participate. I understand that evidence of my insurability may be required, at my own expense, if I decide to elect this coverage in the future.

Long Term Disability Income Protection Insurance Plan Highlights

Employer Funded Benefit: 60% of basic monthly earnings to maximum of \$10,000/Month

Employee Buy-Up Option: Increase percentage of 60% to 66.67%
Increase maximum of \$10,000 to \$12,000

Benefits Begin: after 180 Days. (After Short Term Disability)

Benefits End: Maximum is to Age 65 or with a Reducing Benefit Duration after 65

Your Monthly Covered Payroll: Annual Salary / 12

Your Monthly Benefit if Disabled: Monthly Payroll x .60

(B) Your Monthly Cost: Your Monthly Covered Payroll x .0006

Yes, I choose to elect the Long Term Disability Buy-Up Option. 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.

No, I do not wish to participate. I understand that evidence of my insurability may be required, at my own expense, if I decide to elect this coverage in the future.

Your Total Voluntary Disability Cost Per Month: Above answer to (A) + (B) _____

** Final cost may vary slightly due to rounding differences. See reverse side for a sample calculation.*

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 Enrollment Kit, including all statements regarding plan limitations, exclusions and offsets.**

Employee Signature: _____ Date: ___ / ___ / ___

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Sample Cost Calculation: \$50,000 salary/ Age 35

Short Term: $\$50,000 / 52 \times .60 = \576.92 $\$576.92 \times .026 = \$15.00 \text{ per month} = \text{(A)}$

Note: If Weekly Benefit is over \$3,000, use \$3,000.

Annual Salary / 52 x .60 = Weekly Benefit

Weekly Benefit x Age Banded Rate from Table Below = Monthly Cost

Voluntary Short Term Disability Cost Per Month: \$15.00 + \$2.50 = \$17.50

Age	STD Rate
<25	\$0.026
25 – 29	\$0.032
30 – 34	\$0.026
35 – 39	\$0.023
40 – 44	\$0.024
45 – 49	\$0.027
50 – 54	\$0.033
55 – 59	\$0.041
60 – 64	\$0.050
65 – 69	\$0.052
70+	\$0.052

**STD rates are based on five-year increments. Rates increase as you age.*

Long Term: $\$50,000 / 12 = \$4,166.67$ $\$4,166.67 \times .0006 = \$2.50 \text{ per month} = \text{(B)}$

If Monthly Payroll is over \$18,000, use \$18,000

Annual Salary / 12 = Monthly Payroll

Monthly Payroll x .0006 = Monthly Cost