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

Almcoe Refrigeration Company
Long Term Disability Insurance
Enrollment Form
Policy #217587/Div #001

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.)

Rates* per $100 of Covered Salary			
Age	**Rate**	**Age**	**Rate**
< 25	$0.10	50 – 54	$1.18
25 - 29	$0.15	55 – 59	$1.49
30 - 34	$0.26	60 – 64	$1.35
35 - 39	$0.44	65 – 69	$1.13
40 - 44	$0.72	70 +	$0.94
45 - 49	$0.99		

*LTD rates are based on five-year increments. Rates increase as you age. **Age is determined as Plan Year minus Birth Year.**

To calculate the per-paycheck cost for this coverage, complete the calculations below.
Note: *If your annual salary exceeds **$100,000**, use **$100,000** as your annual salary in the calculation.*

_____ (Annual Salary) ÷ 100 = _____ X _____ (Your Rate) = _____ (Annual Cost) ÷ _____ (# Paychecks per Year) = _____ (**Cost per Paycheck***)

* Final cost may vary slightly due to rounding.

☐ **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: __ __/__ __/__ __ __ __

Return Forms To: _____ By: __ __/__ __/__ __ __ __

This section to be completed by your employer:

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