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

Farmington Public School District
Short Term Disability Insurance
Enrollment Form
Policy #409545/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 Benefit			
Age	**Rate**	**Age**	**Rate**
<25	$11.42	50 – 54	$9.35
25 – 29	$12.13	55 – 59	$12.60
30 – 34	$10.43	60 – 64	$16.20
35 – 39	$8.12	65 – 69	$17.25
40 – 44	$8.24	70+	$17.25
45 – 49	$7.83		
**STD rates are based on five-year increments. Rates increase as you age.*			

STD Cost Calculation: To calculate your per-paycheck cost for this coverage, complete the calculations below. *Final Cost may vary slightly due to rounding.

NOTE: If your weekly income exceeds $1,666.66 use $1,666.66 as your weekly income in the calculation.

$_____ X .60 = $ _____
Weekly Income Benefit % Maximum Weekly Benefit

$_____ ÷ 100 = $_____ X _____ = $_____
Elected Weekly Benefit Your Rate Your Monthly Cost

(Employee Choice $100 Increments)

To determine the cost per paycheck, multiply the total monthly cost by 12 and then divide by the number of pay periods per year.

☐ **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: __ __/__ __/__ __ __ __