Diocese of Winona-Rochester

Insurance Enrollment Form For: Supplemental (Term) Life (Policy #604947-001)

Please print legibly and complete this form in its entirety.

Location_____

☐ Beneficiary change only. This form cancels all prior designations. Complete your name, SS# and beneficiary information along with signature and date.
☐This includes employee name change – prior name was_____

Application Type:
☐ **NEW HIRE ONLY: ☐ Enroll OR ☐ Waive enrollment**

☐ **QUALIFYING EVENT: Describe:** Date of Event

☐ **Annual Enrollment:** To make changes to existing elections and/or information. The elections/information you indicate will replace your prior elections/information on file with Unum. **Note: If you do not wish to make any changes, do not complete this form. Please contact your plan administrator with any questions.**

Employee Name (last, first, middle initial)	Policyholder Name	
	Diocese of Winona-Rochester	
Employee Address (street, city, state, zip code)	Social Security Number	Date of Birth

COVERAGE ELECTIONS: Please indicate below the coverage amounts you would like to select for you and your spouse and/or child, if applicable. If you are taking coverage for your spouse, please include spouse's name and date of birth. Dependent life coverage amounts cannot exceed 100% of your life coverage amounts. Any coverage amounts left blank will result in a coverage amount of $0.

Amount of life coverage selected for:

You: $ ☐☐☐ , ☐☐☐ , ☐☐☐ Your Spouse: $ ☐☐☐ , ☐☐☐ Your Child: $ ☐☐ , ☐☐☐

Spouse First & Last Name

Spouse Date of Birth

Note: If you have chosen Life coverage over the Guarantee Issue amount of $200,000 for you or $25,000 for your spouse, you will also need to complete an Evidence of Insurability form. The amount of Life coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective in accordance with the terms of the policy. **If you DO NOT APPLY FOR coverage for you or your dependent(s) during your or their initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage.**

Beneficiary* Information - use an additional sheet if necessary

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

*Note: Benefits cannot be sent directly to a minor. Please consult your policy for additional information

Request for Signature and Certification: *I have read and understand the included "Limitations and Exclusions*".* 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 unless I waive coverage. I understand that my payroll deduction amount will change if my coverage or costs change.

Employee Signature _____ Date _____ Work Phone _____ Home/Cell Phone _____

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER

Please be aware that your coverage may be impacted by certain limitations and exclusions including, but not limited to, the following:

Limitations and Exclusions*

Delayed Effective Date

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Dependent Spouse and/or Child: Insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. Exception: infants are insured from live birth.

"Totally disabled" means that, as a result of an injury, a sickness or a disorder:

Your dependent spouse:

- **is confined in a hospital or similar institution;**
- **is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness;**
- **is cognitively impaired;**
- **is receiving or is entitled to receive any disability income from any source due to**
- **any sickness or injury;**
- **is receiving chemotherapy, radiation therapy or dialysis treatment;**
- **is confined at home under the care of a physician for a sickness or injury; or**
- **has a life threatening condition.**

Your dependent children:

- **are confined in a hospital or similar institution;**
- **are receiving chemotherapy, radiation therapy or dialysis treatment; or**
- **are confined at home under the care of a physician for a sickness or injury.**

Exclusion for Suicide:

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

This Suicide Exclusion does not apply to Washington residents.

Please see your Plan Administrator [or your Policy] for a complete listing of applicable limitations and exclusions.

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