

[] NEW APPLICANT

GROUP INSURANCE ENROLLMENT FORM
UNUM Life Insurance Company of
America

[] CHANGE IN COVERAGE

STATE UNIVERSITIES OF FLORIDA
Enrollment for Group Voluntary Disability Coverage

Social Security No.	Employee ID No	Date of Birth	Date of Hire	University
Last Name, First, MI		Job Title		
Street Address				
City	State	Zip Code	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Department/Building and Room Number/Mail Code			Annual Salary: \$ _____	

I am employed on a [9] [10] or [12] month contract (please circle one). I work [] hours per week.

The disability plan has a pre-existing condition limitation. If I have received medical treatment or consultation or taken prescribed drugs or medicines for any sickness or injury within three months prior to my effective date of coverage, these conditions will not be covered unless the disability begins more than twelve (12) consecutive months after my effective date of coverage. My effective date of coverage will be the first day of the month following the date of this application or approval by UNUM, if applicable, provided that I am actively at work on a full time basis.

I understand that if I do not apply for coverage during my initial eligibility period and choose to enroll at a later date, UNUM may require Evidence of Insurability.

I hereby request coverage under my employer's plan of benefits. I authorize my employer to deduct from my earnings my contributions for the coverage when I become eligible and for each period thereafter, automatically including future rate increases, and to calculate into deduction modes consistent with the payroll system of my employer, including prorated and accelerated deductions, as applicable. The deductions are to be continued until:

(a) I request that this authorization be cancelled; or

(b) termination of my employment.

The amounts deducted are to be paid to The Gabor Agency, Inc., Tallahassee, Florida, then remitted to UNUM Life Insurance Company of America to cover premiums for disability coverage provided for me. UNUM Life Insurance Company of America is solely responsible for paying benefits under the policy.

PLEASE SELECT ONE: 30-Day Elimination Period **-or-** 90-Day Elimination Period

Enrollment Date: _____	Effective Date: _____	_____ Signature
		_____ Agent Signature