UnumProvident

Underwritten by:
Unum Life Insurance Company of America

SHORT TERM & LONG TERM DISABILITY INCOME PROTECTION INSURANCE ENROLLMENT FORM

for

MTA Benefits, Inc.

Policy#: 570975

MTA BENEFITS

ENROLLER: _____

Applicant Name: _____

Address: _____

_____

_____

Payroll Frequency _____ **(10, 12, 24, 26, 52)**

Home Phone: (____) _____

Work Phone: (____) _____

E-mail Address: _____

Social Security #: _____

Date of MTA Membership: __ __ / __ __ / __ __ __ __

School District/Name: _____

Date of Hire: __ __ / __ __ / __ __ __ __

Date of Birth: __ __ / __ __ / __ __ __ __

Gender: ___ Male ___ Female

Annual Earnings: $_____

Hours Worked per Week: _____

You may choose from 2 Income Protection Plans: Short Term Disability and/or Long Term Disability
Please check the option(s) you wish to choose:

STD: ☐ 60% of your weekly salary to a maximum weekly benefit of $1,150

Cost per pay period $_____ (see reverse side of this page for calculation instructions)

LTD: ☐ 60% of your monthly salary to a maximum monthly benefit of $5,000
Cost per pay period $_____ (see reverse side of this page for calculation instructions)

****For rates, please refer to the rating grid on the reverse side of this page***

☐ **Yes, I would like to participate in the plan(s) I checked above.** 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 that my premium is based on my current salary and will increase as my salary increases. I understand a confirmation of coverage statement will be provided to me prior to the policy effective date.

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 exclusions.**

☐ **Yes, I am interested, please have an MTA Benefits representative contact me at _____(Phone#).**

Applicant Signature: _____ **Date:** __ __/__ __/__ __ __ __

Return this form using the enclosed envelope or mail to:
MTA Benefits, c/oVista Financial Group, P.O. Box 250, Northborough, MA 01532
1-888-636-0112, ext. 200
mta_vistafg@charter.net

~ OR ~

Fax to 1-850-521-0111