Unum

Mississippi Schools
Active Employee & Dependents Enrollment Form for Basic Life Insurance and Supplemental Life Insurance
Policy #537377-027

Employee Name (Last name, first, middle initial)		Social Security Number
Employee Address (street, city, state, zip code)		Date of Birth
Gender ☐ Male ☐ Female	Date of Employment	Annual Earnings
Employer ***Pearl River Community College***		Occupation

Employee Life Insurance Amount: $_____ Eligible Active Employees receive coverage of two times annual salary rounded to next highest $1,000, subject to a minimum of $30,000 and a maximum of $100,000.

Note: All employees are automatically covered for Basic Life and AD&D unless a waiver is signed. (waiver on back of this form)

I am: ☐ **New Enrollee** ☐ **Late Enrollee (Evidence of Insurability is required)** ☐ **Changing Beneficiary**

☐ **Changing Name (previous name _____)** ☐ **Adding Dependent(s)**

Beneficiary Information

Designate your beneficiary(ies) for your Basic and Supplemental Life coverage below:

Name	Relationship to You		Benefit %
		Primary ☐ Contingent ☐	
		Primary ☐ Contingent ☐	
		Primary ☐ Contingent ☐	
		Primary ☐ Contingent ☐	

If no primary beneficiary(ies) survive you, the proceeds will be paid to the surviving contingent beneficiary(ies).

SUPPLEMENTAL LIFE AND DEPENDENT LIFE INSURANCE:

Choose from the following for electing Supplemental Life Insurance: List spouse & dependents to be covered:

Employee must notify Unum Life Insurance Company of any change in dependent status effecting coverage

Employee

Life and AD&D

☐ **$10,000** $5

☐ **$25,000** $12.50

☐ **$50,000** $25

☐ **None**

DEPENDENT/FAMILY COVERAGE $7.00

Spouse……$10,000

Per Child……...$ 5,000

To 6 Months per Child….$ 100

☐ **I elect dependent coverage.**

☐ **I decline dependent coverage.**

Spouse cost increases at age 70

Dependent Name	Relationship	Date of Birth

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 at my request. I hereby authorize my employer to deduct monthly, the appropriate life insurance premium and also I further authorize my employer to forward payment of such premium amount to UNUM or its authorized agent/representative on the first working day of each month to cover the cost of my life insurance. I understand that UNUM and/or its authorized agent/representative is responsible for billing my employer monthly for the appropriate premium amount. I further understand that I am responsible for notifying UNUM and/or its authorized agent/representative concerning cancellation, premium changes, policy questions, and/or general information. Employee and Dependents must be actively at work and not disabled for coverage to be effective.

Employee Signature	Date	Work Phone	Home Phone

STATE OF MISSISSIPPI WAIVER OF BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMEMT PLAN 537377

If you do not want to elect Life coverage at this time, please mark the box below, and complete the form at the bottom. Be sure to sign and date the form.

☐ I do not wish to enroll in the State Life Insurance Plan. I realize that if I choose to enroll at a later date, my application will be subject to Medical Evidence of Insurability.

Employee Name _____ Social Security #_____

School District or Community College_____

Signature_____ Date _____