



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

Mann Financial Inc.
 Voluntary Short Term Disability
 Insurance and
 Voluntary Long Term Disability
 Insurance
 Enrollment Form
 Policy No. 576141

Employee Name:		Occupation:	
Social Security Number: _____ - _____ - _____		Date of Birth: ____/____/_____	
Hours Worked/Week:		Gender:	Location:
Date of Hire: ____/____/_____		Annual Salary:	

Short Term Disability Rates Per \$10 of Volume		Long Term Disability Rates Per \$100 of Covered Salary	
Age	Rate	Age	Rate
< 25 Years	\$1.01	< 25 Years	\$0.24
25 - 29	\$1.12	25 - 29	\$0.28
30 - 34	\$0.97	30 - 34	\$0.36
35 - 39	\$0.82	35 - 39	\$0.46
40 - 44	\$0.82	40 - 44	\$0.60
45 - 49	\$0.88	45 - 49	\$0.80
50 - 54	\$1.03	50 - 54	\$1.03
55 - 59	\$1.38	55 - 59	\$1.25
60 - 64	\$1.38	60 - 64	\$1.34
65 - 69	\$1.78	65 - 69	\$1.52
70 +	\$1.78	70 +	\$1.52

STD Cost Calculation

To calculate your per-paycheck cost for this coverage, complete the calculations below.

NOTE: If your annual salary exceeds \$86,667, use \$86,667 as your annual salary in the calculation.

$$\frac{\text{Annual Salary}}{52} = \text{Weekly Salary} \times \text{Benefit \%} = \text{Your Weekly Benefit}$$

$$\frac{\text{Your Weekly Benefit}}{10} = \text{Your Rate} = \text{Your Monthly Cost}$$

$$\frac{\text{Your Monthly Cost}}{12} = \text{Annual Cost} \div \frac{\text{\# Paychecks per Year}}{24} = \text{Cost per Paycheck*}$$

LTD Cost Calculation

To calculate the per-paycheck cost complete the calculations below.

NOTE: If your annual salary exceeds \$100,000, use \$100,000 as your annual salary in the calculation.

$$\frac{\text{Annual Salary}}{100} = \text{Your Rate} \times \text{Your Annual Cost} \div \frac{24}{\text{\# Paychecks per Year}} = \text{Cost per Paycheck*}$$

* Final cost may vary slightly due to rounding.

- 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 Enrollment Kit, including all statements regarding exclusions.**

- 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: __ __/__ __/____