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

Florida Department of Agriculture and Consumer Services
LTD Enrollment Form
Policy #125474

Employee Name:	Occupation:
Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Date of Birth: ___ ___/___ ___/___ ___ ___ ___
Hours Worked/Week:	Gender: | Effective Date: ___ ___/___ ___/___ ___ ___ ___
Date of Hire: ___ ___/___ ___/___ ___ ___ ___	Annual Salary:

Senior Management Service (SMS) or Selected Exempt Service (SES) Employees) *Per $100 of Covered Salary*		**All Other Employees** *Per $100 of Covered Salary*	
Age	**Rate**	**Age**	**Rate**
< 30	$0.14	< 30	$0.16
30 - 34	$0.15	30 – 34	$0.17
35 - 39	$0.20	35 – 39	$0.22
40 - 44	$0.31	40 – 44	$0.33
45 - 49	$0.45	45 – 49	$0.53
50 - 54	$0.75	50 – 54	$0.88
55 - 59	$1.08	55 – 59	$1.25
60 - 64	$1.19	60 – 64	$1.38
65+	$1.00	65+	$1.16

LTD Benefit Calculation: (The *maximum monthly covered benefit is $5,000.)*

_________ Annual Salary ÷ 12 = _________ Monthly Salary X .60 = _________ Monthly Benefit

LTD Premium Calculation: *(The maximum monthly covered earnings is $8,333.)*

If your annual salary exceeds $100,000, use $100,000 as your annual salary in the calculation. Final cost may vary slightly due to rounding.

_________ Annual Salary ÷ 100 = _________ X _________ Your Rate = _________ Your Annual Cost ÷ 26 # Paychecks per Year = _________ Cost per Paycheck*

☐ **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 Plan Highlights, including all statements regarding exclusions and benefit amounts and offsets.**

☐ **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 within 60 days of your date of employment to: E.B.C.I., P.O. Box 13566, Tallahassee, FL 32317
If you have any questions, please contact Bill Hoard in the Tallahassee Area at (850) 906-9099 or (800) 599-5552.