Accident Enrollment Form — Complete this form to enroll.

THIS IS NOT AN APPLICATION FOR INSURANCE: This is an enrollment form.

Unum Insurance Company
2211 Congress Street Portland, Maine 04122

Please complete both sides of this form to ensure a smooth enrollment. If you need assistance, please contact your employer.
Initial enrollment: To make initial elections; OR **Annual enrollment**: To make changes to existing elections and/or information.
The elections/information you indicate will replace your prior elections/information on file with Unum.

Note: if you do not wish to make any changes, do not complete this form. Please contact your employer with any questions.

Spirit Human Resources LLC

Step 1: Complete your personal information

First name (please print) | M. initial | Last name

Social Security Number | Gender | Date of birth (mm-dd-yyyy)

Street address | Apartment #

City | State | ZIP code

Original hire date | Hours worked per week | Email

Did you recently become eligible for benefits? (Y/N)

Have you been rehired by your company? (Y/N)

If so, please provide a date (mm-dd-yyyy)

Spouse first name | M. initial | Last name

Date of birth (mm/dd/yyyy)

Step 2: Choose your coverage amount

Select the desired plan and who you would like to cover

Your monthly premium	☐ Plan 1	☐ Plan 2
☐ You	$11.83	$9.51
☐ You and your spouse	$21.21	$17.14
☐ You and your children	$27.80	$21.92
☐ Family	$37.18	$29.55

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Accident Enrollment Form (continued)

Step 3: Name your beneficiaries

Your primary beneficiary is the person (or persons) who will receive the benefit payment from your insurance policy if you were to die.
The total percent of benefit must not exceed 100%.

First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit

Your secondary beneficiary would receive the benefit payment from your insurance policy if a primary beneficiary is no longer living.

First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit

Step 4: Signature

☐ **Yes**, I do want Accident insurance.

I understand that my coverage may be subject to limitations, exclusions and terminations as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. 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 to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

_____ ___ / ___ / _____
Signature Date

☐ **No**, I do not want Accident insurance.

_____ ___ / ___ / _____
Signature Date

Return forms to: plan administrator

Note: Your email will only be used if you need to answer health questions to get this coverage. You will receive a link to answer health questions online.

Underwritten by: Unum Insurance Company, Portland, Maine

Critical Illness Enrollment Form — Complete this form to enroll.

THIS IS NOT AN APPLICATION FOR INSURANCE: This is an enrollment form.

Please complete both sides of this form to ensure a smooth enrollment. If you need assistance, please contact your plan administrator.

Step 1: Complete your personal information

First name (please print) | M. initial | Last name

Social Security Number | Gender | Date of birth (mm-dd-yyyy) | Have you used tobacco products (such as cigarettes, cigars, snuff, chew, or pipe) or any nicotine delivery system in the past 12 months? (Y/N)

Street address | Apartment #

City | State | ZIP code

Original hire date | Hours worked per week | Email

Spouse first name | M. initial | Last name

Date of birth (mm/dd/yyyy)

Step 2: Choose your coverage amount

Employee coverage
(Child coverage is automatically included)

- ☐ Option 1: $10,000
- ☐ Option 2: $20,000

Spouse coverage

You can purchase coverage for your spouse as long as you have purchased coverage for yourself. Your spouse coverage will be 50% of your amount.

- ☐ YES, I want coverage for my spouse
- ☐ NO, I do not want coverage for my spouse

If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete a Statement of Health form. The amount of coverage over the Guarantee Issue amount will be subject to medical underwriting and will become effective on the first of the month coincident with or next following the date Unum approves your Statement of Health form.

If you DO NOT APPLY FOR coverage for you or your spouse during your or their initial enrollment period, you will need to complete a Statement of Health form for all amounts of coverage. You may complete and electronically submit the Statement of Health form — please see your Plan Administrator.

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Critical Illness Enrollment Form (continued)

Step 3: Name your beneficiaries

Your primary beneficiary is the person (or persons) who will receive the benefit payment from your insurance policy if you were to die.
The total percent of benefit must not exceed 100%.

First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit

Your secondary beneficiary would receive the benefit payment from your life insurance policy if a primary beneficiary is no longer living.

First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit

Step 4: Signature

☐ I understand that my coverage may be subject to limitations, exclusions and terminations as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. 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 to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

_____ ___ / ___ / _____
Signature Date

☐ **No**, I do not want **Critical Illness**.

I understand that if I elect coverage in the future, I may need to complete a Statement of Health form relative to my health status in order for Unum to determine my eligibility for coverage.

_____ ___ / ___ / _____
Signature Date

Return forms to: plan administrator

Note: Your email will only be used if you requested a level of coverage above the guaranteed issue amount. You will receive a link to answer health questions online.

Underwritten by:
Unum Insurance Company, Portland, Maine

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