



# 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	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2
<input type="checkbox"/> You	\$11.83	\$9.51
<input type="checkbox"/> You and your spouse	\$21.21	\$17.14
<input type="checkbox"/> You and your children	\$27.80	\$21.92
<input type="checkbox"/> Family	\$37.18	\$29.55

# 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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## 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.



# 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	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
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)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street address			Apartment #
<input type="text"/>			<input type="text"/>
City		State	ZIP code
<input type="text"/>		<input type="text"/>	<input type="text"/> - <input type="text"/>
Original hire date	Hours worked per week	Email	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Spouse first name	M. initial	Last name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of birth (mm/dd/yyyy)	<input type="text"/>	
<input type="text"/>		

## 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.

# 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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## 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.

**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

\_\_\_\_\_  
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.