Accident Insurance 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 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.

Montrose County

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

Accident Insurance

Your monthly premium	Option 1
☐ You	$11.54
☐ You and your spouse	$20.43
☐ You and your children	$25.29
☐ Family	$34.18

Continued on back >

Accident Insurance 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: Group Voluntary Term Life and Accident,
Unum Life Insurance Company of America, Portland, MaineUnum Insurance Company, Portland, Maine
Critical Illness
Unum Insurance Company, Portland, Maine