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

Liberty Dialysis, LLC.

Short Term Disability Insurance
Enrollment Form

Policy #094153 Div #

Please complete this form in its entirety. Blank fields will cause significant delays in processing.

Employee Social Security Number ___ - ___ - ____ **Gender** M ☐ F ☐ **Date of Birth (mm/dd/yyyy)** __ / __ / ____ **Hours Worked Per Week** __

Employee First Name _____ **M.I.** ☐ **Last Name** _____

Employee Street Address _____ **City** _____ **State** __ **Zip Code** _____

Original Date of Hire __ / __ / ____ **Annual Salary** ☐ , ☐☐☐ , ☐☐☐ **Occupation** _____

☐ **Exempt** ☐ **Non-Exempt**

☐ **Date entered into an eligible class (*ex: part time to full time*) *or***
☐ **Rehire Date *or***
☐ **Date of promotion to an eligible class**

__ / __ / ____ **(If unknown, consult with your Plan Administrator to complete.)**

STD Rate: $1.17 per $10 of Weekly Benefit

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

NOTE: *If your weekly salary exceeds $65,000, use $65,000 as your weekly salary in the calculation.*

_____ ÷ 52 = _____ X **60%** = _____
Annual Salary — Weekly Salary — Benefit % — **Your Weekly Benefit**

_____ ÷ 10 = _____ X **$1.17** = _____
Your Weekly Benefit — Your Rate — **Your Monthly Cost**

_____ X 12 = _____ ÷ _____ = _____
Your Monthly Cost — Annual Cost — # Paychecks per Year — **Cost per Paycheck**

_____ ÷ 50% = _____
Cost per paycheck — *Employee Cost Per paycheck

*The premiums are shared. The employer pays 50% and the employee pays 50% of premiums. 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 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 To: _____ By: __ __/__ __/__ __ __ __

This section to be completed by your employer:
Coverage Effective Date: __ __/__ __/__ __ __ __

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