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

Mississippi State University
Policy #285772/Div 001

Term Life and AD&D Insurance Enrollment Form

Please print legibly and complete this form in its entirety. Blank fields will cause significant delays in processing.
Application Type:
☐ **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 plan administrator with any questions.**

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** _ , ___ , ___ ☐ **Exempt** ☐ **Non-Exempt** **Occupation** ____

If date below unknown, consult with your Plan Administrator to complete:
☐ **Date entered into an eligible class (*ex: part time to full time*) or**
☐ **Rehire Date or**
☐ **Date of promotion to an eligible class** __ / __ / ____

Spouse First Name (if coverage is selected) ____

Spouse Date of Birth (mm/dd/yyyy) __ / __ / ____

Have any tobacco products been used in the last 12 months? **You:** ☐ **Yes** ☐ **No**

COVERAGE ELECTIONS: Please indicate below the coverage amounts you would like to select for you and your spouse and/or child, if applicable. Dependent life coverage amounts cannot exceed 100% of your life coverage amounts. Any coverage amounts left blank will result in a coverage amount of $0.

Amount of coverage selected for:
Life/ AD&D You: $ _ , ___ , ___ Your Spouse: $ ___ , ___ Your Child: $ __ , ___

Note: If you have chosen Life coverage over the Guarantee Issue amount of $200,000 for you or $100,000 for your spouse, you will also need to complete an Evidence of Insurability form. The amount of Life coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective in accordance with the terms of the policy. If you DO NOT APPLY FOR coverage for you or your dependent(s) during your or their initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage. This applies to Life coverage only.

Beneficiary Information: Please complete the beneficiary information on the reverse side of this form.

Request for Signature and Certification: *I have read and understand the "Limitations and Exclusions" on the reverse side of this enrollment form.* 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.

______________________ __/__/____ ____________ ____________
Employee Signature *Date* *Work Phone* *Home Phone*

RETAIN COPY OF THIS PAGE FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER AA

Beneficiary Information:

Name *(last name, first, middle initial)*:	Relation to You:	Benefit %:
If the beneficiary(ies) named above are not living, then pay:		

Please be aware that your coverage may be impacted by certain limitations and exclusions including, but not limited to, the following:

Limitations and Exclusions

Delayed Effective Date:

Employee: Insurance will be delayed for employees not in active employment until the date they return to work. Regularly scheduled vacation time is considered active employment.

Dependents: Coverage for totally disabled dependents will be delayed until the first of the month, coincident with or next, following the date the individual is no longer disabled. This delay does not apply to newborn children while dependent insurance is in effect. "Totally disabled" means that, as a result of injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; is receiving or is entitled to receive any disability income from any source due to any sickness or injury; is receiving chemotherapy radiation therapy or dialysis treatment; or has a life threatening condition. Disabled children over the maximum child age may be eligible for benefits, please see your plan administer for more details.

Exclusion for Suicide:

Where the cause of death is suicide:
1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

This Suicide Exclusion does not apply to Washington residents.

AD&D Benefit Exclusions

AD&D Benefits would not be paid for losses caused by, contributed to by, or resulting from:
- Disease of the body, mental infirmity, or diagnostic, medical or surgical treatment
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while insane;
- War, declared or undeclared, or any act of war;
- Active participation in a riot;
- Committing or attempting to commit an assault or a felony;
- Voluntary use of any controlled substance. (This is defined in Title II of the Comprehensive Drug Abuse Prevention Control Act of 1970 and all amendments.) This exclusion will not apply if the controlled substance is prescribed for the individual by a physician;
- The presence of that percentage of alcohol in the individual's blood which raises a presumption that he was under the influence of alcohol. The blood-alcohol level which raises this presumption is governed by the laws of the state in which the event occurred;
- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from it while it is being used for test or experimental purposes; you or your dependent is operating, learning to operate, or serving as a member of the crew; it is being operated by, or for, or under the direction of any military authority. (This exclusion does not apply to transport type aircraft operated by the Military Airlift Command of the United States; or similar air transport service of any other country.)
- Travel or flight in any aircraft or device for aerial navigation, including boarding or alighting from it, owned or leased by, or on behalf of your employer.
- Bacterial infection. This exclusion does not apply to you or your dependent when the bacterial infection is due directly to an accidental cut or wound.
- Service on full-time active duty in the Armed Forces of any country or international authority.

Please see your Plan Administrator [or your Policy] for a complete listing of applicable limitations and exclusions.

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Limitations and Exclusions

Delayed Effective Date

Employee:

Insurance will be delayed for employees not in active employment until the date they return to work. Regularly scheduled vacation time is considered active employment.

Dependents:

Coverage for totally disabled dependents will be delayed until the date the individual is no longer totally disabled. This delay does not apply to newborn children while dependent insurance is in effect. "Totally disabled" means that, as a result of sickness or injury, the dependent is unable to perform each of the usual and customary duties or activities of a person of the same age and sex in good health.

Exclusion for Suicide

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date of insurance; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

INSTRUCTIONS AND INFORMATION FOR COMPLETING THE EVIDENCE OF INSURABILITY FORM

Unum Life Insurance Company of America

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries. The insurance product is underwritten by Unum Life Insurance Company of America.

To expedite processing, this form has been designed to be scanned and optically read. Please print neatly and respond to all questions.

1. Fully complete this form when your plan requires you to be individually underwritten to qualify for insurance. Specify what coverage you are requesting. If you are unsure, check with your plan administrator.

2. Make sure you have answered all the questions completely and accurately. Information pertaining to your Employer name, address and Group number, as well as your personal information must be provided. If there are unanswered questions, the underwriting process will not begin.

3. All employees and spouses applying for any coverage requiring underwriting must answer all health questions through section 2. If you are applying for disability coverage, or your life amount requiring underwriting is greater than $150,000, you must also fill out section 3.

4. Please include your work and home phone number; we may need to request additional information by telephone.

5. Please sign and date where indicated and make a copy of this form for your records. Please send the completed form to your plan administrator or mail the form directly to:

   Unum
   P.O. Box 9783
   Portland, ME 04104-5083

In order to evaluate your application we are relying on the information you have provided. In addition, we may need to request supplemental information from you or your physicians. Some coverage and amounts may require a brief medical exam, a blood test, urinalysis and/or EKG. These tests will be performed at your convenience and can be completed at your place of employment or home. We will notify you if any additional information is needed. Unum will pay for any additional information or tests needed to evaluate your application.

CAUTION: If your answers on the application are incorrect or untrue, Unum may deny benefits or rescind your insurance. Any person who, knowingly and with intent to defraud or deceive any insurance company, submits an insurance application containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

EVIDENCE OF INSURABILITY
Unum Life Insurance Company of America

Application Type: ☐ Initial Request ☐ Late Applicant ☐ Annual Enrollment ☐ Change in Status ☐ Increase ☐ Portability

List Your Current Height ___ Ft. - ___ In. **Weight** ___ Lbs.

List Your Spouse's Current Height ___ Ft. - ___ In. **Weight** ___ Lbs.

Employee Social Security Number ___-__-____ **Gender** ☐ Male ☐ Female Group # Group # Division #

Employee First Name **M.I.** **Last Name** **Date of Birth - mm/dd/yyyy** __/__/____

Spouse First Name (if applicable) **M.I.** **Last Name** **Spouse Date of Birth - mm/dd/yyyy** __/__/____

Number & Street Address **Employee Home Number** ( ) -

City **State** **Zip Code** **Employee Work Number** ( ) -

Date of Employment - mm/dd/yyyy __/__/____ **Occupation** **Employee Annual Salary** $,

E-mail Address **Coverages Elected** ☐ Life ☐ LTD ☐ STD

Employer's Name

Employer's Address

City **State** **Zip Code**

Employee		**Spouse**	
Total Life Amount Applied For	Amount Requiring Underwriting	Total Life Amount Applied For	Amount Requiring Underwriting
$, ,	$, ,	$, ,	$, ,

Names of Dependent Children Applying for Coverage	**Date of Birth - mm/dd/yyyy**	**Total Life Amount**
Child	/ /	$,
Child	/ /	$,
Child	/ /	$,

Please answer the following questions to the best of your knowledge and belief:

Question	Employee Yes	Employee No	Spouse Yes	Spouse No
Has any person applying for coverage been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)? Applicant need not disclose Human Immunodeficiency Virus (HIV) test results.	☐ Yes		☐ No	
Section 1 Dependent Children Health Questions				
1. **Within the past 5 years,** have any dependent(s) been treated for diabetes, heart disorder, or cancer (other than basal or squamous cell carcinoma of the skin)? Do any dependent(s) have cerebral palsy, cystic fibrosis or muscular dystrophy? If yes, please provide name(s) of children.	☐ Yes		☐ No	
Section 2 Employee and Spouse Health Questions	**Employee**		**Spouse**	
All employees and spouses applying for coverage must complete this section.	**Yes**	**No**	**Yes**	**No**
1. **Within the past 2 years,** have you used any controlled substances with the exception of those prescribed by a physician, received medical advice or sought treatment for drug or alcohol abuse, or pled guilty, pled no contest to or been convicted of a felony, misdemeanor, or a charge of operating a motor vehicle under the influence of drugs and/or alcohol?	☐	☐	☐	☐
2. **Within the past 2 years,** have you been prescribed three or more medications to be taken concurrently for high blood pressure?	☐	☐	☐	☐
3. **Within the past 5 years,** have you received medical advice or sought treatment for psychosis, internal cancer including melanoma, leukemia or Hodgkin's disease, ALS, muscular dystrophy, angina, or had heart surgery, heart attack or transient ischemic attack (TIA)?	☐	☐	☐	☐
4. **Within the past 10 years,** have you received medical advice or sought treatment for stroke, congestive heart failure, chronic lung disease including emphysema, diabetes treated with insulin or oral medications, hepatitis (other than type A), cirrhosis of the liver, chronic renal disease including hypertension or failure, systemic lupus or any connective tissue disease?	☐	☐	☐	☐
5. **Are you confined** to a wheelchair for reasons other than paraplegia?	☐	☐	☐	☐
Section 3 If your amount requiring underwriting is greater than $150,000 or you are applying for disability coverage, you must complete section 3. Otherwise, please sign and return application.	**Employee**		**Spouse**	
If you answer yes, please provide details requested in the box on the following page.	**Yes**	**No**	**Yes**	**No**
1. **Within the past 2 years,** have you flown as a student or private pilot, engaged in auto or boat racing, scuba diving, hang gliding, ballooning, flying ultralights, parachuting, mountain climbing or any similar sport or avocation?	☐	☐	☐	☐
2. **Have you ever** used barbiturates, amphetamines, cocaine, hallucinogenic drugs or any narcotics except as prescribed by a physician or been advised to reduce your consumption of alcohol or been treated, arrested in connection with alcohol, or been told to have counseling for the use of alcohol or drugs? If yes, provide the frequency of use and date last used, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital name, address and phone number, date of occurrence and driver's license number and issuing state of any arrest.	☐	☐	☐	☐
3. **Have you ever** pled guilty to, pled no contest to or been convicted of a felony or misdemeanor? If yes, list person's name, reason for arrest(s) and/or are you currently on probation.	☐	☐	☐	☐
4. **Within the past 2 years,** have you pled guilty to, pled no contest to, or been convicted of 3 or more speeding or other moving violations? If yes, list person's name, type of violation(s) and date(s), driver's license number and state of issue.	☐	☐	☐	☐
5. **Within the past 10 years,** have you received medical advice or sought treatment for epilepsy, nervous, emotional or mental disorder, paralysis, skin, bone, muscle, back, knee, neck or joint disorder, muscular or neurological disorders, Fibromyalgia, or Chronic Fatigue Syndrome. If yes, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital name, address and phone number.	☐	☐	☐	☐
6. **Within the past 7 years,** have you received medical advice or sought treatment for diabetes, asthma, lung or respiratory disorder, thyroid or other endocrine disease, heart or circulatory disorder, stroke (including TIA), chest pain, high blood pressure, cancer, gastro-intestinal, genitourinary, kidney or liver disease? If yes, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital name, address and phone number.	☐	☐	☐	☐
7. **Within the past 7 years,** have you consistently taken any over the counter medications, natural supplements other than vitamins, or received any therapeutic treatments? If yes, list all over the counter medications including any natural supplements, dosage, condition and date of onset. Please also list therapies and associated conditions and dates treatment received.	☐	☐	☐	☐
8. **Within the past 7 years,** have any medications been prescribed or have you consulted a medical professional for anything other than the conditions above, or are you currently experiencing any symptoms for which you haven't consulted a medical professional? If yes, provide details including symptoms, dates of occurrence, medications, treatment and medical professional's name, address and phone number.	☐	☐	☐	☐
9. **Do you have** any condition that prevents or limits activities or are you now pregnant? If yes, provide details including symptoms and describe the limitation(s). If pregnant, please provide expected delivery date.	☐	☐	☐	☐

Details for any "yes" answers

Question Number	Name	Detailed Description	Date	Duration	Treatment Received and Recovery	Names and Addresses of Physicians and Hospitals

Please attach additional sheet if you need additional space

Authorization

I authorize any person or organization to give Unum subsidiaries or their duly authorized representatives (Unum) any of the following:

- information about any injury or illness I have or I have had, including Acquired Immune Deficiency Syndrome (AIDS), mental illness or drug or alcohol abuse. This authorization excludes disclosure of Human Immunodeficiency Virus (HIV) test results. Such test results shall not be disclosed or published. I understand that nothing in this caveat will prohibit this authorization from including the fact that an applicant has Acquired Immune Deficiency Syndrome (AIDS).
- information about my medical history including any consultations, prescriptions, treatments or benefits.
- copies of all records that may be requested concerning me or my family members, and
- non-medical information about me or my family members.

The term person or organization, which is used above, means a physician or medical practitioner, a hospital, clinic or other medical treatment facility, any insurance or reinsurance company, insurance support or reporting agency, pharmacy, government agency, or employer.

I understand that the information obtained by use of this authorization will be used by Unum to determine eligibility for insurance and eligibility for benefits. Unum will not release any of the obtained information to any other person or organization except reinsuring companies or other persons or organizations performing services in connection with my application or claim.

I understand that this authorization shall be valid for two years from the date shown on the application and that a photographic copy of this authorization shall be as valid as the original. I understand that I have the right to revoke this authorization at any time except to the extent it has been relied on prior to written notice of revocation. I also understand that, if I revoke this authorization, such revocation may be a basis for denying insurance benefits. This authorization may be revoked by sending written notice to: Unum, Attn: Group Medical Underwriting, P.O. Box 9783, Portland ME 04104-5083.

The statements I have made on this application are true to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the group policy for which Evidence of Insurability is required. I have read and understand the Authorization, and I and my authorized representative have a right to receive a copy. I understand that failure to sign this Authorization may impair Unum's ability to process my application or evaluate a claim, and that this may be a basis for denying my application or claim for benefits.

Employee Signature ______________ Date ______ Spouse Signature ______________ Date ______

Child Signature (if 18 or older) ______________ Date ______

Unum's Commitment to Privacy

Unum understands your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

Collecting Information

We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations, and service providers.

Sharing Information

We share the types of NPI described above primarily with people who perform insurance, business, and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

Safeguarding Information

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

Access to Information

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

Correction of Information

If you believe NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

Coverage Decisions

If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

Contacting Us

For additional information about Unum's commitment to privacy, please visit www.Unum.com/privacy or www.coloniallife.com or write to: Privacy Officer, Unum, 2211 Congress Street, C467, Portland, Maine 04122. We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and The Paul Revere Variable Annuity Insurance Company.

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UNUM Term Life Enrollment Form Instructions

- Application type- check initial enrollment
- Enter employee social security number
- Enter gender
- Enter date of birth
- Enter hours worked per week
- Enter employee first name/middle initial/last name
- Enter employee street address/city/state/zip code
- Enter original date of hire
- Enter annual salary
- Enter occupation
- Answer tobacco products question

Coverage Elections:

- Enter amount of coverage selected for employee/spouse if enrolled/child if enrolled
- Enter employee signature/date/work phone/home phone

Beneficiary Information: Page 2

- Enter beneficiary name-last/first/middle initial
- Enter relationship to "You"
- Enter Benefit percentage
- Enter secondary beneficiary if desired

Note: Coverage amount for employee cannot be more than five times your earnings and must be in increments of $10,000. The maximum amount of coverage is $750,000.00.

Note: Spouse can be covered for up to $500,000 but cannot exceed the coverage amount of the employee and must be in increments of $5,000.

Note: Children can be covered up to $10,000 in increments of $2,000. One policy covers all children until their 19th birthday or until their 26th birthday if they are full-time students. Children age live birth to 6 months can be covered with a maximum of $1,000.

Note: The chart listed below explains the rules concerning the Evidence of Insurability portion of the insurance application. Any scenario that requires you to provide evidence of insurability is subject to UNUM underwriting. If you are subject to underwriting, you will receive a letter in the mail from UNUM stating whether your coverage was approved or denied.

	Enrollment Period	**Amount**	**Evidence of Insurability**	**Maximum amount of coverage**
EMPLOYEE	New Hire	Up to $200,000	No	$750,000
	Open enrollment (with current coverage)	Up to $200,000	No	$750,000
	Open enrollment (with current coverage)	Over $200,000	Yes	$750,000
	Open enrollment (no current coverage)	Any amount	Yes	$750,000
SPOUSE	New Hire	Up to $100,000	No	$500,000
	Open enrollment (with current coverage)	Up to $100,000	No	$500,000
	Open enrollment (with current coverage)	Over $100,000	Yes	$500,000
	Open enrollment (no current coverage)	Any amount	Yes	$500,000

CHILD	New Hire	Up to $10,000	No	$10,000
(7 months	Open enrollment (with current coverage)	Up to $10,000	No	$10,000
to age 19)	Open enrollment (no current coverage)	Up to $10,000	Yes	$10,000

CHILD	New Hire	Up to $1,000	No	$1,000
(live birth	Open enrollment (with current coverage)	Up to $1,000	No	$1,000
to 6 months)	Open enrollment (no current coverage)	Up to $1,000	Yes	$1,000

Please send completed form to the Human Resource Department via:

- In person: 245 Barr Ave, 150 McArthur Hall
- U. S. Mail: PO Box 9603, Mississippi State, MS 39762
- Fax: 662 325-0753
- Secure e-mail: contact your benefit specialist listed on the website: hrm.msstate.edu for information how to send secure email. To find your benefit specialist, view the home page, about us, our staff.
- Campus mailstop 9603