MISSISSIPPI STATE UNIVERSITY

GROUP INSURANCE ELECTION FORM
POLICY #574505

Name:		Social Security #:	
Billing Division:		Annual Salary:	
Effective Date:		Date of Birth:	
		Date of Hire:	

IMPORTANT! *This form must be returned to your employer prior to the end of the enrollment period.*

Re-enrollment period: If your form is not signed, dated and returned *before* the effective date of the plan year for which elections are being made, you will remain in the option(s) you had previously, or a plan most similar, although your cost may change. Any *Employee Paid* coverage left blank will result in a coverage amount equal to $0.

Long Term Disability (You pay the cost of your coverage):	
1)	**60% integrated benefit with 90 day elimination period:** 60% of monthly earnings to a maximum benefit of $10,000 per month.
2)	**25% non-integrated benefit with 90 day elimination period:** 25% of monthly earnings to a maximum benefit of $10,000 per month.
3)	**60% integrated benefit with 180 day elimination period:** 60% of monthly earnings to a maximum benefit of $10,000 per month.
4)	**Employees who elect 25% non-integrated benefit with 180 day elimination period:** 25% of monthly earnings to a maximum benefit of $10,000 per month.

I elect Option _____ **This coverage is only offered through post-tax deductions.***

*See next page to calculate your cost

Annual Enrollment/Change in Status: You can increase your coverage subject to the pre-existing condition provision.

See your Plan Administrator or refer to your enrollment materials for details about pre-existing condition limitations and/or exclusions.

Delayed Effective Date: Initial insurance, and any increased or additional insurance will be delayed if an employee is not in active employment because of an injury, sickness, leave of absence or temporary lay-off on the date that insurance would otherwise be effective.

Request for Signature: I understand that by signing and submitting this form to elect coverage, I am making a binding election for my benefits and am authorizing payroll deduction from my earnings. I understand that if I decline any of the above coverages, I cannot elect coverage until the next annual enrollment period.

_____ _____

Employee Signature Date

UNUM DISABILITY RATES Effective January 1, 2022

PREMIUMS ARE BASED ON AGE AND EARNINGS AND ADJUSTED ANNUALLY EFFECTIVE WITH THE MARCH PREMIUM, WHICH IS DEDUCTED FROM THE FEBRUARY PAYCHECKS.

****Employee Age Band**	**OPTION 1 RATE** 60% *INTEGRATED 90 DAY ELIMINATION	**OPTION 2 RATE** 25% *NON-INTEGRATED 90 DAY ELIMINATION	**OPTION 3 RATE** 60% *INTEGRATED 180 DAY ELIMINATION	**OPTION 4 RATE** 25% *NON-INTEGRATED 180 DAY ELIMINATION
< 25	0.24	0.20	0.21	0.16
25 – 29	0.26	0.21	0.22	0.17
30 – 34	0.30	0.24	0.25	0.19
35 – 39	0.39	0.31	0.33	0.25
40 – 44	0.56	0.43	0.45	0.34
45 – 49	0.79	0.61	0.63	0.49
50 – 54	1.09	0.82	0.90	0.66
55 – 59	1.47	1.12	1.16	0.90
60 – 64	1.58	1.21	1.23	0.98
65 – 69	1.77	1.35	1.38	1.09
70 +	2.86	2.21	1.98	1.78

ESTIMATED RATE CALCULATOR:

_____ ÷ 100 x _____ = $_____ ÷ _____ = _____

Annual Salary | Rate | Annual Cost | Pay Periods | Cost per Paycheck

****Employee Age Band range is the age you will be <u>WITHIN</u> the year, regardless of when your birthday falls within the year.**

FINAL COST MAY VARY FROM THE RATE CALCULATOR ABOVE. FINAL COST IS CALCULATED BASED ON PRIOR YEAR EARNINGS, IF APPLICABLE.

<u>MONTHLY BENEFIT:</u>

OPTION 1: EMPLOYEES WHO ELECT 60% *INTEGRATED BENEFIT WITH A 90 DAY ELIMINATION PERIOD
60% OF MONTHLY EARNINGS TO A MAXIMUM BENEFIT OF $10,000 PER MONTH

OPTION 2: EMPLOYEES WHO ELECT 25% *NON-INTEGRATED BENEFIT WITH A 90 DAY ELIMINATION PERIOD
25% OF MONTHLY EARNINGS TO A MAXIMUM BENEFIT OF $10,000 PER MONTH

OPTION 3: EMPLOYEES WHO ELECT 60% *INTEGRATED BENEFIT WITH A 180 DAY ELIMINATION PERIOD
60% OF MONTHLY EARNINGS TO A MAXIMUM BENEFIT OF $10,000 PER MONTH

OPTION 4: EMPLOYEES WHO ELECT 25% *NON-INTEGRATED BENEFIT WITH A 180 DAY ELIMINATION PERIOD
25% OF MONTHLY EARNINGS TO A MAXIMUM BENEFIT OF $10,000 PER MONTH

*INTEGRATED BENEFIT – UNUM SUBTRACTS ANY DEDUCTIBLE SOURCES OF INCOME FROM YOUR GROSS DISABILITY PAYMENT
*NON-INTEGRATED BENEFIT – UNUM DOES NOT SUBTRACT ANY DEDUCTIBLE SOURCES OF INCOME FROM YOUR GROSS DISABILITY PAYMENT

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.

1335361735174

Reset

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:

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 _____

1335361735174

1253294422

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.

UNUM Long Term Disability Enrollment Form Instructions

Employee information:

- Enter name
- Enter social security number
- Enter annual salary
- Enter date of birth
- Enter date of hire

You have 4 plans to select from

- Enter plan option- 1, 2, 3, or 4
- Select post-tax (this plan can only be a post-tax deduction)

Request for signature:

- Employee sign and date

Note: The evidence of insurability form should be completed if enrollment is outside of original hire date. If you enrolled during your original hire date period and are increasing your coverage during open enrollment you will need to complete an evidence of insurability form also. Both situations are subject to underwriting.

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