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

Florida State Court System Judges

Long Term Disability Insurance

Enrollment Form
Policy #24035

Employee Name:	**Florida Employee ID Number:**
Occupation:	**Location:**
Social Security Number: _ _ _ /_ _ /_ _ _ _	**Date of Birth: _ _ / _ _ / _ _ _ _**
Hours Worked/Week:	**Gender:**
Date of Hire: _ _ / _ _ / _ _ _ _	**Annual Salary**

Long Term Disability Insurance Rates per $100 of Covered Salary

**Age	50% of Salary	40% of Salary	25% of Salary
< 25 Years	0.40	0.33	0.25
25-29	0.45	0.40	0.28
30-34	0.55	0.45	0.33
35-39	0.73	0.60	0.43
40-44	1.02	0.88	0.58
45-49	1.45	1.20	0.80
50-54	2.00	1.68	1.08
55-59	2.68	2.20	1.45
60-64	4.10	3.40	2.20

*LTD rates are based on five-year increments. Rates increase as you age.

LTD Cost Calculation
To calculate the per-paycheck cost complete the calculations below. **NOTE: If your annual salary** *exceeds:*
50% Plan: $120,*000.00 use* $120,000.00 *as your annual salary in the calculation*
40% Plan: $150,000.00 *use* $150,000.*00 as your annual salary in the calculation*
25% Plan: $240,000.00 *use* $240,000.00 *as your annual salary in the calculation*

_____ / 100 X = _____ = _____ / 12 = _____
Annual Salary Cost per Year | Your Rate | Your Annual | Your Monthly Cost*

* Final cost may vary slightly due to rounding.

☐ Yes, I would like to participate. The percent of earning I wish to insure is:_____%.
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 provided, including all statements regarding exclusions.**

☐ 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: __ __ / __ __ / __ __ __ __

Please complete, sign and return form to Life Solutions, P.A., PO Box 15698, Tallahassee, FL 32317, or Life Solutions, P.A. Fax 904-647-1204.

****Age = Current year - Birth year**