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

For Florida State Court System
Employees Other than Judges

Long Term Disability Insurance

Enrollment Form
Policy #24033

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	0.66	0.57	0.40
25-29	0.75	0.63	0.43
30-34	0.95	0.80	0.57
35-39	1.23	1.03	0.66
40-44	1.74	1.40	0.95
45-49	2.40	2.00	1.32
50-54	3.29	2.72	1.75
55-59	4.29	3.52	2.23
60-64	4.63	5.21	3.29

*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 Your Rate Your Annual **Your Monthly**
Cost per Year **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**