Underwritten by:
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122
Florida College System Risk Management Consortium – Pensacola State College Div 0820
Policy # 69872 & 144981

Term Life and AD&D and Lifestyle 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 Retirement 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.**

Retiree Social Security Number | **Gender** M ☐ F ☐ | **Date of Birth (mm/dd/yyyy)** | **Hours Worked Per Week**

Retiree First Name | **M.I.** | **Last Name**

Retiree Street Address | **City** | **State** | **Zip Code**

Original Date of Retirement | **Original Date of Hire**

COVERAGE ELECTIONS: Please indicate below the coverage amounts you would like to select. Any coverage amounts left blank will result in a coverage amount of $0.

Check Option:	Life Insurance Coverage Options:	Monthly Premium
☐	**$5,000**	**$11.80**
☐	**$10,000***	**$23.60**
☐	**$25,000***	**$59.00**
☐	**$50,000***	**$118.00**

***Coverage amount(s) will reduce according to the following schedule:**

Age:	Insurance Amount Reduces to:
65	65% of the original amount
70	50% of original amount
75	25% of original amount

Coverage may not be increased after a reduction.

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 to pay the premium when my insurance becomes effective. I understand that my deduction amount will change if my coverage or costs change.

_____ __ __/__ __/__ __ __ _____ _____
Employee Signature *Date* *Work Phone* *Home Phone*