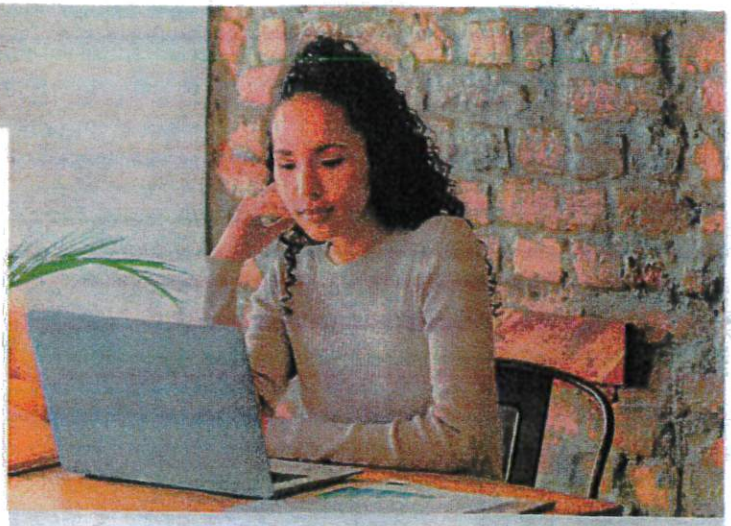
City of Dover

Learn about your benefits: Important information inside!

City of Dover

For you from Unum



Don't miss your chance: Get valuable financial protection now!

Your employer is offering coverage from Unum, a leading provider of employee benefits. You'll have the opportunity to get benefits that provide valuable financial protection now — and in the future.

City of Dover is offering you this coverage:

- Term Life Insurance

Your benefits package is an important part of your total compensation.

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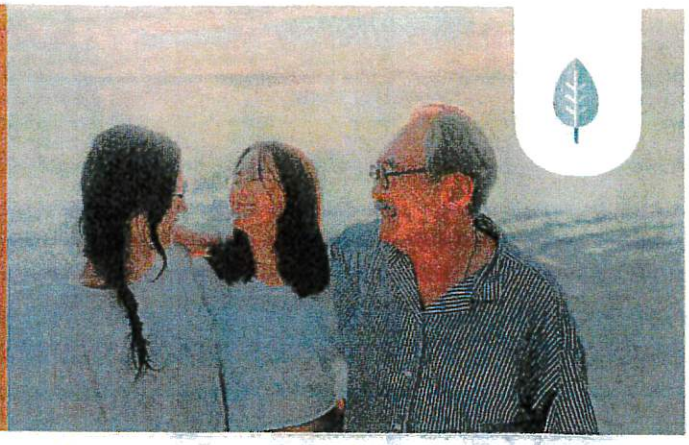
Term Life Insurance



How does it work?

You choose the amount of coverage that's right for you, and you keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

Why is this coverage so valuable?

If you previously purchased coverage, you can increase it up to $150,000 to meet your growing needs — with no medical underwriting.

What else is included?

A 'Living' Benefit — If you are diagnosed with a terminal illness with less than 12 months to live, you can request 50% of your life insurance benefit (up to $750,000) while you are still living. This amount will be taken out of the death benefit, and may be taxable. These benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements, and may be taxable. Recipients should consult their tax attorney or advisor before utilizing living benefit payments.

Waiver of premium — Your cost may be waived if you are totally disabled for a period of time.

Portability — You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

Who can get Term Life coverage?

If you are actively at work at least 20 hours per week, you may apply for coverage for:

You:	Choose from $10,000 to $500,000 in $10,000 increments, up to 5 times your earnings. If you previously purchased coverage, you can increase it up to $150,000 with no medical underwriting. If you previously declined coverage, you may have to answer some health questions.
Your spouse:	Get up to $500,000 of coverage in $5,000 increments. Spouse coverage cannot exceed 100% of the coverage amount you purchase for yourself. If you previously purchased coverage for your spouse, they can increase their coverage up to $25,000 with no medical underwriting, if eligible (see delayed effective date). If you previously declined spouse coverage, some health questions may be required.
Your children:	Get up to $10,000 of coverage in $2,000 increments if eligible (see delayed effective date). One policy covers all of your children until their 19th birthday – or until their 26th birthday if they are full-time students. The maximum benefit for children live birth to 6 months is $1,000.

How much coverage can I get?

Calculate your costs

1. Enter the coverage amount you want.
2. Divide by the amount shown.
3. Multiply by the rate. Use the rate table (at right) to find the rate based on age.

   (Choose the age you will be when your coverage becomes effective. See your plan administrator for your plan effective date. To determine your spouse rate, choose the age the employee will be when coverage becomes effective. See your plan administrator for your plan effective date.)
4. Enter your cost.

	1	2	3	4
Employee	$_____,000	÷ $10,000 = $_____	X $_____	= $_____
Spouse	$_____,000	÷ $5,000 = $_____	X $_____	= $_____
Child	$_____,000	÷ $2,000 = $_____	X $_____	= $_____
			Total cost	

	Employee monthly rate	Spouse monthly rate	Child monthly rate
Age	Per $10,000 of coverage	Per $5,000 of coverage	$0.080 per $2,000 of coverage
	Cost	Cost	
15-24	$0.760	$0.380	
25-29	$0.760	$0.380	
30-34	$0.860	$0.430	
35-39	$1.200	$0.600	
40-44	$1.970	$0.985	
45-49	$3.420	$1.710	
50-54	$5.730	$2.865	
55-59	$10.000	$5.000	
60-64	$10.520	$5.260	
65-69	$18.600	$9.300	
70-74	$32.200	$16.100	
75+	$51.560	$25.780	

Billed amount may vary slightly.
If you apply for coverage above the guaranteed issue amount, you may be subject to medical underwriting which may affect your ability to get the larger coverage amount. In order to purchase coverage for your dependents, you must buy coverage for yourself. Coverage amounts cannot exceed 100% of your coverage amounts.

Term Life Insurance

Actively at work

Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence or lay off.

An unmarried handicapped dependent child who becomes handicapped prior to the child's attainment age of 26 may be eligible for benefits. Please see your plan administrator for details on eligibility.

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Employees must be actively employed in the United States with the Employer to receive coverage. Employees must be insured under the plan for spouses and dependents to be eligible for coverage.

Exclusions and limitations

Life insurance benefits will not be paid for deaths caused by suicide occurring within 24 months after the effective date of coverage. The same applies for increased or additional benefits.

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Delayed Effective Date: If your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan.

Age Reduction

Coverage amounts for Life for you will reduce to 50% of the original amount when you reach age 70. Coverage may not be increased after a reduction.

Termination of coverage

Your coverage and your dependents' coverage under the policy ends on the earliest of:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are actively employed (unless coverage is continued due to a covered layoff, leave of absence, injury or sickness), as described in the certificate of coverage

In addition, coverage for any one dependent will end on the earliest of:

- The date your coverage under a plan ends
- The date your dependent ceases to be an eligible dependent
- For a spouse, the date of a divorce or annulment
- For dependents, the date of your death

Unum will provide coverage for a payable claim that occurs while you and your dependents are covered under the policy or plan.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form CFP-1 et al or contact your Unum representative.

Life Planning Financial & Legal Resources services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Unum complies with state civil union and domestic partner laws when applicable.

Underwritten by: Unum Life Insurance Company of America, Portland, Maine

Term Life Insurance Enrollment Form — Complete this form to enroll.

THIS IS NOT AN APPLICATION FOR INSURANCE: This is an enrollment form.

If you already have Unum coverage: Please be aware that any new benefit elections on this form will replace all existing elections. If you do not wish to make changes, you do not need to complete this form. Please contact your plan administrator for assistance.

City of Dover

Step 1: Complete your personal information

First name (please print) | M. Initial | Last name | 670530

Social Security Number | Gender | Date of birth (mm-dd-yyyy)

Street address | Apartment #

City | State | ZIP code

Original hire date | Annual salary $ | Occupation | Hours worked per week

Did you recently become eligible for benefits? (Y/N) ☐

Have you been rehired by your company? (Y/N) ☐

If so, please provide a date (mm-dd-yyyy)

Spouse first name (please print) | M. Initial | Last name

Date of birth (mm/dd/yyyy)

Step 2: Choose a coverage amount (you may use the worksheet to calculate your cost)

Remember: The coverage amounts you choose for your spouse cannot exceed 100% of the coverage amount you purchase for

Term Life Insurance

* If you previously purchased coverage and are now electing an amount over $150,000 for you or $25,000 for your spouse or if you were previously offered coverage during your initial eligibility period and declined to enroll, please complete Evidence of Insurability. Ask your Plan Administrator for details.

Employee	Spouse	Child
Coverage amount	Coverage amount	Coverage amount
☐ $10,000	☐ $5,000	☐ $2,000
☐ $30,000	☐ $10,000	☐ $4,000
☐ $50,000	☐ $15,000	☐ $6,000
☐ $70,000	☐ $20,000	☐ $8,000
☐ $100,000	☐ $25,000 *	☐ $10,000
☐ $150,000 *		

Want a different amount? ☐ $_____ ☐ $_____

DETACH AND RETURN THIS FORM

Continued on back >

Step 3: Name your beneficiaries

Your primary beneficiary is the person (or persons) who will receive the benefit payment from your life insurance policy if you were to die. The total percent of benefit must not exceed 100%.

First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit

Your secondary beneficiary would receive the benefit payment from your life insurance policy if a primary beneficiary is no longer living.

First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit

Step 4: Sign and certify

☐ I have read and understand the "Exclusions and limitations" listed on the Benefit Brochure. All statements are true to the best of my knowledge and belief. 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, or if I've made an error completing this form.

_____ ___ / ___ / _____

Signature Date

☐ No, I do not want coverage under the Term Life Insurance

I understand that if I elect coverage in the future, I may need to complete evidence of insurability relative to my health status in order for Unum to determine my eligibility for coverage.

_____ ___ / ___ / _____

Signature Date

Return forms to: plan administrator

Email: _____

Note: Your email will only be used if you requested a level of coverage above the guaranteed issue amount. You will receive a link to answer health questions online.

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Delayed Effective Date: If your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan. Exception: Infants are insured from live birth.

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.

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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.	☐	☐	☐	☐

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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 _____

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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.colonialife.com or write to: Privacy Officer, Unum, 2211 Congress Street, C476, 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.

Instructions for Enrolling In Universal Life Insurance
DURING YOUR OPEN ENROLLMENT PERIOD

1) Please review pricing sheets and choose a benefit amount for which you would like to enroll. It should be noted that there are different rates for non-tobacco and tobacco users. **Use the age you will be on the effective date.**

2) Please Complete Application

Applicant Information – Complete **all** personal information,

Dependent Information – Only if you applying for spouse and/or children coverage

Beneficiary - Complete

Universal Life – Benefit Selection

- Check the box for whom you intend to apply for - applicant (you), spouse, children.
- Write the Benefit Amount for which you would like to enroll in the "Universal Life Face Amount" column. Write the premium in the "Premium" column using the age you and dependents will be on the effective date.

Eligibility & Medical Questions

- Questions 1 & 2 must be completed for all applicants.
- If you are applying for greater than $150,000 for yourself or greater than $15,000 for your spouse, please contact the representative below.

Life Replacement – Please indicate if you are replacing other coverage (this is usually no)

Sign - Please sign & date where is says "applicant" on pages 3 and 4.

3) Please submit application to Human Resources representative.

Please note that if there is a discrepancy between the benefit amount and any premiums written in the "Premium Per Period column, the benefit amount selected will prevail.