



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

Virginia Community College System  
Long Term Disability Insurance  
Enrollment Form  
Policy #532552

Please complete this form in its entirety. Blank fields will cause significant delays in processing.

Employee Name: _____		Occupation: _____	
Social Security Number: _____ - _____ - _____		Date of Birth: ____/____/____	
Hours Worked/Week: _____		Gender: _____	Location: _____
Date of Hire: ____/____/____		Annual Salary: _____	

Long Term Disability Rates per \$100 of Covered Salary			
Age	50% Rate	40% Rate	25% Rate
< 25 Years	\$0.24	\$0.20	\$0.15
25 – 29	\$0.27	\$0.23	\$0.17
30 – 34	\$0.36	\$0.30	\$0.21
35 – 39	\$0.49	\$0.41	\$0.28
40 – 44	\$0.70	\$0.57	\$0.38
45 – 49	\$1.06	\$0.86	\$0.56
50 – 54	\$1.64	\$1.33	\$0.85
55 – 59	\$2.09	\$1.68	\$1.07
60 – 64	\$3.03	\$2.43	\$1.54
65 – 69	\$3.03	\$2.43	\$1.54
70 +	\$3.03	\$2.43	\$1.54

\*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:** \$xxx,xxx use \$xxx,xxx as your annual salary in the calculation  
**40% Plan:** \$xxx,xxx, use \$xxx,xxx as your annual salary in the calculation  
**25% Plan:** \$xxx,xxx use \$xxx,xxx as your annual salary in the calculation

_____ ÷ 100 = _____ X _____ = _____ ÷ 24 _____ = _____	_____ ÷ _____ = _____	_____ ÷ _____ = _____	_____ ÷ _____ = _____
Annual Salary	Your Rate	Your Annual Cost	# Paychecks per Year
			Cost per Paycheck*

\* Final cost may vary slightly due to rounding.

calculate the per-paycheck cost for this coverage, complete the calculations below.

**Note:** If your annual salary exceeds \_\_\_\_\_, use \_\_\_\_\_ as your annual salary in the calculation.

_____ ÷ 100 = _____ X _____ = _____ ÷ _____ = _____	_____ ÷ _____ = _____	_____ ÷ _____ = _____	_____ ÷ _____ = _____
Annual Salary	Your Rate	Annual Cost	# Paychecks per Year
			<b>Cost per Paycheck*</b>

\* Final cost may vary slightly due to rounding.

**Yes,** I would like to participate. 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 in the Plan Highlights, including all statements regarding exclusions and benefit amounts and offsets.**

**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: \_\_\_\_/\_\_\_\_/\_\_\_\_

Return Forms To: \_\_\_\_\_ By: \_\_\_\_/\_\_\_\_/\_\_\_\_

**This section to be completed by your employer:**

**Coverage Effective Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

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