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

MAINE MUNICIPAL EMPLOYEES HEALTH TRUST
Long Term Disability Insurance
Enrollment Form
Policy #588949

Employee Name:	Employer:	
Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ __	Date of Birth: ___ ___ / __ __ / ___ ___ ___ ___	
Hours Worked / Week:	Gender:	Location:
Date of Hire: ___ ___ / __ __ / ___ ___ ___ ___	Annual Salary:	
Address:		

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.** My signature verifies the accuracy of information contained on this form.

Employee Signature: ______________________________ Date: __________________________

Return Forms To: YOUR PLAN ADMINISTRATOR

This section to be completed by your employer: Coverage Effective Date: __ ___ / __ ___ / ___ ___ ___ ___