BASIC GROUP INSURANCE ENROLLMENT FORM

unum

HEALTHCARE POLICY &
BENEFIT SERVICES DIVISION
Please complete and return to your agency benefits staff

Please print legibly and complete this form in its entirety. Blank fields will cause delays in processing.

☐ **Open 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 employer with any questions.

Policyholder Name			**Policy No.**
State of Connecticut			938614
Employee ID	**Employee Social Security Number**	**Sex** ◯ **Male** ◯ **Female**	**Date of Birth** (mm/dd/yyyy)

Employee Legal First Name **M.I.** **Last Name**

Employee Street Address	**City**	**State**	**Zip Code**

Original Date of Hire	**Agency/Department ID**

Note: If you **DO NOT APPLY FOR** coverage during this open enrollment period, you will need to complete a Statement of Health form for all amounts of coverage.

Beneficiary Information: Please complete the beneficiary information below.

Request for Signature and Certification: I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy(ies) issued to the employer listed above. I understand that if I am not actively at work on the effective date of my coverage my insurance will not begin until the day I return to work.

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.

_____	_____	_____	_____
Employee Signature	Date	Mobile Phone	Work Phone

Beneficiary Information:

Name (last name, first, middle initial):	**Relation to You:**	**SSN:**	***Benefit %:**
If the beneficiary(ies) named above are not living, then pay:			

* Whole number values only.
Total must equal 100%

This is NOT an application for insurance – this is an Enrollment Form

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR Agency HR/Payroll Benefit Specialist.
Once processed, your agency will provide you a confirmation statement detailing your elected coverage.