

VOLUNTARY TERM LIFE AND AD&D

The MMIA Employee Benefits Program now offers a very competitively-priced Voluntary Term Life and AD&D program for our membership. The carrier is the same as the Basic Group Life and AD&D - UNUM Life Insurance Company. Voluntary Life can be offered without providing the Basic Life. Each employee can select an amount of life insurance benefits that best fits their circumstances and needs. Rates are based on the age of the covered person.

Employer Contribution: None; this program requires the premium be paid 100% by the employee.

Coverage Amount: The maximum amount an employee can apply for is 5x their salary up to the maximum of \$500,000. Employees may purchase benefits increments of \$5,000. Spouses may receive coverage, up to 100% of the employee amount, not to exceed \$500,000.

Guarantee Issue Amount: Up to \$200,000 for Employee; \$25,000 for spouse. Amounts in excess of the Guarantee Issue Amount will require a health statement.

Monthly Premium Rates per Thousand: Rates are age-banded for voluntary life and are shown below. AD&D rates are \$0.05 per thousand for all ages. Volumes can be selected separately for voluntary life and AD&D coverage.

Age Category	Voluntary Life Rate per Thousand Dollars	AD&D Rates per Thousand Dollars
15-34	\$0.08	\$0.05
35-39	\$0.11	
40-44	\$0.15	
45-49	\$0.26	
50-54	\$0.47	
55-59	\$0.72	
60-64	\$1.37	
65-69	\$2.17	
70 +	\$3.82	

Dependent Child Benefit: Employees can cover their child(ren) in increments of \$2,000, up to a maximum of \$10,000. The cost is the same for one child or multiple children. The rate is \$.16 per \$1,000 of coverage. Employee coverage is required. AD&D coverage is not available for children. *Eligible children must be less than 26 years of age.*

Benefit Descriptions:

Waiver of Premium:	Included
Portability	Available
Accelerated Benefits	Included
Travel Assistance	Included

Benefits are paid subject to the terms and conditions contained in the Group Insurance Policy.

Please share this information with your employees, whether or not they are covered by our group health benefits. All employees are eligible to participate in this program if minimum participation requirements are met.

For additional information or enrollment forms, contact the MMIA Employee Benefits Department at 1-800-635-3089.



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

MMIA

Term Life and AD&D Insurance Enrollment Form

Policy #217680/Div 001

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

Application Type:

- Initial 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.**

Employee Social Security Number Gender Date of Birth (mm/dd/yyyy) Hours Worked Per Week

- - M F / /

Employee First Name M.I. Last Name

Employee Street Address City State Zip Code

Original Date of Hire Annual Salary Occupation

/ / , ,

Exempt Non-Exempt

If date below unknown, consult with your Plan Administrator to complete:

- Date entered into an eligible class (ex: part time to full time) or
 - Rehire Date or
 - Date of promotion to an eligible class Spouse First Name (if coverage is selected) Spouse Date of Birth (mm/dd/yyyy)
- / / / /

Have any tobacco products been used in the last 12 months? You: Yes No Your Spouse: Yes No

COVERAGE ELECTIONS: Please indicate below the coverage amounts you would like to select for you and your spouse and/or child, if applicable. Dependent life and/or AD&D coverage amounts cannot exceed 100% of your life and/or AD&D coverage amounts. Any coverage amounts left blank will result in a coverage amount of \$0.

Amount of coverage selected for:

Life You: \$, , Your Spouse: \$, Your Child: \$,

AD&D You: \$, , Your Spouse: \$, Your Child: \$,

Note: If you have chosen Life coverage over the Guarantee Issue amount of \$200,000 for you or \$25,000 for your spouse, you will also need to complete an Evidence of Insurability form. The amount of Life coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective in accordance with the terms of the policy. If you DO NOT APPLY FOR coverage for you or your dependent(s) during your or their initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage. This applies to Life coverage only.

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 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.

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

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER

Beneficiary Information

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

Limitations and Exclusions

Delayed Effective Date:

Employee: Insurance will be delayed for employees not in active employment until the first of the month, coincident with or next, following the date they return to work. Regularly scheduled vacation time is considered active employment.

Dependents: Coverage for totally disabled dependents will be delayed until the first of the month, coincident with or next, following the date the individual is no longer disabled. This delay does not apply to newborn children while dependent insurance is in effect. "Totally disabled" means that, as a result of injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; or has a life threatening condition.

Exclusion for Suicide:

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

This Suicide Exclusion does not apply to Washington residents.

AD&D Benefit Exclusions

AD&D Benefits would not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders;
- Suicide, self-destruction while sane, or self-inflicted injury;
- War, declared or undeclared, or any act of war;
- Active participation in a riot;
- Attempt to commit or commission of a crime;
- The voluntary use of any prescription or non-prescription drug, poison, fume or any other chemical substance unless used according to the prescription or direction of the individual's doctor. This exclusion does not apply to the individual if the chemical substance is ethanol; or
- Intoxication. ("Intoxicated" means that the individual's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.)

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**BENEFICIARY DESIGNATION FORM
GROUP LIFE AND GROUP ACCIDENTAL DEATH
& DISMEMBERMENT INSURANCE**

Unum Life Insurance Company of America
Provident Life and Accident Insurance Company
The Paul Revere Life Insurance Company

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper. **Return the completed form to your employer.**

SECTION 1: Employee Information

Name (Last Name, Suffix, First Name, MI) _____ Social Security Number _____

Employer Name _____ Check the coverages listed below to which this beneficiary designation applies:
 Basic Life Supplemental Life AD&D All

SECTION 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

SECTION 3: Contingent Beneficiary (ies)

If all primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

SECTION 4: Signature

X _____
Employee Signature Date

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Important Information About Designation of Beneficiaries

Beneficiary Information

- **Primary Beneficiary(ies)** means the person(s) you choose to receive your life insurance benefits. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any primary beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining primary beneficiary(ies).
- **Contingent Beneficiary(ies)** means the person(s) you choose to receive your life insurance benefits only if all primary beneficiaries are disqualified or die before you. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any contingent beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining contingent beneficiary(ies).
- **Minor Beneficiary(ies)** – When you designate minors as beneficiaries, it is important to understand that insurance benefits may not be released to a minor child. They may, however, be paid to a court appointed guardian of the child's estate. The regulations governing minor beneficiaries vary by state.
- **Trust** – You may designate a valid trust as a beneficiary.

Types of Coverage Information

- **Basic Life** is life insurance provided by your employer for which they pay the premiums.
- **Supplemental Life** is life insurance elected by you for which you pay the premiums.
- **AD&D** is Accidental Death & Dismemberment coverage.
- If you wish to designate different beneficiaries for any of the above coverages, please complete a separate form.

General Information

- **Updates to Your Beneficiary Designation** – You can change your beneficiary designation at any time. You may wish to review your designation periodically.
- **Consult an Attorney** – This information is not intended to be relied on as legal advice. You may wish to get the assistance of an attorney to help ensure your beneficiary designation correctly reflects your intentions.