#

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

Term Life and AD&D Insurance Enrollment Form

EMPLOYEE NAME *(last name, first, middle initial)*		EMPLOYER NAME **BROADWAY SERVICES, INC.**	
EMPLOYEE ADDRESS *(street, city, state, zip code)*		LIFE INSURANCE POLICY # **573628**	
SEX ☐ *Male* ☐ *Female*	DATE OF EMPLOYMENT	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ANNUAL EARNINGS xxxxxxxxxxxxxxxxxxxxx	HOURS WORKED PER WEEK	OCCUPATION	

COVERAGE ELECTIONS

BASIC LIFE/BASIC AD&D	X 1 Times Salary (Note: Basic life insurance is employer funded). Please list beneficiaries below. (Section A)
SUPPLEMENTAL LIFE/ SUPPLEMENTAL AD&D	__ 1Times Salary ___ 2 Times Salary ____ Waive Coverage Please list beneficiaries below if different than those for Basic Life/AD&D (Section B)

Note: If you are enrolling late, you will also need to complete an Evidence of Insurability form. As a late enrollee, the amount selected will be subject to medical underwriting approval and will become effective on the first of the month coincident with or next following the date Unum approves your Evidence of Insurability form. This applies to Life coverage only

A. Primary Beneficiary Designation For Basic Life & AD&D

FULL NAME (LAST, FIRST, MIDDLE INITIAL)	**RELATIONSHIP**	**DATE OF BIRTH**	**ADDRESS (STREET, CITY, STATE, ZIP)**	**SHARE %**
Payment will be made in equal shares or all to the survivor unless otherwise indicated				**100%**

IF THE BENEFICIARY(IES) NAMED ABOVE ARE NOT LIVING, THEN PAY:
Contingent Beneficiary Designation For Basic Life & AD&D

FULL NAME (LAST, FIRST, MIDDLE INITIAL)	**RELATIONSHIP**	**DATE OF BIRTH**	**ADDRESS (STREET, CITY, STATE, ZIP)**	**SHARE %**
Payment will be made in equal shares or all to the survivor unless otherwise indicated				**100%**

B. Primary Beneficiary Designation For Supplemental Life & AD&D

FULL NAME (LAST, FIRST, MIDDLE INITIAL)	**RELATIONSHIP**	**DATE OF BIRTH**	**ADDRESS (STREET, CITY, STATE, ZIP)**	**SHARE %**
Payment will be made in equal shares or all to the survivor unless otherwise indicated				**100%**

IF THE BENEFICIARY(IES) NAMED ABOVE ARE NOT LIVING, THEN PAY:
Contingent Beneficiary Designation For Supplemental Life & AD&D

FULL NAME (LAST, FIRST, MIDDLE INITIAL)	**RELATIONSHIP**	**DATE OF BIRTH**	**ADDRESS (STREET, CITY, STATE, ZIP)**	**SHARE %**
Payment will be made in equal shares or all to the survivor unless otherwise indicated				**100%**

REQUEST FOR SIGNATURE *Please read the back of this form carefully before signing below.*

CERTIFICATION: 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 at my request. I have read and understand the INFORMATION ABOUT DELAYED EFFECTIVE DATES and EXCLUSIONS on the reverse side of this enrollment form. If I elect Supplemental Life coverage, 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*

LIMITATIONS AND EXCLUSIONS

DELAYED EFFECTIVE DATE

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.

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 of insurance; 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.

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
- Operating any motorized vehicle while intoxicated. ("Intoxicated" means that the individual's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state where the accident occurred.)
- Commission of a crime for which you or your dependent has been convicted.
- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from it while it is being used for test or experimental purposes; you or you dependent is operating, learning to operate, or serving as a member of the crew; it is being operated by, or for, or under the direction of any military authority. (This exclusion does not apply to transport type aircraft operated by the Military Airlift Command of the United States; or similar air transport service of any other country.)
- Travel or flight in any aircraft or device for aerial navigation, including boarding or alighting from it, owned or leased by, or on behalf of your employer.
- Bacterial infection. This exclusion does not apply to you or your dependent when the bacterial infection is due directly to an accidental cut or wound.
- Experimental medical procedures or investigational medical procedures.