



Underwritten by:
Unum Life Insurance Company of America

**SHORT TERM & LONG TERM DISABILITY
INCOME PROTECTION INSURANCE
ENROLLMENT FORM**

for

MTA Benefits, Inc.

Policy#: 570975



ENROLLER: _____

Applicant Name: _____

Social Security #: _____

Address: _____

Date of MTA Membership: ___ / ___ / _____

MTA Membership Number: _____

School District/Name: _____

Date of Hire: ___ / ___ / _____

Payroll Frequency _____ (10, 12, 24, 26, 52)

Date of Birth: ___ / ___ / _____

Home Phone: (____) _____

Gender: ___ Male ___ Female

Work Phone: (____) _____

Annual Earnings: \$ _____

E-mail Address: _____

Hours Worked per Week: _____

*You may choose from 2 Income Protection Plans: Short Term Disability and/or Long Term Disability
Please check the option(s) you wish to choose:*

STD: 60% of your weekly salary to a maximum weekly benefit of \$1,150

Cost per pay period \$ _____ (see reverse side of this page for calculation instructions)

LTD: 60% of your monthly salary to a maximum monthly benefit of \$5,000

Cost per pay period \$ _____ (see reverse side of this page for calculation instructions)

**For rates, please refer to the rating grid on the reverse side of this page*

Yes, I would like to participate in the plan(s) I checked above. 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 that my premium is based on my current salary and will increase as my salary increases. I understand a confirmation of coverage statement will be provided to me prior to the policy effective date.

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 Enrollment Kit, including all statements regarding exclusions.**

Yes, I am interested, please have an MTA Benefits representative contact me at _____ (Phone#).

Applicant Signature: _____ **Date:** ___ / ___ / _____

**Return this form using the enclosed envelope or mail to:
MTA Benefits, c/oVista Financial Group, P.O. Box 447, Grafton, MA 01519
1-877-401-4083
mta@vistafg.com**

~ OR ~

Fax to 1-850-521-0111

| Age Band* | STD | LTD |
|-----------|------|------|
| < 25 | .52 | .28 |
| 25 – 29 | .54 | .31 |
| 30 – 34 | .56 | .33 |
| 35 – 39 | .63 | .43 |
| 40 – 44 | .81 | .56 |
| 45 – 49 | .96 | .74 |
| 50 – 54 | 1.12 | 1.07 |
| 55 – 59 | 1.51 | 1.27 |
| 60 – 64 | 1.93 | 1.39 |
| 65 – 69 | 2.21 | 1.56 |
| 70+ | 2.21 | 2.20 |

**Your age as of the next July 1st*

To calculate your per-paycheck cost for the STD coverage, complete the calculation below:

Annual Salary _____ ÷ 52 = Weekly Salary \$ _____ x 60 % = \$ _____ Weekly Benefit

Weekly Benefit \$ _____ ÷ 10 = \$ _____ X Rate _____ = \$ _____ Monthly Cost

Monthly Cost \$ _____ X 12 = Annual Cost \$ _____ ÷ _____ # of Paycycles = _____ Cost Per Pay Period**

To calculate your per-paycheck cost for the LTD coverage, complete the calculation below:

Annual Salary _____ ÷ 100 = _____ x _____ (Rate) = Your Annual Cost (\$) _____

Your Annual Cost (\$) _____ ÷ _____ (# of Paycycles per Year) = (\$) _____ Cost Per Pay Period **

For example, if you were 45 years old, earned \$45,000 annually, and were paid in 26 paycycles per year, your calculation would be:

STD: \$45,000 (Annual Salary) ÷ 52 = 865.38 x 60% = \$519.23 Your Weekly Benefit
 \$519.23 (Your Weekly Benefit) ÷ 10 = \$51.92 X .96 (Rate) = \$49.85 Monthly Cost
 \$49.85 (Monthly Cost) X 12 = \$598.20 (Annual Cost) ÷ 26 (# of paycycles) = \$23.01 per Pay Period**

LTD: \$45,000 (Annual Salary) ÷ 100 = 450 x .74 (Rate) = \$333.00 (Your Annual Cost)
 \$333.00 ÷ 26 (# of Paycycles Per Year) = \$12.81 Per Pay Period**

**** Final cost may vary slightly due to rounding differences. Your premium is based on your current salary and will increase as your salary increases.**