*Underwritten by:*
Unum Life Insurance Company of America

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

for

## MTA Benefits, Inc.

**Policy#: 570975**

**BENEFIT COUNSELOR:_____**

**Eff Date: _____** **Monthly Cost: LTD _____ STD _____**

For internal use

**Member Name:_____** **Social Security #:_____**

**Date of MTA Membership: __ __ / __ __ / __ __ __ __**

**Address: _____** **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 two 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 $1,750

☐ 14 Day Elimination Period

☐ 30 Day Elimination Period

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 $7,500

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 and that I may obtain the Plan Certificate at any time on *www.mtabenefits.com* under Disability Insurance.

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#).**

**Member Signature: _____ Date: __ __/__ __/__ __ __ _**

**Return this form using the enclosed envelope or mail to:**
**MTA Disability, c/oVista Financial Group, 100 Cummings Center Ste. 363C Beverly, MA 01915**
**1.877.401.4083**
**mta@vistafg.com**
**~ OR ~**
**Fax to 1.850.521.0111**

| Age Band* | Enhanced STD Rate – 14 Day Elimination | Standard STD Rate – 30 Day Elimination | LTD Rate |
|---|---|---|---|
| < 25 | $0.88 | $0.58 | $0.33 |
| 25 – 29 | $0.91 | $0.60 | $0.36 |
| 30 – 34 | $0.94 | $0.62 | $0.40 |
| 35 – 39 | $1.06 | $0.70 | $0.51 |
| 40 – 44 | $1.36 | $0.90 | $0.66 |
| 45 – 49 | $1.62 | $1.07 | $0.88 |
| 50 – 54 | $1.86 | $1.23 | $1.27 |
| 55 – 59 | $2.55 | $1.68 | $1.51 |
| 60 – 64 | $3.23 | $2.14 | $1.65 |
| 65 – 69 | $3.70 | $2.45 | $1.85 |
| 70+ | $3.70 | $2.45 | $2.61 |

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

***To calculate your per-paycheck cost for the STD coverage, first choose your elimination period to determine your rate. Then 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 are age 45, earn $45,000 annually, and are paid in 26 paycycles per year, your calculation would be as follows:***

**STD:** $45,000 (Annual Salary) ÷ 52 = 865.38 x 60% = $519.23 Your Weekly Benefit
$519.23 (Your Weekly Benefit) ÷ 10 = $51.92 x 1.07 (Rate) = $55.55 Monthly Cost
$55.55 (Monthly Cost) x12 = $666.60 (Annual Cost) ÷ 26 (# of Paycycles) = $25.64 Per Pay Period**

**LTD:** $45,000 (Annual Salary) ÷ 100 = 450 x .88 (Rate) = $396.00 (Your Annual Cost)
$396.00 ÷ 26 (# of Paycycles Per Year) = $15.23 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.*