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: _____

Member Name:_____

Address: _____

_____

_____

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

Home Phone: (____) _____

Work Phone: (____) _____

E-mail Address: _____

Social Security #:_____

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

MTA Membership Number: _____

School District/Name: _____

Date of Hire: __ __ / __ __ / __ __ __ __

Date of Birth: __ __ / __ __ / __ __ __ __

Gender: ___ **Male** ___ **Female**

Annual Earnings: $_____

Hours Worked per Week: _____

You may choose from two Income Protection Plans: Short Term Disability and/or Long Term Disabilit.y
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 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, P.O. Box 447, Grafton, MA 01519
1.877.401.4083
mta@vistafg.com

~ OR ~

Fax to 1.850.521.0111

Age Band*	STD Rate	LTD Rate
< 25	$0.58	$0.33
25 – 29	0.60	0.36
30 – 34	0.62	0.40
35 – 39	0.70	0.51
40 – 44	0.90	0.66
45 – 49	1.07	0.88
50 – 54	1.23	1.27
55 – 59	1.68	1.51
60 – 64	2.14	1.65
65 – 69	2.45	1.85
70+	2.45	2.61

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 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 .82 (Rate) = $369.00 (Your Annual Cost)
$369.00 ÷ 26 (# of Paycycles Per Year) = $14.19 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.*