



Underwritten by:  
 Unum Life Insurance Company of America  
 2211 Congress St., Portland, Maine 04122

**Life Insurance Enrollment Form**

*for*

**Trustees of Phillips Academy**

**Policy # 148108**

**For Employees and Their Eligible Spouses**

|                                 |   |
|---------------------------------|---|
| Employee Name:                  | Date of Birth: ___ / ___ / _____        |
| Hours Worked/Week:              | Gender:                                 |
| Date of Hire: ___ / ___ / _____ | Annual Salary:                          |
| Spouse Name:                    | Spouse Date of Birth: ___ / ___ / _____ |

**BASIC LIFE AND AD&D BENEFITS - EMPLOYER PAID**

**Employee:** 1x Annual Earnings to a maximum of \$50,000

**ADDITIONAL LIFE AND AD&D BENEFITS – EMPLOYEE PAID**

**Employee Life and AD&D:** 1 or 2x Annual Earnings to a maximum of \$350,000  
 (Basic and Additional Combined)

**Spouse Life and AD&D:** Option 1: \$10,000  
 Option 2: 50% of the Employee’s Life Insurance Benefit to a maximum of \$25,000

*Note: AD&D is automatically purchased with any additional life election.*

**ADDITIONAL LIFE AND AD&D RATES**

| Age Band | Employee LIFE/AD&D rate per \$1,000 | Spouse LIFE/AD&D rate per \$1,000 |
|----------|-------------------------------------|-----------------------------------|
| <30      | \$0.091                             | \$0.110                           |
| 30-34    | \$0.111                             | \$0.130                           |
| 35-39    | \$0.121                             | \$0.170                           |
| 40-44    | \$0.131                             | \$0.260                           |
| 45-49    | \$0.191                             | \$0.390                           |
| 50-54    | \$0.310                             | \$0.670                           |
| 55-59    | \$0.492                             | \$1.060                           |
| 60-64    | \$0.765                             | \$1.280                           |
| 65-69    | \$1.031                             | \$2.190                           |
| 70-74    | \$2.795                             | \$5.830                           |



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**COVERAGE ELECTIONS**

AMOUNT OF COVERAGE SELECTED FOR:

**LIFE/AD&D:**                      You: \$ \_\_\_\_\_                      YOUR SPOUSE: \$ \_\_\_\_\_

| Life and AD&D Cost Calculation   |                                    |                               |                           |                                   |
|--|------------------------------------|-------------------------------|---------------------------|-----------------------------------|
| To calculate your or your spouse's monthly cost for this coverage, complete the calculations below (based on insurance age). |                                    |                               |                           |                                   |
| <b>Employee</b>  | <b>Coverage Amount</b><br>\$ _____ | <b>Increment</b><br>÷ \$1,000 | <b>Rate</b><br>X \$ _____ | <b>Monthly Cost</b><br>= \$ _____ |
| <b>Spouse</b>  | <b>Coverage Amount</b><br>\$ _____ | <b>Increment</b><br>÷ \$1,000 | <b>Rate</b><br>X \$ _____ | <b>Monthly Cost</b><br>= \$ _____ |

**Beneficiary Information**                      *Designate your beneficiary(ies) below.*

| NAME OF BENEFICIARY<br>(last name, first, middle initial) | SOCIAL SECURITY No. | RELATION TO YOU | BENEFIT % |
|---|---------------------|-----------------|-----------|
|   |                     |                 |           |
|   |                     |                 |           |

| IF THE BENEFICIARY(IES) NAMED ABOVE ARE NOT LIVING, THEN PAY: |  |  |  |
|---|--|--|--|
|   |  |  |  |
|   |  |  |  |

**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 covered in the highlight sheets provided to me. 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**