UNUMPROVIDENT®

ENROLLMENT/REFUSAL REQUEST FORM

THE PAUL REVERE LIFE INSURANCE COMPANY
18 Chestnut Street, Worcester, MA 01608-1528

FOR PAUL REVERE USE ONLY DATE RECEIVED:	
MEMBER NUMBER	OCC CODE:
EFFECTIVE/RECORDED DATE:	

☐ NEW EMPLOYEE	☐ PREVIOUSLY INELIGIBLE EFF DATE _____ REASON:	☐ REINSTATED EMPLOYEE DATE REHIRED _____	☐ PART-TIME TO FULL TIME DATE REHIRED _____	☐ CHANGE OF STATUS

GROUP NO.	ACCT.	CLASS	EMPLOYER NAME AND ADDRESS

EMPLOYEE NAME: (LEAVE SPACE BETWEEN LAST MI FIRST)

NO. OF HOURS WORKED PER WEEK	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE # CHILDREN ____	SOCIAL SECURITY NO.	DATE HIRED FULL TIME	DATE OF BIRTH	☐ UNION ☐ NON-UNION

BASIC EARNINGS (Refer to your Plan Administrator for proper Earnings definition.)
$_____ + $_____ = $_____ = $_____
BASE EARNINGS | COMMISSIONS (if applicable) | BONUS (if applicable) | TOTAL EARNINGS

☐ HOURLY ☐ MONTHLY
☐ WEEKLY ☐ SEMI-MONTHLY
☐ BI-WEEKLY ☐ ANNUALLY

☐ SALARIED ☐ EXEMPT
☐ HOURLY ☐ NON-EXEMPT
☐ COMMISSIONED

OCCUPATION: (List Job Title & Major Responsibilities)	STATE YOU LIVE IN	ZIP CODE

EMPLOYEE COVERAGE REQUESTED Select or refuse only the coverage(s) included in your Employer's policy or certificate

	Request	Refuse
Long Term Disability (LTD)	☐	☐
Core LTD + Buy-Up LTD	☐	☐
Voluntary LTD	☐	☐
Short Term Disability (STD)	☐	☐
Core STD + Buy-Up STD	☐	☐
Employee Basic Life and	☐	☐
Accidental Death & Dismemberment (AD&D)	☐	☐
Employee Basic Life	☐	☐
Basic Dependent Life	☐	☐
Employee Supplemental Life	☐ $_____	☐

	Request	Refuse
Employee Supplemental AD&D	☐ $_____	☐
Supplemental Dependent Life or Life/AD&D Spouse	☐ $_____	☐
Spouse Date of Birth: _____ (No AD&D) Child	☐ $_____	☐
Voluntary Life	☐ $_____	☐
Voluntary Dependent Life	☐	☐
Voluntary AD&D	☐ $_____	☐
Voluntary AD&D Family Plan	☐	☐

BENEFICIARY DESIGNATIONS

PRIMARY – FIRST	MI	LAST Equally or survivor(s), if any	RELATIONSHIP	DATE OF BIRTH
BENEFICIARY ADDRESS (NO., STREET, CITY, STATE, ZIP CODE) REQUIRED FOR FLORIDA AND VIRGINIA RESIDENTS				SOC. SEC. NO.
SECONDARY – FIRST	MI	LAST Equally or survivor(s), if any	RELATIONSHIP	DATE OF BIRTH
BENEFICIARY ADDRESS (NO., STREET, CITY, STATE, ZIP CODE) REQUIRED FOR FLORIDA AND VIRGINIA RESIDENTS				SOC. SEC. NO.

REQUEST FOR CHANGE

☐ 1. PLEASE ADD DEPENDENT BENEFITS TO MY GROUP INSURANCE COVERAGE DATE I ACQUIRED ELIGIBLE DEPENDENTS _____
REASON: ☐ MARRIAGE ☐ BIRTH OF SON/DAUGHTER ☐ OTHER (EXPLAIN):

☐ 2. PLEASE CHANGE MY BENEFICIARY TO: FIRST	MI	LAST Equally or survivor(s), if any	RELATIONSHIP	DATE OF BIRTH
BENEFICIARY ADDRESS (NO., STREET, CITY, STATE, ZIP CODE) REQUIRED FOR FLORIDA AND VIRGINIA RESIDENTS			SOC. SEC. NO.	WITNESSED:

☐ 3. PLEASE CHANGE MY NAME
FROM: TO:

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION SHOWN ABOVE, INCLUDING THE REFUSAL SECTION, IS TRUE AND COMPLETE AND MY SIGNING BELOW INDICATES THAT I UNDERSTAND ALL INFORMATION GIVEN IS SUBJECT TO VERIFICATION. **I UNDERSTAND THAT COVERAGE UNDER THE GROUP POLICY WILL NOT GO INTO EFFECT UNLESS I AM ACTIVELY AT WORK ON OR AFTER THE PROPOSED EFFECTIVE DATE OF COVERAGE.** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

SIGNATURE OF EMPLOYEE	DATE

ENROLLMENT REFUSAL REQUEST FORM

TO THE EMPLOYEE

Regardless of whether or not you contribute to the payment of the insurance, you are required to complete this Enrollment/Refusal Request Form. Be sure you indicate your acceptance or refusal for *each* benefit available to you under the group policy.

Type or print clearly in ball point pen. Date, sign and return your form to your employer within 31 days of the date you become eligible for insurance. Group Insurance will become effective as described in the group policy. Employee insurance will not go into effect unless you are actively at work on the proposed effective date of coverage. Dependents insurance does not begin if the dependent is totally disabled or confined at home, in a hospital or elsewhere.

Those benefits 100% paid by your Employer cannot be refused.

If you contribute to the cost of any benefit, you may refuse that benefit. However, if you refuse coverage now and later request to add that coverage late entrant penalties will apply. For benefits, you will have to furnish, at your own expense, evidence of insurability satisfactory to The Paul Revere for each person applying late.

If you refuse coverage for yourself, you automatically refuse that coverage for any dependents.

You must complete Form G-EVIAP-PA instead of this form G-2508-PA if you are

- applying for a contributory benefit more than 31 days after the date you became eligible for that benefit; or
- you are applying for a contributory benefit that you initially refused; or
- if evidence of insurability is a provision of the group policy

Your Group Insurance Administrator can provide you with Form G-EVIAPP-PA for your completion.

NOTE: A person may not be insured under both Employee and Dependents Life insurance and/or Employee and Dependents Voluntary Accidental Death & Dismemberment Insurance. A dependent child may not be insured for Dependent Life and/or Voluntary AD&D as a dependent of more than one employee.

BENEFICIARY DESIGNATION:

The beneficiary section should only be completed if the Group Policy includes Employee Life Insurance or Voluntary Accidental Death & Dismemberment Insurance. If more than one beneficiary is designated, settlement will be made in equal shares to each of the designated beneficiaries that survive you, unless you designate a specific percentage for each beneficiary.

The employee is automatically the beneficiary for benefits under the Dependent Life Insurance.

TO THE EMPLOYER

1. Be sure to enter your group number and account number in the appropriate boxes.
2. Verify that the employee has completed, dated and signed his/her form.
3. Return the last copy to the employee for his/her records.
4. Retain the second copy for your records.
5. If any benefit is based on earnings, refer to your Group Policy for the definition of Earnings that applies.
6. Send the original copy of this form to The Paul Revere Life Insurance Company, Customer Account Services, P.O. Box 15123, Worcester, MA 01615-0123.

TO THE EMPLOYEE AND THE EMPLOYER

PLEASE READ THIS FORM. OMISSIONS OR MISSTATEMENTS MAY CAUSE AN OTHERWISE VALID CLAIM TO BE DENIED. INSURANCE WILL BE ISSUED ON THE BASIS THAT ALL THE INFORMATION SHOWN IS CORRECT AND TRUE.