Underwritten by:
Unum Life Insurance Company of America

SHORT TERM & LONG TERM DISABILITY INCOME PROTECTION INSURANCE ENROLLMENT FORM

for

MTA Members

Policy#: 570975

BENEFIT COUNSELOR:_____

Eff Date: 07/01/2021 **Monthly Cost: LTD _____ STD _____**

For internal use

Member Name: _____

Address: _____

_____

_____

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

Home Phone: (____) _____

Mobile Phone: (____) _____

Email 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: _____

Short Term Disability and 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 ☐ Enroll ☐ Waive

☐ 14-Day Elimination Period

☐ 30-Day Elimination Period

Cost per pay period $_____ (see reverse for rates and calculation instructions)

LTD: ☐ 60% of your monthly salary to a maximum monthly benefit of $7,500 ☐ Enroll ☐ Waive

Cost per pay period $_____ (see reverse for rates and calculation instructions)

☐ **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.**

Other plans available:

☐ **Accident Insurance (AI)** ☐ **Critical Illness Insurance (CI)**

I'm interested in AI and/or CI, please have an MTA Benefits representative call me at _____ (Ph #).

Member Signature: _____ Date: __ __/__ __/__ __ __ __

Return this form using the enclosed envelope or mail to:

MTA Disability, c/o Vista Financial Group, P.O. Box 447, Grafton, MA 01519

Or, fax to 1.850.521.0111

Questions? Call 1.877.401.4083 or email *mta@vistafg.com*

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 **July 1st 2021*

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 Pay cycles = _____ 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 ($) _____ ÷ _____ (# of Pay cycles per Year) = ($) _____ Cost Per Pay Period **

For example, if you are age 35, earn $65,000 annually, and are paid in 26 Pay cycles per year, your calculation would be as follows:

STD: $65,000 (Annual Salary) ÷ 52 = $1,250 x 60% = $750 Your Weekly Benefit

$750 (Your Weekly Benefit) ÷ 10 = $75 x .70 (Rate) = $52.50 Monthly Cost

$52.50 (Monthly Cost) x 12 = $630 (Annual Cost) ÷ 26 (# of Pay cycles) = $24.23 Per Pay Period**

LTD: $65,000 (Annual Salary) ÷ 100 = 650 x .51 (Rate) = $331.50 (Your Annual Cost)

$331.50 ÷ 26 (# of Pay cycles Per Year) = $12.75 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.*