



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: _____

Monthly Cost: LTD _____ STD _____

For internal use

Member Name: _____

Social Security #: _____

Address: _____

Date of MTA Membership: ___ / ___ / _____

MTA Membership Number: _____

School District/Name: _____

Date of Hire: ___ / ___ / _____

Date of Birth: ___ / ___ / _____

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

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 for rates and calculation instructions)

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

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.**

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/o Vista 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*	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 35, earn \$65,000 annually, and are paid in 26 paycycles 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 Paycycles) = \$24.23 Per Pay Period**

LTD: \$65,000 (Annual Salary) ÷ 100 = 650 x .51 (Rate) = \$331.50 (Your Annual Cost)
 \$331.50 ÷ 26 (# of Paycycles 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.*

02-01-2020