Underwritten by:
Unum Life Insurance Company of America

SHORT TERM & LONG TERM DISABILITY INCOME PROTECTION INSURANCE ENROLLMENT FORM

for

MTA Benefits, Inc.

Policy#: 570975

MTA BENEFITS Massachusetts Teachers Association

BENEFIT COUNSELOR:_____

Eff Date: _____ **Monthly Cost: LTD _____ STD _____**

For internal use

Member Name:_____ **Social Security #:_____**

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

Address: _____ **MTA Membership Number: _____**

_____ **School District/Name: _____**

_____ **Date of Hire:** __ __ / __ __ / __ __ __ __

Payroll Frequency _____ (10, 12, 24, 26, 52) **Date of Birth:** __ __ / __ __ / __ __ __ __

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 side of this page for calculation instructions)

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

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, 100 Cummings Center Ste. 363C Beverly, MA 01915
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 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 .88 (Rate) = $396.00 (Your Annual Cost)
$396.00 ÷ 26 (# of Paycycles Per Year) = $15.23 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.*