



Underwritten by:
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

Term Life and AD&D Insurance Enrollment Form

FOR EMPLOYEE TO COMPLETE

GROUP PLAN #: 595105 DIVISION: 0001

EMPLOYEE NAME (<i>last name, first, middle initial</i>)		EMPLOYER NAME JAG PROFESSIONAL SERVICES, INC.	
EMPLOYEE ADDRESS (<i>street, city, state, zip code</i>)		SOCIAL SECURITY NUMBER	DATE OF BIRTH
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF EMPLOYMENT	HOURS WORKED PER WEEK	OCCUPATION
ANNUAL EARNINGS	HAVE YOU USED ANY TOBACCO PRODUCTS IN THE LAST 12 MONTHS? <input type="checkbox"/> Yes <input type="checkbox"/> No		

COVERAGE ELECTIONS

AMOUNT OF COVERAGE SELECTED FOR:

Life You: \$ _____ YOUR SPOUSE: \$ _____ EACH CHILD: \$ _____
AD&D \$ _____ \$ _____ \$ _____

NOTE: If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete an Evidence of Insurability form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective on the first of the month coincident with or next following the date UnumProvident approves your Evidence of Insurability form. If you DO NOT APPLY FOR coverage for you or your dependent(s) during your initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage. This applies to Life coverage only.

Spouse Information (*complete only if spouse coverage is selected*)

NAME:	SOCIAL SECURITY #:	DATE OF BIRTH:
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Beneficiary Information

NAME (<i>last name, first, middle initial</i>):	RELATION TO YOU:	BENEFIT %:
IF THE BENEFICIARY(IES) NAMED ABOVE ARE NOT LIVING, THEN PAY:		

REQUEST FOR SIGNATURE Please read the back of this form carefully before signing below.

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 on the reverse side of this enrollment form. 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

LIMITATIONS AND EXCLUSIONS

DELAYED EFFECTIVE DATE

Employee:

Insurance will be delayed for employees not in active employment until the first of the month, coincident with or next, following the date they return to work. Regularly scheduled vacation time is considered active employment.

Dependents:

Coverage for totally disabled dependents will be delayed until the first of the month, coincident with or next, following the date the individual is no longer totally disabled. This delay does not apply to newborn children while dependent insurance is in effect. "Totally disabled" means that, as a result of an injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; or has a life threatening condition.

EXCLUSION FOR SUICIDE

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date of insurance; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

AD&D BENEFIT EXCLUSIONS

AD&D Benefits would not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders;
- Suicide, self-destruction while sane, or self-inflicted injury;
- War, declared or undeclared, or any act of war;
- Active participation in a riot;
- Attempt to commit or commission of a crime;
- The voluntary use of any prescription or non-prescription drug, poison, fume or any other chemical substance unless used according to the prescription or direction of the individual's doctor. This exclusion does not apply to the individual if the chemical substance is ethanol; or
- **Intoxication.** ("Intoxicated" means that the individual's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.)