Instructions and Information for completing the Statement of Health form

To expedite processing print neatly and respond to all questions on the form

Application Type

- ☐ Newly Eligible *(This is the first time I have been eligible for coverage)*
- ☐ Change to Existing Coverage (*I am electing a higher level of coverage)*
- ☐ Late; did not apply when first eligible
- ☐ Electing coverage during yearly enrollment

Section 1

Mobile Telephone Number: Provide the best number to reach you in case clarification is needed to process your application.
Policy Number: If not known, please consult with your HR Representative.
Division Number: If not known, please consult with your HR Representative.

Section 2

Complete if applying for spouse coverage.

Section 3

Only complete if applying for child coverage. If you have dependent children with any of the conditions listed, please check "Yes" and write the name(s) in the space provided.

Section 4

Neatly write in the coverage you are requesting. Please write clearly and indicate if the coverage is for the employee (EE), spouse (SP) or child (CH) if applicable.

Coverage Selections:

Coverage options:

Group Life – indicate amount (see instructions below)
Critical Illness - indicate amount
Group Long Term Disability (LTD) – write "LTD" in the box if applying for long term disability
Group Short Term Disability (STD) – write "STD" in the box if applying for short term disability

Employee (EE)	Spouse (SP)	Child (CH)
Life Amount of requested EE Life coverage Amount of existing EE Life coverage	**Life** Amount of requested SP Life coverage Amount of existing SP Life coverage	**Life** Amount of requested CH Life coverage Amount of existing child Life coverage -Names and DOB for all children –
Critical Illness Write in EE coverage amount	**Critical Illness** Write YES or NO for SP coverage	**Critical Illness** Automatically included with EE coverage at no additional charge

Section 5

Complete for all applicants requesting coverage.

Section 6

Complete in full if applying for disability coverage. Provide details for any "yes" answers in **Section 7.**

Section 8

Sign and date where indicated. It's important to retain a copy for your records. Call 1-800-421-0344 with questions or send the completed form through one of these methods:

If you are enrolling in coverage or changing existing coverage, please use the following:

Fax: 1-207-771-4019

Mail: UNUM
P.O. Box 9783
Portland, ME 04104-5083

Email: **UNUMEOI@UNUM.COM**

If continuing insurance from your former employer, please use the following:

Fax: 1-207-575-2993

Mail: UNUM
Portability conversion – C372
2211 Congress Street
Portland, ME 04122

Email: **PortabilityConversion@UNUM.com**

Some coverage and amounts may require supplemental information (e.g., blood test, urinalysis, EKG). These tests will be performed at your convenience and UNUM will cover the cost. If additional information is needed, we will notify you via the contact information provided in Section 1.

STATEMENT OF HEALTH

(Evidence of Insurability)

☐ **Unum Life Insurance Company of America,** 2211 Congress Street, Portland, ME 04122
☐ **Provident Life and Accident Insurance Company,** 1 Fountain Square, Chattanooga, TN 37402
☐ **Unum Insurance Company,** 2211 Congress Street, Portland, ME 04122

Application Type: ☐ Newly Eligible ☐ Late; did not apply when first eligible ☐ Change to Existing Coverage ☐ Electing coverage during yearly enrollment

SECTION 1: Employee (Applicant) Information – Always Complete

Employee Name (First, Middle, Last)		Social Security Number
Home Address (Street/PO Box)		Sex ☐ F ☐ M
City		Date of Birth (mm/dd/yyyy)
State	Zip Code	Mobile Telephone Number
Email Address		Work Phone Number
Employer Name		Date of Hire (mm/dd/yyyy)
Address (Street/PO Box)		Occupation
City		Annual Salary
State		Zip Code
Policy Number		Division Number

SECTION 2: Spouse Information – Complete Only if applying for Spouse Coverage

Spouse Name (First, Middle, Last)

Social Security Number	Sex ☐ F ☐ M	Date of Birth (mm/dd/yyyy)

SECTION 3: Status Questions

Employee:

1. Are you working and able to perform the duties required for your job? ☐ Yes ☐ No
2. Are you a U.S. citizen, a Canadian citizen working in the U.S., or a permanent resident of the U.S. with a valid green card, or a holder of a H1B or H2 visa? ☐ Yes ☐ No

Spouse (if applying):

1. Is your spouse living in the U.S., or, if not, is your spouse a U.S. citizen? ☐ Yes ☐ No
2. In the past 12 months, has your spouse been admitted to a hospital or confined in a nursing facility, or missed five or more consecutive days of work for health reasons, other than for cold, flu, pregnancy, accidents, allergies, or back problems. ☐ Yes ☐ No

Within the last 5 years, has any dependent child (or grandchild, if applicable) for whom you are seeking coverage been diagnosed with, or treated by, a medical professional for diabetes, heart disorder, cancer (other than basal cell or squamous cell of the skin), Acquired Immune Deficiency Syndrome (AIDS), Down syndrome, cerebral palsy, muscular dystrophy or cystic fibrosis? Applicant should answer "no" as to AIDS if the child has tested positive for Human Immunodeficiency Virus (HIV) but has no diagnosis or symptoms of the disease AIDS. ☐ Yes ☐ No

If "yes," provide names of dependents with condition:

Employee (Applicant) Name: _____ SSN: _____

SECTION 4: Coverage Selections

SECTION 5: Health Questions

Employee Height/Weight: ____ft.____in._____lbs. Spouse Height/Weight: ____ft.____in._____lbs.

Within the last 5 years, have you (or your spouse, if applying) had a diagnosis by a medical professional, or received treatment by a medical professional for any of the following:	**Employee Yes | No**	**Spouse Yes | No**
1. Acquired Immune Deficiency Syndrome (AIDS)? Applicant should answer "no" if tested positive for Human Immunodeficiency Virus (HIV) but does not have a diagnosis or symptoms for AIDS.	☐ ☐	☐ ☐
2. Cancer or malignancy other than basal cell or squamous cell of the skin	☐ ☐	☐ ☐
3. Heart disease, coronary artery disease, heart failure, any heart surgery or disease of an artery	☐ ☐	☐ ☐
4. Lung disease (other than asthma) or lung failure	☐ ☐	☐ ☐
5. Hepatitis (other than hepatitis A), liver failure, cirrhosis of the liver, chronic pancreatitis, Barrett's esophagus, Crohn's disease or ulcerative colitis	☐ ☐	☐ ☐
6. Chronic kidney disease (other than kidney stones) or renal failure	☐ ☐	☐ ☐
7. Stroke, muscular dystrophy, myasthenia gravis, multiple sclerosis, transient ischemic attack (TIA), amyotrophic lateral sclerosis (ALS), or Huntington's disease	☐ ☐	☐ ☐
8. Rheumatologic disease (other than osteoarthritis) or systemic lupus erythematosus (SLE)	☐ ☐	☐ ☐
9. Parkinson's disease	☐ ☐	☐ ☐
10. Diabetes (other than gestational or diet-controlled), Cushing's disease or Addison's disease, pancreatic failure	☐ ☐	☐ ☐
11. Disease of abnormal bleeding or clotting or blood disease (other than iron deficiency anemia in pre-menopausal women or HIV)	☐ ☐	☐ ☐
12. Schizophrenia, psychiatric hospitalization or attempted suicide	☐ ☐	☐ ☐
13. Dementia or Alzheimer's disease	☐ ☐	☐ ☐
14. Drug or alcohol abuse, dependence or addiction	☐ ☐	☐ ☐
15. Glaucoma or retinal degeneration	☐ ☐	☐ ☐
Within the last 2 years have you (or your spouse, if applying) pled guilty or no contest to, or been convicted of, a felony or operating a motor vehicle under the influence of drugs and/or alcohol?	☐ ☐	☐ ☐

Employee (Applicant) Name: _____ SSN: _____

SECTION 6:	**Disability Health Questions** Complete if applying for new or increased long or short term disability. Otherwise, continue to Section 8. (Disability coverage is only available for employees)	
Within the last 5 years, have you had a diagnosis by a medical professional or received treatment by a medical professional for any of the following. Include in the table below the dosage of all prescription and over the counter medications.		**Employee Yes | No**
1. Disease of the veins, high blood pressure, or abnormal cholesterol, headache or disease of the brain or nervous system		☐ ☐
2. Disease of the esophagus, stomach, intestines, rectum, liver, pancreas, gall bladder, bladder or reproductive organs		☐ ☐
3. Disease of the bone, joints, muscles, neck, or back; or have you had a joint replacement or an amputation		☐ ☐
4. Any disease of the eyes, ears, nose, throat, skin, endocrine disease (including thyroid disease), or asthma		☐ ☐
5. Chronic fatigue syndrome, fibromyalgia, chronic Lyme disease, postural orthostatic tachycardia syndrome (POTS), multiple chemical sensitivity		☐ ☐
6. Any psychiatric or psychological disease or disorder, including depression or anxiety		☐ ☐
7. Have you had a pregnancy with complications or are you currently pregnant?		☐ ☐
8. Have you had a disease or injury for which you have been prescribed any medication or consulted a medical professional, other than for the conditions above (other than HIV)?		☐ ☐
Are you currently experiencing any symptoms of a physical or mental illness or condition, for which you haven't consulted a medical professional, or do you have any physical or mental illnesses or conditions that prevent or limit your activities?		☐ ☐

SECTION 7: For every "yes" answer in Section 6, please provide the following information:

Condition	Treatment such as medications (including dosage), surgery, or other therapy	Date of Treatment (mm/yyyy)	Name and address of treating physician and/or medical facility
		Started:	
		Ended: (or note on-going)	
		Started:	
		Ended: (or note on-going)	
		Started:	
		Ended: (or note on-going)	

Please attach additional sheets if you need more space.

Employee (Applicant) Name: _____ SSN: _____

SECTION 8: Certification – Please read, sign, date and submit as part of your application.

State Required Notices I confirm that I have read the state required notices attached and I attest that each statement as it applies to me or those for whom I am electing coverage is accurate.

Certification I understand that coverage is not effective until approved. All statements and information found in this application are deemed representations and not warranties. All statements and answers provided above, on behalf of myself or another person, are true and complete and are given, to obtain insurance and may be relied upon by Unum. If the information is incorrect, or untrue, Unum may deny benefits or rescind (void) the coverage to the extent allowed under the plan's incontestability provisions.

Any person who, knowingly, and with intent to defraud or deceive any insurance company, submits an insurance application or files a claim containing any false, incomplete or misleading information, may be subject to civil or criminal penalties, depending on state law.
PLEASE SEE DIFFERENT FRAUD WARNING ATTACHED THAT MAY APPLY IN YOUR STATE

Employee (Applicant) Signature	**Date (mm/dd/yyyy)**
Spouse Signature	**Date (mm/dd/yyyy)**
Child (if >17) Signature	**Date (mm/dd/yyyy)**

Please return completed form using one of the following options:
email to UnumEOI@unum.com, fax to 207-771-4019,
or mail to: Unum, P.O. Box 9783, Portland, ME 04104-5083

Unum
Attn: Medical Underwriting
P.O. Box 9783
Portland, ME 04104-5083

NOTE: Please sign and return this authorization to the address above. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

AUTHORIZATION

I authorize any person or organization to give Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, Unum Insurance Company, or their duly authorized representatives or subsidiaries (individually or collectively referred to as "Unum") any of the following:

- Information about any condition, injury, or illness I have or may have had, including: disorders of the immune system, including but not limited to Acquired Immune Deficiency Syndrome (AIDS); mental or physical history, condition, advice, or treatment (but not psychotherapy notes); drug or alcohol use. This authorization excludes disclosure of Human Immunodeficiency Virus (HIV) test results.
- Information about my medical history including any consultations, prescriptions or prescription drug history, treatments or benefits
- Information that may be requested concerning me or my family members, including non medical information such as driving record, consumer reports, earnings or employment history
- Information about other insurance coverage, claims, or benefits

The terms person or organization mean a physician or medical practitioner, a hospital, clinic or other medical facility, health plan, any insurance or reinsurance company, insurance service provider, third party administrator, producer, insurance support organization or consumer reporting agency, data sources, pharmacy or pharmacy benefit manager, government entity, motor vehicle agency, or employer.

I understand the information obtained with this authorization will be used by Unum to determine eligibility for insurance and benefits. Once my information is disclosed to Unum, privacy protections established by HIPAA may not apply to the information, but other privacy laws continue to apply. Unum will not release any of the information to a third party except reinsuring companies or other persons or organizations performing services in connection with my application, coverage, or claim, or as otherwise permitted by law.

I understand that this authorization shall be valid for two years from its date and that a photographic or electronic copy shall be as valid as the original. I understand that I have the right to revoke this authorization at any time except to the extent it has been relied on prior to written notice of revocation. I also understand that, if I revoke or alter this authorization, it may be a basis for denying insurance coverage or benefits. I can revoke this authorization by sending written notice to the address above.

I have read and understand this authorization, and I and my authorized representatives have a right to receive a copy. I understand that failure to sign this authorization may impair Unum's ability to process my application or evaluate a claim, and that this may be a basis for denying my application or claim for benefits.

_____ _____
(Applicant Signature) (Date Signed)

_____ _____
(Print Name) (Social Security Number)

I signed on behalf of the applicant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Privacy Notice

This Privacy Notice applies to Unum Group's United States insurance operations and is being provided on behalf of its affiliates listed below ("Unum" "we"), as required by the Gramm-Leach Bliley Act and state insurance laws. This Notice describes how we collect, share, and protect nonpublic personal information (NPI).

COLLECTING INFORMATION

We collect NPI about our customers to provide them with insurance products and services, perform underwriting, provide stop loss coverage, and administer claims. The types of NPI we collect for these purposes may include telephone number, address, Social Security number, date of birth, occupation, income, and medical history, including treatment. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

SHARING INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us perform underwriting, provide stop loss coverage, pay claims, detect fraud, and to provide reinsurance or auditing. We may share NPI with medical providers for insurance and treatment purposes and with insurance support organizations. The organizations may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes, with parties for a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

SAFEGUARDING INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

ACCESS TO INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing, providing your full name, address, telephone number and policy number if we have issued a policy, and send it to the address below. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTION OF INFORMATION

If you believe the NPI we have about you is incorrect, please write to us and include your full name, address, telephone number and policy number if we have issued a policy, and the reason you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years, if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct and the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

COVERAGE DECISIONS

If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

CONTACTING US

For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit: unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, Portland, Maine 04122 or at Privacy@unum.com.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and Starmount Life Insurance Company.

MK-1883 (04/19)

Wolla Trucking, LLC
Policy # 660210

Please read carefully the following description of your Unum Term Life and AD&D insurance plan.

Your Plan

Eligibility

All employees working at least 40 hours each week in active employment in the U.S. with the employer, and their eligible spouses and children (up to age 19, or to 26 if they are full-time students).
*Note: *Disabled children over the maximum child age may be eligible for benefits, please see your plan administer for more details.*

Coverage Amounts

Your Term Life coverage options are:

Employee: Up to 5 times salary in increments of $10,000.
Not to exceed $500,000.

Spouse: Up to 100% of employee amount in increments of $5,000.
Not to exceed $500,000. Benefits will be paid to the employee.

Child: Up to 100% of employee coverage amount in increments of $2,000.
Not to exceed $10,000.
The maximum death benefit for a child between the ages of live birth and 6 months is $1000. Benefits will be paid to the employee.

In order to purchase Life coverage for your spouse and/or child, you must purchase Life coverage for yourself.

Your AD&D coverage options are:

Employee: Up to 5 times salary in increments of $10,000.
Not to exceed $500,000.
You may purchase AD&D coverage for yourself regardless of whether you purchase Life coverage.

Spouse: Up to 100% of employee amount in increments of $5,000.
Not to exceed $500,000. Benefits will be paid to the employee.

Child: Up to 100% of employee coverage amount in increments of $2,000.
Not to exceed $10,000.
The maximum death benefit for a child between the ages of live birth and 6 months is $1,000. Benefits will be paid to the employee.

In order to purchase AD&D coverage for your spouse and/or child, you must purchase AD&D coverage for yourself.

AD&D Benefit Schedule: The full benefit amount is paid for loss of:

- Life
- Both hands or both feet or sight of both eyes
- One hand and one foot
- One hand and the sight of one eye
- One foot and the sight of one eye
- Speech and hearing

Other losses may be covered as well. Please see your Plan Administrator.

Coverage amount(s) will reduce according to the following schedule:

Age:	Insurance Amount Reduces to:
65	65% of original amount
70	50% of original amount

Coverage may not be increased after a reduction.

Guarantee Issue

Current Employees: You may apply for any amount of Life insurance coverage up to $100,000 for yourself and any amount of coverage up to $15,000 for your spouse. Any Life insurance coverage over the Guarantee Issue amount(s) will be subject to evidence of insurability. If you and your eligible dependents do not enroll on or before 01/01/2019, you can apply for coverage only during an annual enrollment period and will be required to furnish evidence of insurability for the entire amount of Life insurance coverage. AD&D coverage does not require evidence of insurability.

If you and your eligible dependents enroll on or before 01/01/2019, and later wish to increase your Life insurance coverage, you may increase your coverage with evidence of insurability at anytime during the year. However, you may wait until the next annual enrollment and only coverage over the Guarantee Issue amount(s) will be subject to evidence of insurability.

Employees hired on or after 01/01/2019: You may apply for any amount of Life insurance coverage up to $100,000 for yourself and any amount of coverage up to $15,000 for your spouse. Any Life insurance coverage over the Guarantee Issue amount(s) will be subject to evidence of insurability. If you and your eligible dependents do not enroll within 31 days of your eligibility date, you can apply for coverage only during an annual enrollment period and will be required to furnish evidence of insurability for the entire amount of coverage. AD&D coverage does not require evidence of insurability.

If you and your eligible dependents enroll within 31 days of your eligibility date, and later, wish to increase your coverage, you may increase your Life insurance coverage, with evidence of insurability, at anytime during the year. However, you may wait until the next annual enrollment and only Life insurance coverage over the Guarantee Issue amount(s) will be subject to evidence of insurability.

Please see your Plan Administrator for your eligibility date.

Term Life Coverage Rates Rates shown are your Monthly deduction:

Age Band	Employee per $1,000	Spouse per $1,000	Child per $1,000
- 24	$.11	$.058	$.431
25-29	$.112	$.074	
30-34	$.143	$.105	NOTE: The premium paid for child coverage is based on the cost of coverage for one child, regardless of how many children you have.
35-39	$.204	$.158	
40-44	$.313	$.240	
45-49	$.495	$.369	
50-54	$.733	$.547	
55-59	$1.067	$.793	
60-64	$1.401	$1.078	
65-69	$1.976	$1.555	
70-74	$3.738	$2.941	
75+	$11.555	$9.09	

NOTE: Your rate will increase as you age and move to the next age band.

AD&D Coverage Rates

	AD&D Cost Per:	Monthly Rate
Employee:	$ 1,000	$.067
Spouse:	$ 1,000	$.07
Child:	$ 1,000	$.035

Insurance Age Your rate is based on your insurance age, which is your age immediately prior to and including the anniversary/effective date.

To calculate your cost, complete the following by selecting your coverage amount and rate (based on your insurance age).

Term Life Calculation Worksheet

Coverage Amount		**Increment**	**Rate**		**Monthly Cost**
Employee	$_____	÷ $10,000 x	$_____	=	$_____
Spouse	$_____	÷ $ 5,000 x	$_____	=	$_____
Children	$_____	÷ $ 2,000 x	$_____	=	$_____
	Total Monthly Cost			=	$_____

AD&D Calculation Worksheet

Coverage Amount		**Increment**	**Rate**		**Monthly Cost**
Employee	$_____	÷ $10,000 x	$_____	=	$_____
Spouse	$_____	÷ $ 5,000 x	$_____	=	$_____
Children	$_____	÷ $ 2,000 x	$_____	=	$_____
	Total Monthly Cost			=	$_____

Additional Benefits

Life Planning Financial & Legal Resources This personalized financial counseling service provides expert, objective financial counseling to survivors and terminally ill employees at no cost to you. This service is also extended to you upon the death or terminal illness of your covered spouse. The financial consultants are master level consultants. They will help develop

strategies needed to protect resources, preserve current lifestyles, and build future security. At no time will the consultants offer or sell any product or service.

Portability/Conversion

If you retire, reduce your hours or leave your employer, you can take this coverage with you according to the terms outlined in the contract. However, if you have a medical condition which has a material effect on life expectancy, you will be ineligible to port your coverage. You may also have the option to convert your Term life coverage to an individual life insurance policy.

Accelerated Benefit

If you become terminally ill and are not expected to live beyond a certain time period as stated in your certificate booklet, you may request up to 100% of your life insurance amount up to $250,000, without fees or present value adjustments. A doctor must certify your condition in order to qualify for this benefit. Upon your death, the remaining benefit will be paid to your designated beneficiary(ies). This feature also applies to your covered dependents.

Waiver of Premium

If you become disabled (as defined by your plan) and are no longer able to work, your premium payments will be waived during the period of disability.

Retained Asset Account

Benefits of $10,000 or more are paid through the Unum Retained Asset Account. This interest bearing account will be established in the beneficiary's name. He or she can then write a check for the full amount or for $250 or more, as needed.

Additional AD&D Benefits

Education Benefit: If you or your insured spouse die within 365 days of an accident, an additional benefit is paid to your dependent child(ren). Your child(ren) must be a full-time student beyond grade 12. (Not available in Illinois or New York.)

Seat Belt/Air Bag Benefit: If you or your insured dependent(s) die in a car accident and are wearing a properly fastened seat belt and/or are in a seat with an air bag, an amount will be paid in addition to the AD&D benefit.

Limitations/Exclusions/ Termination of Coverage

Suicide Exclusion

Life benefits will not be paid for deaths caused by suicide in the twelve months after your effective date of coverage.

No increased or additional benefits will be payable for deaths caused by suicide occurring within 12 months after the day such increased or additional insurance is effective.

AD&D Benefit Exclusions

AD&D benefits will 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, intentionally self-inflicted injury while sane, or self-inflicted injury while insane;
- 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 other chemical substance unless used according to the prescription or direction of your or your dependent's doctor. This exclusion does not apply to you or your dependent if the chemical substance is ethanol;
- 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.)

Termination of Coverage

Your coverage and your dependents' coverage under the Summary of Benefits ends on the earliest of:

- The date the policy or plan is cancelled;
- The date you no longer are in an eligible group;
- The date your eligible group is no longer covered;
- The last day of the period for which you made any required contributions;
- The last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in the certificate of coverage;
- For dependent's coverage, the date of your death.

In addition, coverage for any one dependent will end on the earliest of:

- The date your coverage under a plan ends;
- The date your dependent ceases to be an eligible dependent;
- For a spouse, the date of divorce or annulment.

Unum will provide coverage for a payable claim which occurs while you and your dependents are covered under the policy or plan.

Next Steps

How to Apply

Current employees: To apply for coverage, complete your enrollment form by enrollment deadline.

For employees hired on or after 01/01/2019: To apply for coverage, complete your enrollment form within 31 days of your eligibility date.

All employees: If you apply for coverage after your effective date, or if you choose coverage over the guarantee issue amount, you will need to complete a medical questionnaire which you can get from your Plan Administrator. You may also be required to take certain medical tests at Unum's expense.

Effective Date of Coverage

Please see your Plan Administrator for your effective date.

Delayed Effective Date of Coverage

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Dependent: Insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. Exception: infants are insured from live birth.

"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; is receiving or is entitled to receive any disability income from any source due to any sickness or injury; is receiving chemotherapy radiation therapy or dialysis treatment; or has a life threatening condition.

Changes to Coverage

Each year you and your spouse will be given the opportunity to change your Life coverage and AD&D coverage. You and your spouse may purchase additional Life coverage up to the Guarantee Issue amounts without evidence of insurability if you are already enrolled in the plan. Life coverage over the Guarantee Issue amounts will be medically underwritten and will require evidence of insurability and approval by Unum's Medical Underwriters. The suicide exclusion will apply to any increase in coverage. AD&D coverage does not require evidence of insurability for increase amounts.

Questions

If you should have any questions about your coverage or how to enroll, please contact your Plan Administrator.

This plan highlight is a summary provided to help you understand your insurance coverage from Unum. Some provisions may vary or not be available in all states. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern. For complete details of coverage, please refer to policy form number C.FP-1, et al.

Life Planning is provided by Ceridian Incorporated. The services are subject to availability and may be withdrawn by Unum without prior notice.

Underwritten by: **Unum Life Insurance Company of America,** 2211 Congress Street, Portland, Maine 04122, www.unum.com