



First Unum Life Insurance Company
 666 Third Avenue-Suite 301
 New York, NY 10017

Benefit Election Form

IPN:

Employee Basic Information

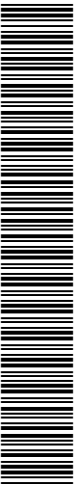
Last Name	First Name	Gender	Date of Birth	Age	Social Security Number
Home Address			City	State	Zip Code
Employee Home/Cell Phone Number			Employer Name The Jewish Theological Seminary - Semi Monthly		
Date of Hire	Monthly Income	Occupation			

Individual Short Term Disability Insurance Elimination Period: 30 days Benefit Period: 6 months

OPTION	MONTHLY BENEFIT	PER PAY PERIOD DEDUCTION
<input type="checkbox"/> High Option	\$	\$
<input type="checkbox"/> Low Option	\$	\$
<input type="checkbox"/> I would like to opt out of Individual Short Term Disability insurance		

Are you replacing any STD coverage? Yes No If yes, you are not eligible for coverage at this time.

11000 000226 01440



Request for Signature and Certification: I understand that my coverage may be subject to exclusions and limitations as described in the enrollment materials that have been provided to me by my employer. All persons I have enrolled for coverage, including myself, are eligible under the eligibility requirements for this offering. 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 to me at my request. 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.

If any person for whom I am electing coverage is eligible for Medicare, I have been provided with the Guide to Health Insurance for People with Medicare and the Important Notice to Persons on Medicare.
 If required, I have received an Outline of Coverage.

Any reference to Spouse also applies to Registered Domestic Partner or Civil Union Partner

Employee Signature	Date
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Voluntary Workplace Benefits

Non-Occ: Sickness and Off Job
Rate Class: AAA

Short Term Disability - ISTD
Semi-Monthly Premiums

Non-Occ: Sickness and Off Job
Rate Class: AAA

These rates are not for use in California, Michigan, New Hampshire, or Vermont

30% Monthly Income Range		Maximum Monthly Benefit	30 days Accident / 30 days Sickness / 6 months Benefit	
			Issue ages 17 - 49	Issue ages 50 - 69
			Sickness & Off Job Accident	Sickness & Off Job Accident
\$1,001	\$1,333	\$400	\$3.15	\$4.66
1,334	1,666	500	3.95	5.83
1,667	2,000	600	4.73	7.00
2,001	2,333	700	5.51	8.17
2,334	2,666	800	6.29	9.34
2,667	3,000	900	7.07	10.49
3,001	3,333	1,000	7.87	11.66
3,334	3,666	1,100	8.65	12.83
3,667	4,000	1,200	9.43	14.00
4,001	4,333	1,300	10.21	15.15
4,334	4,666	1,400	11.01	16.32
4,667	5,000	1,500	11.79	17.49
5,001	5,333	1,600	12.57	18.66
5,334	5,666	1,700	13.35	19.81
5,667	5,999	1,800	14.15	20.98
6,000	6,333	1,900	14.93	22.15
6,334	6,666	2,000	15.71	23.32
6,667	6,999	2,100	16.49	24.49
7,000	7,333	2,200	17.27	25.64
7,334	7,666	2,300	18.07	26.81
7,667	8,000	2,400	18.85	27.98
8,001	8,333	2,500	19.63	29.15
8,334	8,666	2,600	20.41	30.29
8,667	9,000	2,700	21.22	31.46
9,001	9,333	2,800	22.00	32.63
\$7,001	\$7,250	\$2,900	\$22.78	\$33.80
7,251	7,500	3,000	23.56	34.95

Voluntary Workplace Benefits

Non-Occ: Sickness and Off Job
Rate Class: AAA

Short Term Disability - ISTD
Semi-Monthly Premiums

Non-Occ: Sickness and Off Job
Rate Class: AAA

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40% Monthly Income Range		Maximum Monthly Benefit	30 days Accident / 30 days Sickness / 6 months Benefit	
			Issue ages 17 - 49	Issue ages 50 - 69
			Sickness & Off Job Accident	Sickness & Off Job Accident
\$751	\$1,000	\$400	\$3.15	\$4.66
1,001	1,250	500	3.95	5.83
1,251	1,500	600	4.73	7.00
1,501	1,750	700	5.51	8.17
1,751	2,000	800	6.29	9.34
2,001	2,250	900	7.07	10.49
2,251	2,500	1,000	7.87	11.66
2,501	2,750	1,100	8.65	12.83
2,751	3,000	1,200	9.43	14.00
3,001	3,250	1,300	10.21	15.15
3,251	3,500	1,400	11.01	16.32
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\$7,001	\$7,250	\$2,900	\$22.78	\$33.80
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