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

FCMM Benefits & Retirement
901 East 78th Street, Minneapolis, MN 55420
Group Short and Long Term Disability Insurance
with Term Life/AD&D
Update Form
Policy #930391/Div #001

Form 104: Application Addendum for Updates

This form is used only during the annual open enrollment period. It is given to eligible employees who are currently enrolled in the FCMM Benefit Plan after an employer has updated its *Form 120: Employer Benefit Agreement*. Employees with any changes determined on Form 120 including plan type, premium payment method, or Life/AD&D Insurance coverage amount must submit this form during the annual open enrollment period for a January 1 effective date for changes.

Employee Full Name _____

Employee Email Address _____

Employer Name _____

Employer Address _____

Employer Contact Name _____

Employer Email Address _____

Employer Completion REQUIRED

This section must be completed by the employer per *Form 120: Employer Benefit Agreement.*
Complete one of the employer pre-determined plan options for the employee listed above.

☐ **Option 1: Standard Plan (LTD & Life/AD&D)**

Long Term Disability Class #____
☐ Staff Benefit
☐ Payroll Deduction (after-tax deduction)
☐ Conventional ☐ Tax Choice

Life/AD&D Class #____
☐ Staff Benefit
☐ Payroll Deduction (after-tax deduction)
Coverage amount:
☐ $10,000
☐ $50,000
☐ One times (1x) Annual Salary*

☐ **Option 2: Plus Plan (STD, LTD & Life/AD&D)**

Short Term & Long Term Disability Class #____
☐ Staff Benefit
☐ Payroll Deduction (after-tax deduction)
☐ Conventional ☐ Tax Choice

Life/AD&D Class #____
☐ Staff Benefit
☐ Payroll Deduction (after-tax deduction)
Coverage amount:
☐ $10,000
☐ $50,000
☐ One times (1x) Annual Salary*

*Complete an updated *Form 103: Salary Worksheet* if 1x Annual Salary coverage amount was elected for correct premium calculations.

If payroll deduction for any benefit (STD, LTD, and/or Life/AD&D) OR declining all benefits, affirm below:

☐ Yes, I would like to participate in the FCMM Benefit Plan (Disability and Life/AD&D) at this time, and I authorize my employer to make the necessary deductions from my salary to pay the benefit premiums when my insurance becomes effective. I understand my payroll deduction amount will change if my coverage or costs change.

☐ No, I do not wish to participate in the FCMM Benefit Plan (Disability and Life/AD&D) at this time through payroll deduction. I understand I cannot enroll again until the annual open enrollment, if I wish to elect this coverage in the future. Enrolling at a future date will include a pre-existing limitation on coverage.

Employee Signature: _____ **Date:** _____

Authorized Employer Signature: _____ **Date:** _____

For questions regarding this form, contact FCMM Client Services at (800)995-5357 or benefits@fcmmbenefits.org.

Form Submission:
Employer, please submit this completed form to FCMM during open enrollment dates by secure file exchange, fax, or mail.

Secure File Exchange:
https://fcmmbenefits.leapfile.net/

Fax:
(952)853-8474

Mail:
FCMM Benefits & Retirement
901 East 78th Street, Minneapolis, MN 55420

FCMM USE ONLY

No.	Received in Good Order	Processed

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