Columbia University in the City of New York

unum | Individual Disability Insurance

Progress

- Personal info
- Eligibility
- Confirmation

TEST, Confirm your personal information

Fields that require your attention will be highlighted in Edit mode

Personal information

SSN

Show SSN

SSN is required, please use format xxx-xx-xxxx

First Name

TEST

Middle Name

G

Last Name

TESTA

Country of Birth

Country of Birth

This is a required field

Gender

Male (M)

Address

123 Test Avenue

Address 2

Address 2

City

Irvington

State

New York

Zip Code

10533

Personal/Mobile Phone

xxx-xxx-xxxx

This is a required field

Work Phone

111-111-1111

Email

test@test.com

Work information

Occupation

TEST APPLICANT

Hours Worked per Week

0.00

Value must be greater than zero

Citizenship

Are you a U.S. Citizen

No | Yes

Cancel | Save

unum

Have questions? Just call 866-920-2683

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Application Form: AE-1090-NY

Progress

- Personal info
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Please answer the following questions

For the period of time commencing 180 days prior to , and including, the date of this application:

Have You missed 1 or more days of work, or been homebound or admitted to a medical facility, due to injury or sickness?

No | Yes

Have You had any restrictions or limitations to your ability to work on a full time basis due to injury or sickness?

No | Yes

Do You need human assistance of any kind to perform everyday activities such as bathing, continence, dressing, eating, using the toilet or transferring (for example, from the chair to Your bed), or do You have any memory loss or confusion?

No | Yes

Do You use any medical equipment or appliances such as a cane, wheelchair, catheter, oxygen tank, pacemaker or artificial limb?

No | Yes

Do you have any known indication of blindness or deafness, or the loss of use of both arms, both legs, or one arm and/or one leg or any other amputation, or any speech defect?

No | Yes

Current or pending coverage

We've identified the following coverage plans:

Company	Amount	Replace?	Employer paid
Other	$15,000.00		NO

Did we get the above correct? If not, please call us at 866-920-2683
Are any missing? Please select YES below to provide coverage details

Do You have any Group Long Term Disability coverage, in force or being applied for?

YES

What is the monthly benefit amount?

$15,000.00

Is this coverage Employer pay?

NO

Do You have any Individual Disability coverage, in force or being applied for?

No | Yes

Back | Next

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Confirmation

Application details

Maximum Benefit

Monthly benefit amount	$6,396.00
Benefit period	to age 67
Elimination period	180 days
Catastrophic Disability benefit	$9,169.00
COLA Fixed	YES
Monthly premium	$317.94

Edit plan

Send a summary of my application

Email address

test@test.com

Payment

If you would like to complete the bank draft form online, you may do so now. Or, you can enter your email address above and we will send you a summary of the form that you can mail to us.

How would you like to receive your bank draft form?

Complete online | Email form

Bank draft details

Bank name

Name as shown on bank account

Account type

Please select

Desired withdrawal day

Please select

9 digit routing number

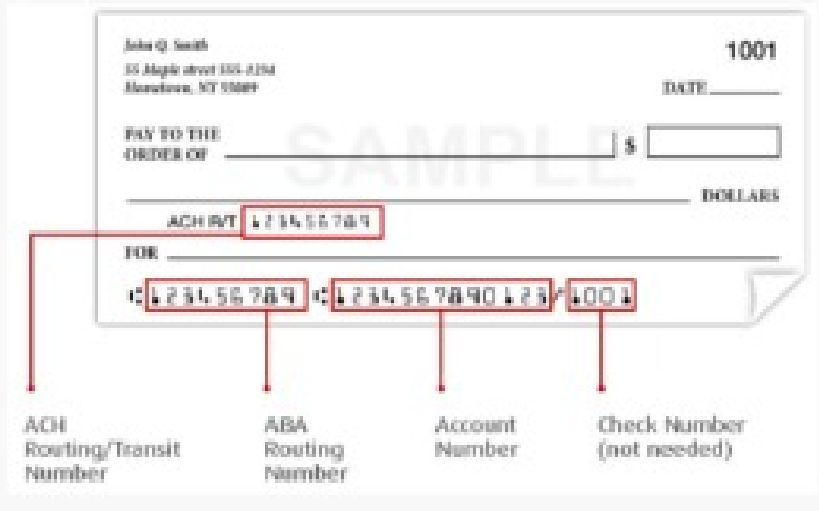
Confirm routing number

Account number

Confirm account number

Is this your personal account?

Yes | No



Some banks show the routing number and the account number in a different order. If your check has an ACH Routing Transit number(shown in the graphic above), please enter this as the routing number. The routing number is typically the first set of digits on the bottom left corner of the check.

Benefit details

Definition of Total Disability

Total Disability Benefit - The policy pays benefits for the duration of the benefit period if you are totally disabled in your occupation, which means you are unable to work in your occupation, not working in another occupation, and are under the care of a doctor.

Voluntary Suspension During Unemployment

View more

I agree to the Bank Draft and Declaration, Agreement and Authorization and confirm receipt of the following documents and information:

Exclusions and Limitations
Advertising Disclaimer

By submitting this application, I understand, acknowledge, and agree that this is an electronic signature, and that this document may be electronically signed. My electronic signature on this document has the same legal effect as if handwritten for the purposes of validity, enforceability, and admissibility.

Proceed by clicking "Submit" to complete your enrollment.

Back | Submit

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