

Notification of Social Security Number Collection and Usage by Human Resources

In compliance with Florida Statute 119.071(5), this document serves to notify you of the purpose for the collection and usage of your social security number by the University of West Florida (UWF).

UWF collects and uses your social security number only if specifically authorized by law to do so or it is imperative for the performance of its duties and responsibilities as prescribed by law. Specifically, UWF collects your social security number for the purpose of completing and processing:

- Federal Form I-9, Employment Eligibility Verification (US Department of Homeland Security)
- Federal forms W-4, W-2, 1099 (US Department of Treasury)
- Federal Social Security taxes (FICA)
- Unemployment reports (Florida Department of Revenue)
- Florida retirement contribution reports and forms (Florida Department of Revenue)
- Workers compensation claims (FCCRMS and Department of Labor)
- I.R.C. Section 403b and 457b contribution reports (Internal Revenue Service)
- State sponsored insurance enrollment forms and reports (group health, life, and dental coverage)
- Background Screening (background screening of finalists for the purpose of employment consideration)
- Verification of Employment (prior to 2000)
- Dual Employment and Compensation Request Form (State of Florida)
- State of Florida New Hire Report (Department of Revenue)
- Transcript Request

[] NEW APPLICANT

GROUP INSURANCE ENROLLMENT FORM

Unum Life Insurance Company of America

[] CHANGE IN COVERAGE

STATE UNIVERSITIES OF FLORIDA

Enrollment for Group Voluntary Disability Coverage

Social Security No Employee ID No Date of Birth Date of Hire University

Last Name, First, MI

Job Title

Street Address

City

State

Zip Code

Male Female

Annual Salary: \$ _____

Department/Building & Room Number/Mail Code

I am employed on a [9] [10] or [12] month contract [please circle one]

I work [] hours per week.

The disability plan has a pre-existing condition limitation. If I have received medical treatment or consultation or taken prescribed drugs or medicines for any sickness or injury within three months prior to my effective date of coverage, these conditions will not be covered unless the disability begins more than twelve (12) consecutive months after my effective date of coverage. My effective date of coverage will be the first day of the month following the date of this application or approval by Unum, if applicable, provided that I am actively at work on a full time basis.

I understand that if I do not apply for coverage during my initial eligibility period and choose to enroll at a later date, Unum may require Evidence of Insurability.

I hereby request coverage under my employer's plan of benefits. I authorize my employer to deduct from my earnings my contributions for the coverage when I become eligible and for each period thereafter, automatically including future rate increases, and to calculate into deduction modes consistent with the payroll system of my employer, including prorated and accelerated deductions, as applicable. The deductions are to be continued until:

- (a) I request that this authorization be cancelled; or
- (b) termination of my employment.

The amounts deducted are to be paid to The Gabor Agency, Inc., Tallahassee, Florida, then remitted to Unum Life Insurance Company of America to cover premiums for disability coverage provided for me. Unum Life Insurance Company of America is solely responsible for paying benefits under the policy.

PLEASE SELECT ONE: 30-day Elimination Period **-or-** 90 day Elimination Period

Enrollment Date: _____

Effective Date: _____

Signature

Agent Signature