



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

CSX Engineers

Short Term Disability Insurance and
 Long Term Disability Insurance
 Enrollment Form

Policy #

Class One
 (Less than 10 years of RR Service) **Class Two**
 (10 years or more of RR Service)

Employee Name:	Date of Birth: ___/___/_____	
Social Security Number: _____ - _____ - _____	RR ID # _____	
Hours Worked/Week:	Gender:	Division #:
Date of Hire: ___/___/_____	Annual Salary:	
Occupation:	Phone:	
Address:	City:	
State:	Zip:	
State of Birth:	Plan Desired:	

- Yes**, I would like to participate in the STD & LTD program.
- Yes**, I would like to participate in the STD program only.
- Yes**, I would like to participate in the LTD program only.

I authorize my employer to deduct from my salary or wages the necessary premium for this coverage. My signature verifies the accuracy of information contained on this form. I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would otherwise become effective.

I have made application to Railroad Marketing Specialist, LLC (TRMS) or it's affiliated companies for a policy of insurance and you are hereby requested and authorized to deduct the amount of the monthly premium and railroad deduction fee from my wages each month and to transmit such premium and fees to the said company. I authorize the increase of future premiums as it applies to my policy for the above deduction, if applicable.

This authorization shall be effective until (1) Termination of my employment, (2) Written notice from me of the cancellation of this authorization, stating when such cancellation shall be effected, or (3) Termination of the Salary Deduction Plan.

I agree that insurance will not become effective until the first of the month after a full months premium has been deducted from my wages and underwriting approval from the insurance carrier.

I have also read and understand the information in the Plan Highlights, including all statements regarding exclusions and benefit amounts and offsets.

- No**, I do not wish to participate. I understand that evidence of insurability will be required, at my own expense, if I decide to elect this coverage in the future.

Employee Signature: _____

Date: ___/___/_____

Return Forms To: _____

By: ___/___/_____

Please mail this application back to:	Railroad Marketing Specialists
	PO Box 787
Coverage Effective Date: ___/___/_____	Santa Clara UT 84765-0787