<u>IMPORTANT INSTRUCTIONS</u>: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on <u>www.unuminfo.com/AXIONRMS</u> or in a paper enrollment kit. You can request a paper enrollment kit by calling 1-800-227-4165. DO NOT submit this form if you have not reviewed those materials.

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Underwritten by: Unum Life Insurance Company of America LTC Department 2211 Congress Street Portland, Maine 04122

### AXION RMS <u>Family</u> Benefit Election Form Long Term Care - Policy #141044

Your Name: (Last Name, First, Middle Initial)		Social Security Number		Date of Birth (MM/DD/YYYY)		
		· · ·	·	/	/	
Street Address		Gender		Date of H	Hire (MM/DD/YYYY)	
		Male	Female	/	/	
City, State, Zip Code		Home Telephone #		Work Te	Work Telephone #	
		(	)	(	)	
Applicant's Email Address						
Employee's Name	Employee Social Security No.		Employee Date of Bir	th Emp	oloyee Date of Hire	
			//		//	

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## If yes, please note that all elections made below will replace existing coverage upon underwriting approval, if applicable.

All applicants must complete this form. Applicant is:					
Parent or Grandparent	□ Sibling <i>(minimum age 18)</i>	□ Child <i>(minimum age 18)</i>			

#### Plans – Check one

🗆 Plan 1	🗆 Plan 2	🗆 Plan 3	🗆 Plan 4
<ul> <li>Long Term Care Facility</li> <li>100% Professional Home &amp; Community Care</li> </ul>	<ul> <li>Long Term Care Facility</li> <li>50% Total Choice Home Care</li> </ul>	<ul> <li>Long Term Care Facility</li> <li>100% Professional Home &amp; Community Care</li> </ul>	<ul> <li>Long Term Care Facility</li> <li>50% Total Choice Home Care</li> </ul>
		<ul> <li>Compound Inflation</li> </ul>	<ul> <li>Compound Inflation</li> </ul>

#### Facility Monthly Benefit Amount – Check one

□ \$2,000	□ \$3,000	□ \$4,000	□ \$5,000	□ \$6,000	□ \$7,000	□ \$8,000	□ \$9,000

#### Note: Duration of benefits may vary depending on where benefits are received.

#### Facility Benefit Duration – Check one.

□ 3 Years	6 Years	
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All applicants must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire) for any selection.

A signed Authorization to Request Medical Information (form #6720-03 in the kit) must accompany all medical questionnaires.

#### **Calculate Your Premium:**

Please refer to rate sheet in your kit to determine the rate for the plan chosen.

X \_\_\_\_\_ ÷ \$1,000 = \_\_\_ Your premium

Rate for plan chosen Monthly benefit amount

**Disclosures:** 

#### Note: We may have the right to deny benefits or rescind insurance if any of the information provided on this enrollment form is incorrect.

**REQUEST FOR SIGNATURE:** Please read this entire form carefully before signing below.

I certify that all statements are true to the best of my knowledge and belief. I have read and understand that loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after my effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to my coverage.

Final cost of coverage will be based on your Insurance Age. If you enroll for coverage on or before the group policy effective date, Insurance Age is your age on the group policy effective date. If you enroll for coverage after the group policy effective date, Insurance Age is your age on the date you sign this enrollment form.

I acknowledge that I have received the Potential Rate Increase Disclosure Form and Personal Worksheet.

All eligible Family Members : Please select payment method:  Monthly Automatic Payments (deducted from your checking account – complete Authorization/Agreement for Automatic Payments), OR					
Billed directly (paper) by the insural	nce company:	Quarterly	Semi-Annually	□ Annually	
Your premium: \$	_ (transfer from	calculation above)			
	//			//	
Applicant's Signature	Date		Employee's Signature	Date	

#### Please sign and mail all required signature forms to Unum (address at top of page). Retain a copy for your records. (J5)

If you have questions about Long Term Care coverage, please call Unum's toll-free number: 1-800-227-4165.