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

COSTCO WHOLESALE CORPORATION
Group #5 Benefit Election Form
For Eligible Medically Underwritten Applicants
Long Term Care - Policy #543523-002

Your Name: (Last Name, First, Middle Initial)	Social Security Number __ __ __ - __ __ - __ __ __ __	Date of Birth (MM/DD/YYYY) __ __/__ __/__ __ __ __
Street Address	Gender ☐ Male ☐ Female	Date of Hire (MM/DD/YYYY) __ __/__ __/__ __ __ __
City, State, Zip Code	Home Telephone # ( )	Work Telephone # ( )

Complete the following only if applicant is not the employee

Employee's Name	Employee Social Security No. __ __ __ - __ __ - __ __ __ __	Employee Date of Birth __ __/__ __/__ __ __ __	Employee Date of Hire __ __/__ __/__ __ __ __

Applicant Is: (This Benefit Election Form must be completed for any selection)

☐ Employee's Parent or Grandparent	☐ Sibling *(minimum age 18)*
☐ Spouse's / Domestic Partner's Parent or Grandparent	☐ Child *(minimum age 18)*

Plans

(Check one)

☐ **Plan 1**	☐ **Plan 2**
• Long Term Care Facility • Simple Inflation • Professional Home Care	• Long Term Care Facility • Simple Inflation • Professional Home Care • Total Home Care

Facility Monthly Benefit Amount

(Check one)

☐ $1,000	☐ $2,000	☐ $3,000	☐ $4,000	☐ $5,000	☐ $6,000

Facility Benefit Duration ***(Duration of benefits may vary depending on where benefits are received.)***

(Check one)

☐ 3 Years	☐ 6 Years

ELIGIBLE FAMILY MEMBERS: The Long Term Care Application (medical questionnaire), the Benefit Election form and a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit, must be completed and you must be approved for coverage in order to enroll in the Long Term Care plan.

Calculate your Premium (The rate sheet is included in the kit)

_____ (Bi-Weekly Rate for plan chosen) **X** _____ (Facility Monthly Benefit Amount) ÷ $1,000 = _____ (Bi-Weekly Cost (From Rate Sheet))

_____ (Bi-Weekly Cost) **X** 26 Weeks = _____ (Yearly Cost) ÷ **12** **=** _____ (Monthly Cost)

E**ligible 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 insurance company: ☐ Quarterly ☐ Semi-Annually ☐ Annually

Caution: If your answers on this Enrollment Form are incorrect or untrue, we may have the right to deny benefits or rescind your insurance.

By signing below, you signify that you have read and understand that loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after your effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to your coverage.

_____ *Applicant's Signature* __ __/__ __/__ __ __ __ *Date* _____ *Employee's Signature* __ __/__ __/__ __ __ __ *Date*

All applicants, sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (M5)

If you have questions about Long Term Care coverage, please call Unum's toll-free number: 1-877-403-9348.