IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/EpiscopalDioceseCA002 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.



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

EPISCOPAL DIOCESE OF CALIFORNIA Benefit Election Form

Long Term Care-Policy #523615-002

-							Fully #323013-002
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 #	
Applicant's Email Address:							
Complete the following only if applicant is not the employee							
Employee's Name		Employee Social Security No.		Employee Date of I		Birth	Employee Date of Hire//
Applicant Is: (This Benefit Election Form must be completed for any selection)							
☐ Employee		☐ Employee's Parent or Grandp		parent		ee	
☐ Employee's Spouse/Registered Domestic Partner's		☐ Spouse's/Registered Domestic Partner's Parent or Grandparent			☐ Retiree's Spouse		
	Plan						
	Long Term Care Facility100% Professional HomeSimple Inflation	e Care					
	Facility Monthly B	enefit Amoun	nt				
(Check one)	□ \$1,000	\$2,000	□ \$3,000 □		⊐ \$4,000)	□ \$5,000 *
Facility Benefit Duration (Duration of benefits may vary depending on where benefits are received.)							
	Facility Benefit Du	ration (Duration	on of benefits ma	y vary dep	ending on	where be	enefits are received.)
(Check one)	□ 3 Years	,	on of benefits ma Years	y vary dep	- i		enefits are received.) ed Duration *
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If you have questions about Long Term Care coverage, please call Unum's toll-free number: 1-800-227-4165.