

IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/leawood 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 Company of America
LTC Department
2211 Congress Street,
Portland, Maine 04122

CITY OF LEAWOOD
Benefit Election Form
Long Term Care - Policy #124736

Your Name: (Last Name, First, Middle Initial)	Social Security Number ____ - ____ - ____	Date of Birth (MM/DD/YYYY) ____/____/____
Street Address	Gender <input type="checkbox"/> Male <input type="checkbox"/> 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 Birth ____/____/____	Employee Date of Hire ____/____/____
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All applicants must complete this form. Applicant is:

<input type="checkbox"/> Employee	<input type="checkbox"/> Employee's Parent or Grandparent	<input type="checkbox"/> Sibling (<i>minimum age 18</i>)
<input type="checkbox"/> Employee's Spouse	<input type="checkbox"/> Spouse's Parent or Grandparent	<input type="checkbox"/> Child (<i>minimum age 18</i>)

Plans – Check one

<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4
<ul style="list-style-type: none"> • Long Term Care Facility • Professional Home & Community Care 	<ul style="list-style-type: none"> • Long Term Care Facility • Total Choice Home Care 	<ul style="list-style-type: none"> • Long Term Care Facility • Professional Home & Community Care • Compound Inflation 	<ul style="list-style-type: none"> • Long Term Care Facility • Total Choice Home Care • Compound Inflation

Facility Monthly Benefit Amount – Check one

<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$6,000	<input type="checkbox"/> \$7,000 *	<input type="checkbox"/> \$8,000 *	<input type="checkbox"/> \$9,000 *
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Facility Benefit Duration – Check one. Note: Duration of benefits may vary depending on where benefits are received.

<input type="checkbox"/> 3 Years	<input type="checkbox"/> 6 Years	<input type="checkbox"/> Lifetime *
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- ***These options exceed the Guarantee Issue limits** and their selection will require completion of the Long Term Care Insurance Application (medical questionnaire).
- **All active employees and newly hired employees** who enroll after the Guarantee Issue enrollment period or choose benefits over the Guarantee Issue limits must complete the Long Term Care Insurance Application (medical questionnaire).
- **All other 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.

Form is continued on reverse side.

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

Disclosures:

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

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 insurance company: ☐ Quarterly ☐ Semi-Annually ☐ Annually

Your premium: \$_____ (transfer from calculation above)

_____/_____/_____
Applicant's Signature

_____/_____/_____
Date

_____/_____/_____
Employee's Signature
(Required for Spouse Coverage)

_____/_____/_____
Date

Employees & Spouses: Please sign and mail all required signature forms to your employer.
Family Members: Please sign and mail all required signature forms to Unum (address at top of page).
 Retain a copy for your records. (M4)

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