LONG TERM CARE BENEFIT ELECTION FORM

Especially for Employees/Members Only

UNUM Life Insurance Company of America
LTC Department, 2211 Congress Street, Portland, Maine 04122, 1-800-227-4165
If you have questions, please call Long Term Care Specialists at 1-800-764-6585

Bakersfield Elementary School District -- Policy #950420

Employee/Member's Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____

Date of Hire:_____ Employee #:_____ Email:_____

Telephone: (H)_____ (W)_____ Sex: ( ) Male ( ) Female

Plan Options (Check One)

Nursing Facility & Home and Community-Based Care		
Basic Plan Preferred	**Plan Enhanced Plan**	
3 year plan (Lifetime Max $144,000)	4 year plan (Lifetime Max $192,000)	6 year plan (Lifetime Max $360,000)
Monthly Benefit Amount M	onthly Benefit Amount M	onthly Benefit Amount
$4,000 Nursing Facility $	4,000 Nursing Facility $	5,000 Nursing Facility
$2,800 Residential Care Facility	$2,800 Residential Care Facility	$3,500 Residential Care Facility
$2,000 Home and Community-Based Care	$2,000 Home and Community-Based Care	$2,500 Home and Community-Based Care
With Compound Inflation ☐	With Compound Inflation ☐	With Compound Inflation ☐
Without Compound Inflation ☐	Without Compound Inflation ☐	Without Compound Inflation ☐

Important Note: Active Employees/Members who select a plan do NOT need to complete the Long Term Care Application (medical questionnaire) if enrolling during the Guarantee Issue enrollment period. If you enroll after the Guarantee Issue enrollment period, you will be required to fill out the application/evidence of insurability.
ALL application/evidence of insurability must accompany a signed Authorization to Request Medical Information Form #6720-03-CA located in the enrollment kit.

Your Premium: $_____ *(Transfer the premium amount from the rate sheet.)*

Your Insurance Age is your age as of the effective date of coverage.

Billing:
Your premium will be paid through payroll deduction from your paycheck. You must sign below to authorize your employer to make the payroll deduction.

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 Activities of Daily Living (ADL) loss or severe cognitive impairment must occur after your effective date of coverage in order to be covered by this Long Term Care plan, and that certain limitations and exclusions apply to your coverage.

_____ _____
Employee/Member's Signature **Date**

Please sign and send this original to:
Specialists in Long Term Care Insurance Services, Inc.
P.O. Box 6630
Auburn, CA 95604-9904
If there are any questions, please call: 1-800-764-6585
Retain a copy for your records. (K5)