Underwritten by:

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

Booz | Allen | Hamilton

Benefit Election Form
Division 0001
Long Term Care - Policy #394295

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

Plans

(Check one)

☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 4**
• Long Term Care Facility • Non Forfeiture • Professional Home Care	• Long Term Care Facility • Non Forfeiture • Professional Home Care • Total Home Care	• Long Term Care Facility • Non Forfeiture • Professional Home Care • Compound Inflation	• Long Term Care Facility • Non Forfeiture • Professional Home Care • Total Home Care • Compound Inflation

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

*** EMPLOYEES: Selection of this option exceeds the Guarantee Issue limits and requires completion of 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. ALL Medical Questionnaires must accompany a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit. *NOTE TO EMPLOYEES:* All Active Employees & Newly Hired Employees – who enroll after the Guarantee Issue enrollment period or choose benefits over the Guarantee Issue limits will be required to fill out a medical questionnaire and signed Form #6720-03.**

If you are an **Active Employee, Spouse, Civil Union Partner or Domestic Partner**, your premium will be deducted from the employee's paycheck. You must sign below to authorize this deduction.

All other eligible Family Members or Retirees: 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

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

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. You also acknowledge that you have received the **Potential Rate Increase Disclosure Form** and **Personal Worksheet.**

All information is contained in your kit.

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

_____	__ __/__ __/__ __ __ __	_____	__ __/__ __/__ __ __ __
Applicant's Signature	*Date*	*Employee's Signature (Required for Spouse/ Domestic Partner/ Civil Union Partner Coverage))*	*Date*

Employees & Spouses/Civil Union Partners/Domestic Partners &Family Members/Retirees:
Please sign and mail all required signature forms to Unum.
(address at top of page)
Domestic Partners must also complete and submit Form #1434-97 located in the kit.
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.

Voluntary