



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

CITY OF AUBURN
EMPLOYEE Benefit Election Form
Long Term Care - Policy #573342

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 # (____) _____

Funded Plan (Employer Paid)

Level of Care:	Long Term Care Facility and 100% Professional Home Care
Monthly Benefit:	\$1,000 Long Term Care Facility/ 100% Professional Home Care
Benefit Duration:	3 Years Long Term Care Facility/ 100% Professional Home Care

Your employer is funding Plan 1. You may purchase additional coverage. Please make your selections below:

Plans							
(Check one)	<input type="checkbox"/> Plan 1 (Funded Plan)	<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 • 100% Professional Home Care 	<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home Care • 100% Total Home Care 	<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home Care • Compound Inflation 	<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home Care • 100% Total Home Care • Compound Inflation 			
Facility Monthly Benefit Amount							
(Check one)	<input type="checkbox"/> \$1,000 (Funded Plan)	<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*
Facility Benefit Duration (Duration of benefits may vary depending on where benefits are received.)							
(Check one)	<input type="checkbox"/> 3 Years (Funded Plan)		<input type="checkbox"/> 6 Years			<input type="checkbox"/> Unlimited Duration *	

* **EMPLOYEES:** Selection of this option exceeds the Guarantee Issue limits and requires completion of the Long Term Care Insurance Application (medical questionnaire) and 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 a signed Form #6720-03.

Your premium for the buy-up options 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 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.

All information is contained in your kit.

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

 Employee's Signature

____ / ____ / ____
 Date

Please sign and mail all required signature forms to your employer.
 Retain a copy for your records. (M5)

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