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

COSTCO WHOLESALE CORPORATION
Benefit Election Form
Long Term Care - Policy #543523

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 Birth __ __/__ __/__ __ __ __	Employee Date of Hire __ __/__ __/__ __ __ __

Applicant Is: (This Benefit Election Form must be completed for any selection)

☐ Employee	☐ Employee's Spouse	☐ Employee's Parent or Grandparent	☐ Sibling *(minimum age 18)*
☐ Previous Employee	☐ Employee's Domestic Partner	☐ Spouse's / Domestic Partner's Parent or Grandparent	☐ Child *(minimum age 18)*

Plans

(Check one)	☐ **Plan 1**	☐ **Plan 2**
	• Long Term Care Facility • Simple Inflation • Professional Home Care	• Long Term Care Facility • Simple Inflation • Professional Home Care • Total Home Care

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

NOTE TO EMPLOYEES: **All Active Employees – who enroll after the Guarantee Issue enrollment period will be required to fill out a the Long Term Care Insurance Application (medical questionnaire) and sign Form #6720-03. 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.**

All Applicants: 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

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.**

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

_____ __ __/__ __/__ __ __ __ _____ __ __/__ __/__ __ __ __
Applicant's Signature *Date* *Employee's Signature* *Date*

All applicants, 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 kit.
Retain a copy for your records. (M5)

If you have questions about Long Term Care coverage, please call Unum's toll-free number: 1-877-403-9348 (Option 3).