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

FLORIDA INSTITUTE OF TECHNOLOGY
Benefit Election Form (FL)
Long Term Care - Policy #496500

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:

☐ Employee	☐ Employee's Parent or Grandparent
☐ Employee's Spouse	☐ Spouse's Parent or Grandparent

Plans

(Check one)

☐ **Plan A**	☐ **Plan B**	☐ **Plan C**
• Long Term Care Facility / $1,000 Monthly Benefit • Simple Inflation • 2 Years Benefit Duration *	• Long Term Care Facility / $2,500 Monthly Benefit • Simple Inflation • 4 Years Benefit Duration *	• Long Term Care Facility / $4,000 Monthly Benefit • Simple Inflation • 6 Years Benefit Duration *

Do you want to add the Total Home Care option? ☐ YES ☐ NO

Duration of benefits may vary depending on where benefits are received

NOTE TO EMPLOYEES: **All Active Employees & Newly Hired Employees – who enroll after the Guarantee Issue enrollment period will be required to fill out a 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.**

Active Employee or Spouse: Your premium will be paid through the Employee's payroll deduction. Employee must sign below to authorize the Employer to make the payroll deduction.
All other 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
Caution: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
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 with Unum in order to be covered by this Long Term Care plan, 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 rate sheet.)***

_____	__ __/__ __/__ __ __ __	_____	__ __/__ __/__ __ __ __
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. (J1)

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