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

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

HORIZON HOUSE Benefit Election Form Long Term Care - Policy #574184-002

Your Name: (Last Name, First, Middle Initial)			Social Security Number		Date	Date of Birth (MM/DD/YYYY)	
						_//	
Street Address			Gender		Date	e of Hire (MM/DD/YYYY)	
			□ Male □ Female _			_//	
City, State, Zip Code			Home Telephone #		Wor	k Telephone #	
			()		()	
Applicant's Email Address:							
Complete the following only if applicant is not the Board Member:							
Board Member's Name Board Memb		Board Member	er Social Security No. Board		Board Membe	d Member Date of Birth	
Applicant Is: (This Benefit Election Form must be completed for any selection)							
Board Member	□ Spouse	Parent or G	or Grandparent 🛛 Sibling (minimum age 18) 🛛 Child (minimum		Child (minimum age 18)		

All applicants must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire) for any selection.

A signed Authorization to Request Medical Information (form #6720-03 in the kit) must accompany all medical questionnaires.

	Plans						
(Check one)) 🗖 Plan 1			🗆 Plan 2			
	Long Term Care Facility			Long Term Care Facility			
	100% Professional Home Care			100% Professional 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						e received.)	
(Check one)	□ 3 Years		□ 6 Years		Unlimited Duration		

Form is continued on reverse side.

Board Member or All other eligible Family Members: Please select payment method							
Billed directly (paper) by the insu	rance company:	Quarterly	Semi-Annually	Annually			
Caution: If your answers on th	Caution: If your answers on this Enrollment Form are incorrect or untrue, we may have the right to deny						
benefits or rescind your insura	ince.						
I acknowledge that I have received the Potential Rate Increase Disclosure Form and Personal Worksheet.							
By signing below, you signify that	t you have read an	d understand the	at loss of Activities of Dai	ly Living (ADL) or Severe			
Cognitive Impairment must occur				Care plan in order to be			
covered, and that certain limitation	ons and exclusions	apply to your co	overage.				
All information is contained in your kit							
All information is contained in your kit.							
Your Premium: \$ (Transfer the premium amount from the calculation on the rate sheet)							
	//			//			
Applicant's Signature	Date		rd Member's Signature	Date			
(Required for Spouse Coverage) Please sign and mail all required signature forms to Unum (address at top of page).							
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.