IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/lafra004 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

LOS ANGELES FIREMEN'S RELIEF ASSOCIATION, INC.

Employee/Spouse/Registered Domestic Partner Benefit Election Form

Long Term Care - Policy #951328-004

(one form to be completed by each applicant)

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 # ( )
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 __ __/__ __/__ __ __ __

☐ **Employee: LAFRA will contribute up to $9.15 per month toward the cost for the coverage you select**

☐ **Spouse/Registered Domestic Partner: You may choose any plans listed below.**

Plans – Check one (this Benefit Election Form must be completed for any selection).

☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**
• 100% Facility • 100% Home and Community Based Care	• 100% Facility • 100% Home and Community Based Care • 5% Simple Inflation	• 100% Facility • 100% Home and Community Based Care • 5% Compound Inflation

Facility Monthly Benefit Amount – Check one

☐ $1,500	☐ $2,500	☐ $3,500	☐ $4,500	☐ $5,500	☐ **$6,500 ***	☐ **$7,500 ***	☐ **$8,500 ***

Facility Benefit Duration – Check one. **Duration of benefits may vary depending on where benefits are received.**

☐ 2 Years	☐ 5 Years	☐ **Lifetime***

- ➢ ***These options exceed the Guarantee Issue limits** and their selection will require completion of the Long Term Care Insurance Application (medical questionnaire).
- ➢ **All active employees and newly hired employees** who enroll after the Guarantee Issue enrollment period or choose benefits over the Guarantee Issue limits must complete 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.
- ➢ A signed Authorization to Request Medical Information (form #6720-03 in the kit) must accompany all medical questionnaires.

Form is continued on reverse side.

Calculate Your Premium:

To calculate your premium using the formula below: 1. Refer to the rate sheet available at www.lafraltcenroll.com or 2. Contact Unum at 1-800-227-4165 to request an enrollment kit, which includes the rate sheet. You can also use the online calculator available at www.lafraltcenroll.com to calculate your premium.

_____	**X**	_____	**÷ $1,000**	**=** _____ **(A)**
Rate for plan chosen		Monthly benefit amount		Monthly Cost for Coverage

For Employee Only

_____ **(A)**	**-**	**$9.15** **(B)**	**=** _____
Monthly Cost		Monthly benefit amount	**Employee's Monthly Cost**

Disclosures:

NOTE: I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this insurance with and without the Uncapped Compound Growth Inflation Protection Option and I accept ☐ / reject ☐ this option.

Note: We may have the right to deny benefits or rescind insurance if any of the information provided on this enrollment form is incorrect.

REQUEST FOR SIGNATURE: Please read this entire form carefully before signing below.

I certify that all statements are true to the best of my knowledge and belief. I have read and understand that, for coverage that does not require me to submit evidence of insurability, loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after my effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to my coverage.

All eligible Employees/Employee Spouse/Registered Domestic Partners: Your signature below authorizes your Association to deduct the required premium from your paycheck. Final cost of coverage will be based on your Insurance Age. If you enroll for coverage on or before the group policy effective date, Insurance Age is your age on the group policy effective date. If you enroll for coverage after the group policy effective date, Insurance Age is your age on the date you sign this enrollment form.

Your premium: $_____ (transfer from calculation above)

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

Please sign and mail all required signature forms to your Association.
Retain a copy for your records. (M8)

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