



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

NOBLE ENERGY, INC.
Benefit Election Form
Long Term Care - Policy #139211

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 # () - - -

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 ____ / ____ / ____
-----------------	--	--	---

All applicants must complete this form. Applicant is:

<input type="checkbox"/> Employee	<input type="checkbox"/> Employee's Parent or Grandparent	<input type="checkbox"/> Sibling (<i>minimum age 18</i>)
<input type="checkbox"/> Employee's Spouse	<input type="checkbox"/> Spouse's Parent or Grandparent	<input type="checkbox"/> Child (<i>minimum age 18</i>)

Plans – Check one

<input type="checkbox"/> Plan 1	<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 & Community Care 	<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home & Community Care • Simple Inflation 	<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home & Community Care • 10 Year APO 	<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home & Community Care • Simple Inflation • 10 Year APO

Facility Monthly Benefit Amount – Check one

<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 *	<input type="checkbox"/> \$9,000 *
----------------------------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------	------------------------------------	------------------------------------	------------------------------------

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

<input type="checkbox"/> 3 Years	<input type="checkbox"/> 6 Years	<input type="checkbox"/> 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:

Please refer to rate sheet in your kit to determine the rate for the plan chosen.

$$\frac{\text{Rate for plan chosen}}{\text{Rate for plan chosen}} \times \frac{\text{Monthly benefit amount}}{\text{Monthly benefit amount}} \div \$1,000 = \frac{\text{Your premium}}{\text{Your premium}}$$

Disclosures:

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 certain limitations and exclusions apply to my coverage.

Active Employees & Spouses: I authorize my employer to make the necessary payroll deduction to pay the premium when my insurance becomes effective.

All 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

Your premium: \$ _____ (transfer from calculation above)

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. (L4)

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