

**IMPORTANT INSTRUCTIONS:** Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on [www.unuminfo.com/primaris](http://www.unuminfo.com/primaris) 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

**PRIMARIS**

**FAMILY Benefit Election Form**  
**Long Term Care - Policy #090049-001**

Your Name: (Last Name, First, Middle Initial)		Social Security Number ____ - ____ - ____	Date of Birth (MM/DD/YYYY) ____ / ____ / ____
Street Address		Home Telephone # (____) ____ - ____	Work Telephone # (____) ____ - ____
City, State, Zip Code		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
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 ____ / ____ / ____
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**Applicant Is: (This Benefit Election Form must be completed for any selection)**

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

You may choose any of the plans listed below. The Long Term Care Application (medical questionnaire), the Benefit Election form and a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit, must be completed and you must be approved for coverage in order to enroll in the Long Term Care plan.

(Check one)	<b>Plans</b>	
	<input type="checkbox"/> <b>Plan 1</b> • Long Term Care Facility • 100% Professional Home Care	<input type="checkbox"/> <b>Plan 2</b> • Long Term Care Facility • 100% Professional Home Care • Compound Inflation
(Check one)	<b>Facility Monthly Benefit Amount</b>	
	<input type="checkbox"/> \$1,000 <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	
(Check one)	<b>Facility Benefit Duration</b> (Duration of benefits may vary depending on where benefits are received.)	
	<input type="checkbox"/> 3 Years <input type="checkbox"/> 6 Years <input type="checkbox"/> Unlimited Duration	

**REQUEST FOR SIGNATURE:** Must check either accept or reject. Please read this entire form carefully before signing below.

**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.

**Active Employee's 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:** 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 (Required for Spouse Coverage)	____ / ____ / ____ Date
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**Spouses:** Please sign and mail all required signature forms to the employer.

**Family Members:** Please sign and mail all required signature forms to Unum (address at top of page).

**Retain a copy for your records. (A3)**

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