



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



STATE OF GEORGIA
Benefit Election Form
Long Term Care - Policy #513565

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	
Employee's Name		Employee Social Security No.	Employee Date of Birth		Employee Date of Hire
Applicant's Email Address:					
Applicant Is: (This Benefit Election Form must be completed for any selection)					
<input type="checkbox"/> Employee's Spouse		<input type="checkbox"/> Employee's Parent		<input type="checkbox"/> Employee's Parent-In-Law	

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.

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"> • Nursing Home Facility Care • Professional Home Care • Total Home Care • Return of Premium 	<ul style="list-style-type: none"> • Nursing Home Facility Care • Professional Home Care • Total Home Care • Return of Premium • Compound Inflation 	<ul style="list-style-type: none"> • Nursing Home Facility Care • Professional Home Care • Total Home Care • Return of Premium • Paid Up 	<ul style="list-style-type: none"> • Nursing Home Facility Care • Professional Home Care • Total Home Care • Return of Premium • Compound Inflation • Paid Up
Facility Daily Benefit Amount			
(Check one)	Nursing Home Facility Care	Assisted Living Facility & Home Care	Lifetime Maximum
	<input type="checkbox"/> \$75.00	\$ 45.00	\$136,875.00
	<input type="checkbox"/> \$100.00	\$ 60.00	\$182,500.00
	<input type="checkbox"/> \$125.00	\$ 75.00	\$228,125.00
Facility Benefit Duration is 5 Years			
<i>Duration of benefits may vary depending on where benefits are received</i>			

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

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 Monthly Premium: \$_____ (Transfer the premium amount from the Enrollment Workbook rate page).

_____/_____/_____
 Applicant's Signature Date Employee's Signature Date
 (Required for Spouse Coverage)

Spouses & Family Members: Please sign and mail all required signature forms to Unum (address at top of page). Retain a copy for your records. (K2)

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