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

SPRINT CORPORATION
Benefit Election Form
Long Term Care - Policy #556912

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 # ( )

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 __ __/__ __/__ __ __ __

Applicant Is:

☐ Employee	☐ Employee's Parent or Grandparent	☐ Sibling *(minimum age 18)*
☐ Employee's Spouse	☐ Spouse's / Domestic Partner's Parent or Grandparent	☐ Child *(minimum age 18)*
☐ Employee's Domestic Partner		

Plans

(Check one)

☐ Plan 1	☐ Plan 2	☐ Plan 3	☐ Plan 4
• Long Term Care Facility • Professional Home Care	• Long Term Care Facility • Professional Home Care • Total Home Care	• Long Term Care Facility • Professional Home Care • Compound Inflation	• Long Term Care Facility • Professional Home Care • Total Home Care • Compound Inflation

Facility Monthly Benefit Amount

(Check one)

☐ $1,000	☐ $3,000	☐ $6,000

Facility Benefit Duration *(Duration of benefits may vary depending on where benefits are received.)*

(Check one)

☐ 3 Years	☐ 6 Years

NOTE TO EMPLOYEES: **All Active Employees & Newly Hired Employees – who enroll after the Guarantee Issue enrollment period will be required to fill out a medical questionnaire and sign.**
Form #6720-03. ALL OTHER APPLICANTS must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire) for any selection. ALL Medical Questionnaires must accompany a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit.

Active Employee or Spouse/Domestic Partner: 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, Unum may have the right to deny benefits or rescind your insurance.

By signing below, you signify that you have read and understand that Activities of Daily Living (ADL) loss or severe cognitive impairment must occur after your effective date of coverage with Unum in order to be covered by this Long Term Care plan, and that certain limitations and exclusions apply to your coverage.

All information is contained in your kit.

I acknowledge that I 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*	*Date*

Employees & Spouses/ Domestic Partners: Please sign and mail all required signature forms to Unum (address at top of page).
Domestic Partners must also complete and submit Form #1434-97 located in kit.
Family Members: Please sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (M4)

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