IMPORTANT INSTRUCTIONS: Prior to submitting this form, all applicants must review the important disclosures and information found on www.unuminfo.com/spu name or in a paper enrollment kit. You can request a paper enrollment kit by calling 1-877- 286-2852. 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

SEATTLE PACIFIC UNIVERSITY Benefit Election Form Long Term Care - Policy #576300

	Social	Social Security Number			Date of Birth (MM/DD/YYYY)						
Street Address					 r e	- — — □ Fem	Date of Hire (MM/DD/YYYY)				
City, State, Zip Code					Home Telephone #			Work Telephone #			
Work Email Address:					Personal Email Address:						
		t is not the empl									
Employee's Name			Employee Social Security No.			Employee Date of Birth		Employee Date of Hire			
Applicant I	S: (This Ben	efit Electi	on Form must I	be completed	l for a	any selec	ction)				
			☐ Employee's Parent or Grandpa		rent Sibling (minimum age		e 18)				
Employee ID#:			П ол		4	. Повал с		л. Пр.::			
			☐ Spouse's Parent or Grandparent ☐ Child (minimum a				O (minimum age	e 18)			
(Chaok ana)	Plans										
(Check one)	■ Plan 1 • Long Term Care Facility				☐ Plan 2Long Term Care Facility						
	100% Professional Home Care				• 10	 Long Term Care Facility 100% Professional Home Care 5% Compound Inflation 					
	Facility M	ınt	•	•							
(Check one)	□ \$1,000	□ \$2,000	3,000	□ \$4,000	□\$	55,000	□ \$6,000	□ \$7	7,000 *	□ \$8,000 *	
	Facility B	enefit D	u ration (Durati	on of benefits	nay va	ary depen	ding on where	benefi	ts are re	ceived.)	
(Check one)	☐ 3 Years ☐ 6 Years ☐ Unlimited Duration *								n *		
Insurance Appl Long Term Card accompany a si <u>EMPLOYEES:</u> A	ication (medic e Insurance A igned Authori all Active Emp	cal question pplication (zation to Ro loyees & N	exceeds the Gua maire). <u>ALL OTH</u> medical question equest Medical Ir ewly Hired Emplo	ER APPLICAN nnaire) for any nformation Fo	Selec m #67	ust comp tion. <u>ALL</u> 720-03 loc	lete this Bend Medical Que cated in the e Guarantee Iss	efit Elecestionna estionna nrollme ue enre	ction Fo aires mu ent kit. <u>N</u> ollment	rm and the est <u>IOTE TO</u>	
				oquired to fill			uunetinnnaira				
	Active Employee or 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 or Retirees: Please select payment method: ☐ Monthly Automatic Payments (deducted from your checking account – complete Authorization/Agreement for Automatic Payments), OR											
	le Family Mer	ke the payronte nbers or Re	ium will be paid th ll deduction. etirees: Please se	elect payment n	out a r loyee's nethod	medical q s payroll d : □ Mont	deduction. Em	oloyee r	nust sigr	rm #6720-03. n below to	
your checking a Billed directly (p	le Family Mer account – comp paper) by the ir	ke the payro nbers or Re plete Authori nsurance col	ium will be paid th Il deduction. etirees: Please se zation/Agreement mpany: □ Qua	rough the Emp elect payment n t for Automatic arterly □	out a railoyee's nethod Payme Semi-	medical q s payroll o : Montents), OR Annually	deduction. Emplededuction. Em	ployee r Paymer ally	must sigr	rm #6720-03. In below to	
your checking a Billed directly (p Caution: if you	le Family Mer account – composper) by the ir r answers on	ke the payro nbers or Re plete Authori nsurance col	ium will be paid th Il deduction. etirees: Please se zation/Agreement	rough the Emp elect payment n t for Automatic arterly □	out a railoyee's nethod Payme Semi-	medical q s payroll o : Montents), OR Annually	deduction. Emplededuction. Em	ployee r Paymer ally	must sigr	rm #6720-03. In below to	
your checking a Billed directly (p Caution: if you your insurance By signing belo Impairment mus limitations and e	ole Family Mer account – compose paper) by the ir r answers on a. w, you signify to exclusions app	ke the payro mbers or Re blete Authori asurance con this Enrolli that you hav our effective ly to your co	ium will be paid th Il deduction. etirees: Please se zation/Agreement mpany: □ Qua	elect payment not for Automatic arterly acorrect or unto stand that loss under this Lonacknowledge to	nethod Payme Semi- rue, w of Acting Term	medical q s payroll c :	hly Automatic Annu Are the right to be an in order to be	Paymentally o deny OL) or Sole cover	must sigr nts (dedu benefits evere Cored, and	rm #6720-03. In below to Jucted from Sor rescind Degnitive That certain	
your checking a Billed directly (p Caution: if you your insurance By signing belo Impairment mus limitations and e	nle Family Mer account – componency by the in r answers on e. w, you signify the st occur after your exclusions app rm and Person	ke the payro mbers or Re blete Authori nsurance con this Enrolli that you hav our effective ly to your con al Workshe	ium will be paid th Il deduction. etirees: Please se zation/Agreement mpany: Qua ment Form are in e read and unders date of coverage verage. You also	elect payment in the for Automatic arterly correct or unturestand that loss under this Lon acknowledge to is contained	nethod Payme Semi- rue, w of Acting Term nat you in you	medical q s payroll o : : : : : : : : : : : : :	hly Automatic Annu Are the right to the price of the column order to be been decived the Poten in order to be the poten	Paymentally o deny DL) or Some cover ential F	must sigr nts (dedu benefits evere Co red, and Rate Incr	rm #6720-03. In below to Jucted from Sor rescind Degnitive That certain	
your checking a Billed directly (p Caution: if you your insurance By signing belo Impairment mus limitations and e Disclosure For Your Premium	nle Family Mer account – componency by the in r answers on e. w, you signify the st occur after your exclusions app rm and Person	ke the payro mbers or Re blete Authori nsurance con this Enrolli that you hav our effective ly to your con al Workshe	ium will be paid the land the	elect payment in the for Automatic arterly correct or unto stand that loss under this Lon acknowledge to is contained in amount from	nethod Payme Semi- rue, w of Acting Term nat you in you	medical q s payroll o : : : : : : : : : : : : :	hly Automatic Annuave the right to the project of the contract of the project of	Paymentally o deny DL) or Some cover ential F	must sigr nts (dedu benefits evere Co red, and Rate Incr	rm #6720-03. In below to Jucted from Sor rescind Lognitive Ithat certain Lease	
your checking a Billed directly (p Caution: if you your insurance By signing belo Impairment mus limitations and e Disclosure For	ple Family Mer account – composition of the in- r answers on the in- r answers on the in- w, you signify the in- text occur after your occur after your exclusions appirm and Person in the in- text in the in- in-	ke the payro mbers or Re plete Authori asurance coi this Enrolli that you have our effective ly to your co nal Worksho(Tra	ium will be paid the lad deduction. It deduction. It restrictes: Please se zation/Agreement mpany: If a Quament Form are in the read and understy date of coverage verage. You also seet. This informations in the premium	elect payment in the for Automatic arterly correct or unto stand that loss under this Lon acknowledge to on is contained in amount from (Req. (Req.)	loyee's lethod Payme Semi-rue, wo facting Term at you in you make the factor of the fa	medical q s payroll o s payroll o s payroll o continuation continuatio	hly Automatic Annuave the right to the righ	Paymentally o deny DL) or Some cover ential F	must sigr nts (dedu benefits evere Co red, and rate Incr	rm #6720-03. The below to sected from the section of the below to section of	