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

TRI COUNTY HEALTH DEPARTMENT
Family Benefit Election Form
Long Term Care - Policy #125573

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 # ( )

Employee's Name	Employee Social Security No. __ __ __ - __ __ - __ __ __ __	Employee Date of Birth __ __/__ __/__ __ __ __	Employee Date of Hire __ __/__ __/__ __ __ __

Applicant's Email Address:

All applicants must complete this form. Applicant is:

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

Plans – Check one

☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 4**
• Long Term Care Facility • 50% Professional Home & Community Care	• Long Term Care Facility • 100% Professional Home & Community Care	• Long Term Care Facility • 50% Professional Home & Community Care • Compound Inflation	• Long Term Care Facility • 100% Professional Home & Community Care • Compound Inflation

Facility Monthly Benefit Amount – Check one

☐ $2,000	☐ $3,000	☐ $4,000	☐ $5,000	☐ $6,000	☐ $7,000	☐ $8,000	☐ $9,000

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

☐ 3 Years	☐ 6 Years	☐ Lifetime

- **All 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.

_____	X	_____	÷ $1,000 =	_____
Rate for plan chosen		Monthly benefit amount		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 loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after my effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to my coverage.

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

I acknowledge that I have received the **Potential Rate Increase Disclosure Form** and **Personal Worksheet**.

Your premium: $_____ (transfer from calculation above)

_____	__ __/__ __/__ __ __ __	_____	__ __/__ __/__ __ __ __
Applicant's Signature	*Date*	*Employee's Signature*	*Date*

Please sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (JO)

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