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

# BAYLOR UNIVERSITY
## Benefit Election Form
## Long Term Care – Policy: 509470

| Your Name: (Last Name, First, Middle Initial) | Social Security Number<br>__ __ __ - __ __ - __ __ __ __ | Date of Birth (MM/DD/YYYY)<br>__ __/__ __/__ __ __ __ |
|---|---|---|
| Street Address | Gender<br>☐ Male ☐ Female | Date of Hire (MM/DD/YYYY)<br>__ __/__ __/__ __ __ __ |
| City, State, Zip Code | Home Telephone #<br>( ) | Work Telephone #<br>( ) |
| Applicant's Email Address: | | |

**Complete the following only if applicant is not the employee**

| Employee's Name | Employee Social Security No.<br>__ __ __ - __ __ - __ __ __ __ | Employee Date of Birth<br>__ __/__ __/__ __ __ __ | Employee Date of Hire<br>__ __/__ __/__ __ __ __ |
|---|---|---|---|

**Applicant Is: (This Benefit Election Form must be completed for any selection)**

| | | |
|---|---|---|
| ☐ Employee | ☐ Employee's Parent or Grandparent | ☐ Retiree |
| ☐ Employee's Spouse | ☐ Spouse's Parent or Grandparent | ☐ Retiree's Spouse |

**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)* | ☐ **Plan 1** | ☐ **Plan 2** | ☐ **Plan 3** | ☐ **Plan 4** |
|---|---|---|---|---|
| | • Long Term Care Facility<br>• Professional Home Care | • Long Term Care Facility<br>• Professional Home Care<br>• Total Home Care | • Long Term Care Facility<br>• Professional Home Care<br>• Simple Inflation | • Long Term Care Facility<br>• Professional Home Care<br>• Total Home Care<br>• Simple Inflation |

**Facility Monthly Benefit Amount**

| *(Check one)* | ☐ $1,000 | ☐ $2,000 | ☐ $3,000 | ☐ $4,000 |
|---|---|---|---|---|

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

| *(Check one)* | ☐ 3 Years | ☐ 6 Years | ☐ Unlimited Duration |
|---|---|---|---|

***Calculate your Premium:***

_____ (Rate for plan chosen) **X** _____ (Facility Monthly Benefit Amount) ÷ $1,000 = _____ (Your Premium)

**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**

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.** All information is contained in your kit.

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

**Employees & Spouses: Please sign and mail all required signature forms to your employer.**
**Family Members/Retirees: Please sign and mail all required signature forms to Unum (address at top of page).**
**Retain a copy for your records. (L4)**

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

Voluntary