<u>IMPORTANT INSTRUCTIONS</u>: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on <a href="http://www.unuminfo.com/connerstrong002">http://www.unuminfo.com/connerstrong002</a> or 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

## CONNER, STRONG & BUCKELEW Benefit Election Form-NJ Long Term Care - Policy #136147-002

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 #				
Applicant's Email Address:											
Complete the following only if applicant is not the employee											
Employee's Name Employee			Social Security No.	Employee [	Employee Date of Birth		Employee Date of Hire				
Is this a change to existing coverage? □ Yes □ No If yes, please note that all elections made below will replace existing coverage upon underwriting approval, if applicable.											
All applicants must complete this form. Applicant is:											
□ Employee			☐ Employee's Parent or Grandparent		□ Sibling (minimum age 18)						
□ Employee's Spouse/Civil Union Partner			☐ Spouse's/Civil Union			☐ Child (minimum age 18)					
☐ Employee's Domestic Partner			Partner/Domestic Partner's Parent or Grandparent								
Plans – Check one											
□ Plan 1 □ Pl		☐ Plan 2	Plan 2		□ Plan 3		□ Plan 4				
Long Term Care Facility		Long Term Care Facility		<ul> <li>Long Term Care Facility</li> </ul>		Long Term Care Facility					
• 100% Professional Home &		• 100% Professional Home &		• 100% Professional Home &		• 100% Professional Home &					
Community Care		Community Care  • 3 Year SBP		Community Care  Compound Inflation		Community Care  Compound Inflation					
		• 3 fear SBP		• Compound Inhalion			3 Year SBP				
						• 3 Teal SDF					
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.											
□ 2 Years			6 Years		☐ Lifetim		e *				
*These options exceed the Guarantee Issue limits and their selection will require completion of the Long Term Care Insurance Application (medical questionnaire).											
> All active employees and newly hired employees who enroll after the Guarantee Issue enrollment period or choose											

benefits over the Guarantee Issue limits must complete the Long Term Care Insurance Application (medical

A signed Authorization to Request Medical Information (form #6720-03 in the kit) must accompany all medical

All other applicants must complete this Benefit Election Form and the Long Term Care Insurance Application (medical

questionnaire) for any selection.

questionnaire).

questionnaires.

<b>Calculate Your Prem</b>	nium:			
Please refer to rate she	et in your kit to determine	the rate for the	plan chosen.	
	x	÷ \$1 000 =		
Rate for plan chosen			Your premium	
Disclosures:				
Note: We may have the enrollment form is inc		or rescind ins	surance if any of the informati	on provided on this
REQUEST FOR SIGNA	TURE: Please read this	entire form car	efully before signing below.	
does not require me to s must occur after my effe	submit evidence of insurat	oility, loss of A	and belief. I have read and und ctivities of Daily Living (ADL) or Ferm Care plan in order to be co	Severe Cognitive Impairment
	ouse, Civil Union Partne the premium when my in		c Partners: I authorize my empnes effective.	oloyer to make the necessary
	nbers: Please select payr		☐ Monthly Automatic Paymen natic Payments), <b>OR</b>	ts (deducted from your
Billed directly (paper) by	the insurance company:	☐ Quarter	y ☐ Semi-Annually	☐ Annually
I acknowledge that I have	e received the Potential	Rate Increase	Disclosure Form and Person	al Worksheet.
Your premium: \$	(transfer fro	m calculation a	bove)	
	/ /			/ /
Applicant's Signatur	e Dat	e	Employee's Signature (Required for Spouse, Domestic Partner/Civil Union	Date

Employees & Spouses/Civil Union Partners/Domestic Partners: Please sign and mail all required signature forms to your employer.

Domestic Partners must also complete and submit Form #1434-97 provided 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. (KO)

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