

IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on <http://www.unuminfo.com/connerstrong002> 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 <input type="checkbox"/> Male <input type="checkbox"/> 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 Date of Birth ____/____/____	Employee Date of Hire ____/____/____
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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:

<input type="checkbox"/> Employee	<input type="checkbox"/> Employee's Parent or Grandparent	<input type="checkbox"/> Sibling (<i>minimum age 18</i>)
<input type="checkbox"/> Employee's Spouse/Civil Union Partner	<input type="checkbox"/> Spouse's/Civil Union Partner/Domestic Partner's Parent or Grandparent	<input type="checkbox"/> Child (<i>minimum age 18</i>)
<input type="checkbox"/> Employee's Domestic Partner		

Plans – Check one

<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4
<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home & Community Care 	<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home & Community Care • 3 Year SBP 	<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home & Community Care • Compound Inflation 	<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home & Community Care • Compound Inflation • 3 Year SBP

Facility Monthly Benefit Amount – Check one

<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$6,000	<input type="checkbox"/> \$7,000 *	<input type="checkbox"/> \$8,000 *	<input type="checkbox"/> \$9,000 *
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Facility Benefit Duration – Check one. **Note: Duration of benefits may vary depending on where benefits are received.**

<input type="checkbox"/> 2 Years	<input type="checkbox"/> 6 Years	<input type="checkbox"/> Lifetime *
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- ***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 questionnaire).
- **All other 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.

