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

FOX ASSOCIATES, L.L.C.
Employee/Spouse/ Domestic Partner
Benefit Election Form
Long Term Care - Policy #226550

(one form to be completed by each applicant)

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 # ( )
Work Email Address:		
Personal Email Address:		

Divisions: (please check one)

001 Fox Associates, L.L.C.	002 Metropolitan Tickets, Inc.	003 Fox Theatricals, L.L.C.	004 Briar Street Theatre

Complete the following only if applicant is not the employee:

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

Funded Plan (Employer Paid)

Level of Care:	**Long Term Care Facility and 100% Professional Home and Community Care**
Monthly Benefit:	**$1,000 Long Term Care Facility / 100% Professional Home and Community Care**
Benefit Duration:	**6 Years Long Term Care Facility / 100% Professional Home and Community Care**

Check which category you fall under:

Employee - Your employer is funding Plan 1. You may purchase additional coverage. Please make your selections below.

Spouse/ Domestic Partner - You may choose any plan listed below. **

Plans – Check one (this Benefit Election Form must be completed for any selection).

Plan 1 (Funded for Employees Only)	**Plan 2**	**Plan 3**
• Long Term Care Facility • 100% Professional Home and Community Care	• Long Term Care Facility • 100% Professional Home and Community Care • 5% Simple Inflation	• Long Term Care Facility • 100% Professional Home and Community Care • 5% Compound Inflation

Facility Monthly Benefit Amount – Check one

$1,000 **(Funded for Employees Only)**	$2,000	$3,000	$4,000	$5,000	$6,000	**$7,000 ***	**$8,000 ***	**$9,000 ***

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

6 Years **(Funded for Employees Only)**	**Lifetime ***

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

3 Years	6 Years	Lifetime

For Employees:

- ***This option exceeds the Guarantee Issue limits** and its 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 must complete the Long Term Care Insurance Application (medical questionnaire).

**** Spouses and Domestic Partners:**

- You 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:

To calculate your premium, please refer to the rates and use the calculation below, or refer to the rate calculator at https://w3.unum.com/enroll/fox.

________________ Rate for plan chosen	X	________________ Monthly benefit amount	÷ **$1,000**	= ________________ Your premium **(A)**
For Employees Only:		________________ Rate for funded Plan 1 (6 Year duration)		= ________________ Employer Paid Amount **(B)**
			(A) MINUS (B)	________________ **EMPLOYEE'S COST**

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: You must check either accept or reject. Please read this entire form carefully before signing below.

Accept/Reject Inflation Protection Option
I have reviewed the Outline of Coverage and the graphs that compare benefits and premiums for this insurance with and without the 5% Compound Inflation Protection option and:
❒ I Accept Compound Inflation
❒ I Reject Compound Inflation
7616-04

I certify that all statements are true to the best of my knowledge and belief. I have read and understand that, for coverage that does not require me to submit evidence of insurability, 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.

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

Active Employees & Spouses or Domestic Partners: Your signature below authorizes your employer to deduct the required premium from your paycheck. Final cost of coverage will be based on your Insurance Age. If you enroll for coverage on or before the group policy effective date, Insurance Age is your age on the group policy effective date. If you enroll for coverage after the group policy effective date, Insurance Age is your age on the date you sign this enrollment form.

Your premium: $______________ (transfer from calculation above)

____________________ *Applicant's Signature*	__ __/__ __/__ __ __ __ *Date*	____________________ *Employee's Signature* (Required for Spouse or Domestic Partner Coverage)	__ __/__ __/__ __ __ __ *Date*

Please sign and mail all required signature forms to:
LTC Solutions, 14715 NE 95th Street, Ste. 200, Redmond, WA 98052.
Domestic Partners must also complete and submit Form #1434-97 provided in kit.
Retain a copy for your records. (A3)

If you have questions about Long Term Care coverage, please call LTC Solutions' toll-free number 1-877-286-2852 or email info@ltc-solutions.com.