

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

**ICSVEBA IMPERIAL COUNTY SCHOOLS  
 VOLUNTARY EMPLOYEES BENEFITS  
 ASSOCIATION)**

**Benefit Election Form**

**Long Term Care - Policy #522828**

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:

**DIVISION # /SCHOOL NAME OR LOCATION:**

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

<input type="checkbox"/> Employee	<input type="checkbox"/> Employee's Parent or Grandparent	<input type="checkbox"/> Retiree
<input type="checkbox"/> Employee's Spouse/ Registered Domestic Partner	<input type="checkbox"/> Spouse's/Registered Domestic Partner's Parent or Grandparent	<input type="checkbox"/> 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-CA 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.

<b>Plans</b>						
(Check one)	<input type="checkbox"/> <b>Plan 1</b> • Long Term Care Facility • Professional Home Care	<input type="checkbox"/> <b>Plan 2</b> • Long Term Care Facility • Professional Home Care • Total Home Care	<input type="checkbox"/> <b>Plan 3</b> • Long Term Care Facility • Professional Home Care • Simple Inflation	<input type="checkbox"/> <b>Plan 4</b> • Long Term Care Facility • Professional Home Care • Total Home Care • Simple Inflation		
<b>Facility Monthly Benefit Amount</b>						
(Check one)	<input type="checkbox"/> \$1,000	<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
<b>Facility Benefit Duration is 3 Years</b>						
<i>Duration of benefits may vary depending on where benefits are received</i>						

**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:** 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.

Your Premium: \$ \_\_\_\_\_ (Transfer the premium amount from the calculation on the rate sheet)

_____ / _____ / _____ Applicant's Signature	_____ / _____ / _____ Date	_____ / _____ / _____ Employee's Signature (Required for Spouse/Registered Domestic Partner Coverage)	_____ / _____ / _____ Date
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**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. (M8)

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