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

LA HEALTH SERVICE & INDEMNITY CO DBA BCBS OF LA & IT'S SUBS. & AFFILIATED COMPANIES

Board of Directors Benefit Election Form

Long Term Care - Policy #094733-003

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:		

Is this a change to existing coverage? □ Yes □ No
If yes, new elections made below will replace existing coverage upon underwriting approval, if applicable.

Plans – Check one

□ **Plan 1**	□ **Plan 2**	□ **Plan 3**	□ **Plan 4**
• Long Term Care Facility • 50% Professional Home and Community Care • 3 Year SBP	• Long Term Care Facility • 50% Total Choice Home Care • 3 Year SBP	• Long Term Care Facility • 50% Professional Home and Community Care • Simple Inflation • 3 Year SBP	• Long Term Care Facility • 50% Total Choice Home Care • Simple Inflation • 3 Year SBP

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.**

□ 3 Years	□ 6 Years	□ Lifetime

- **All 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

Calculate Your Premium:

Please refer to rate sheet in your kit to determine the rate for the plan chosen.

_____ **X** _____ **÷ $1,000 =** _____

Rate for plan chosen | Monthly benefit amount | Your premium

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: Please read this entire form carefully before signing below.

I certify that all statements are true to the best of my knowledge and belief. I have read and understand that 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**.

Your premium: $_____ (transfer from calculation above)

_____ __ __/__ __/__ __ __ __

Applicant's Signature *Date*

Please sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (L8)

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