IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/Murchiso002 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.

unum	*Underwritten by:* Unum Life Insurance Company of America LTC Department 2211 Congress Street, Portland, Maine 04122	***MURCHISON & CUMMING, LLP*** **Benefit Election Form** **Long Term Care - Policy #141664-002**

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 # ( )
Email Address:		

Complete the following only if applicant is not the employee

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

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

Applicant is: (Check one) The Minimum age for a sibling or child is 18.

□ Employee □ Spouse/ Registered Domestic Partner □ Parent or Grandparent □ Sibling; □ Child

Plans – Check one

Plan 1	**Plan 2**	**Plan 3**
• Facility • 100% Home and Community Based Care	• Facility • 100% Home and Community Based Care • 5% Simple Inflation	• Facility • 100% Home and Community Based Care • 5% Compound Inflation

Facility Monthly Benefit Amount – Check one

$2,000	$3,000	$4,000	$5,000	$6,000	$7,000	**$8,000 ***

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

3 Years	6 Years	**Lifetime ***

- ***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 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-CA 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.

❒ **I am declining coverage at this time.**

REQUEST FOR SIGNATURE: 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.

Active Employees & Spouse/ Registered 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.

All 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

Your premium: $_____ (transfer from calculation above)

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

<u>Employee & Spouse/ Registered Domestic Partner:</u> Please sign and mail all required signature forms to your employer.
<u>Family Members</u>: 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.**