Underwritten by:
First UNUM Life Ins Company
666 Third Avenue
New York, NY 10017

NORDEA BANK ABP NEW YORK BRANCH
FAMILY Benefit Election Form
Long Term Care - Policy #533943**

**** Amounts below $3500 are called Nursing Home and Home Care**

Your Name: (Last Name, First, Middle Initial)	Social Security Number __ __ __ - __ __ - __ __ __ __	Date of Birth (MM/DD/YYYY) __ __/__ __/__ __ __ __
Street Address	Home Telephone # ( )	Work Telephone # ( )
City, State, Zip Code	Gender ☐ Male ☐ Female	
Applicant's Email Address:		

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

Applicant Is:

☐ Employee's Spouse	☐ Spouse's Parent or Grandparent	☐ Retiree's Spouse
	☐ Employee's Parent or Grandparent	☐ Retiree

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-NY 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.

Plans

(Check one)

☐ **Plan 1**	☐ **Plan 2**
• Long Term Care Facility • Professional Home Care • Total Home Care	• Long Term Care Facility • Professional Home Care • Total Home Care • 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 *(Duration of benefits may vary depending on where benefits are received.)*

(Check one)

☐ 3 Years	☐ 6 Years	☐ Unlimited Duration

Active Employee's 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 or Retirees: 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.

Your Premium: $_____ ***(Transfer the premium amount from the calculation on the rate sheet)***

_____	__ __/__ __/__ __ __ __	_____	__ __/__ __/__ __ __ __
Applicant's Signature	*Date*	*Employee's Signature (Required for Spouse Coverage)*	*Date*

Spouses: Please sign and mail all required signature forms to the 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. (J6)

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