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

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Underwritten by:
Unum Life Insurance Company of America
LTC Department
2211 Congress Street
Portland, Maine 04122

THE RESEARCH CORPORATION OF THE UNIVERSITY OF HAWAII
EMPLOYEE Working a Minimum of 30 Hours Per Week Benefit Election Form
Long Term Care - Policy #536066

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:		

Funded Plan (Employer Paid) **(This Benefit Election Form must be completed for any selection)**

Level of Care:	Long Term Care Facility and 50% Professional Home Care
Monthly Benefit:	$2,000 Long Term Care Facility/ 50% Professional Home Care
Benefit Duration:	3 Years Long Term Care Facility/ 50% Professional Home Care

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

Plans

(Check one)

☐ Plan 1 (Funded Plan)	☐ Plan 2	☐ Plan 3	☐ Plan 4
• Long Term Care Facility • Professional Home Care	• Long Term Care Facility • Professional Home Care • Total Home Care	• Long Term Care Facility • Professional Home Care • Compound Inflation	• Long Term Care Facility • Professional Home Care • Total Home Care • Compound Inflation

Facility Monthly Benefit Amount

(Check one)

☐ $2,000 (Funded Plan)	☐ $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 (Funded Plan)	☐ 6 Years	☐ **Unlimited Duration ***

*** EMPLOYEES: Selection of this option exceeds the Guarantee Issue limits and requires completion of the Long Term Care Insurance Application (medical questionnaire) and a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit. *Note to Employees*: All Active Employees & Newly Hired Employees – who enroll after the Guarantee Issue enrollment period or choose benefits over the Guarantee Issue limits will be required to fill out a medical questionnaire and a signed Form #6720-03.**

Your premium for the buy-up options will be paid through payroll deduction from your paycheck. You must sign below to authorize your employer to make the payroll deduction.

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

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

________________________________ *Employee's Signature*

__ __/__ __/__ __ __ __ *Date*

Please sign and mail all required signature forms to your employer.
Retain a copy for your records. (K6)

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