

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

**STATE OF SOUTH DAKOTA  
EMPLOYEE Benefit Election Form  
Long Term Care - Policy #295435**

Employee 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:		

Please make your selections below: Active employees automatically receive a Basic Plan (PLAN 1) with a facility monthly benefit of \$1,500 for a 2 year duration as part of the State's Group Supplemental Life Plan at no additional cost. Additional coverage (PLAN 2, PLAN 3 or PLAN 4) may be purchased by completing this Benefit Election Form. Please note: This Benefit Election Form *does not* need to be completed if the coverage under the State funded Basic Plan 1 is the only coverage desired. Questions concerning Long Term Care coverage can be directed to Unum's toll-free number: 1-800-227-4165.

**Plans** (Check one)

<input type="checkbox"/> <b>Plan 1 (Funded Plan)</b>	<input type="checkbox"/> <b>Plan 2</b>	<input type="checkbox"/> <b>Plan 3 <u>Partnership</u></b>	<input type="checkbox"/> <b>Plan 4 <u>Partnership</u></b>
<ul style="list-style-type: none"> <li>• Long Term Care Facility – 100%</li> <li>• Assisted Living Facility – 60%</li> <li>• Professional Home Care – 50%</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care Facility – 100%</li> <li>• Assisted Living Facility – 60%</li> <li>• Professional Home Care – 50%</li> <li>• Total Home Care – 50%</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care Facility – 100%</li> <li>• Assisted Living Facility – 60%</li> <li>• Professional Home Care – 50%</li> <li>• Compound Inflation</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care Facility – 100%</li> <li>• Assisted Living Facility – 60%</li> <li>• Professional Home Care – 50%</li> <li>• Total Home Care – 50%</li> <li>• Compound Inflation</li> </ul>

Plans 3 and 4 are "Partnership Qualified" for employees age 75 or younger. For employees 76 or older, all plans are "Partnership Qualified". Please refer to information on the Partnership program located in this enrollment kit.

**Facility Monthly Benefit Amount** (Check one)

<input type="checkbox"/> \$1,500 (Funded Plan)	<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	<input type="checkbox"/> \$7,000	<input type="checkbox"/> \$8,000
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**Facility Benefit Duration** (Check one) (Duration of benefits may vary depending on where benefits are received.)

<input type="checkbox"/> 2 Years (Funded Plan)	<input type="checkbox"/> 6 Years	<input type="checkbox"/> Unlimited Duration *
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**\*EMPLOYEES:** Selection of this option exceeds the Guarantee Issue limits and requires completion of the Long Term Care Insurance Application (Evidence of Insurability) and a signed Authorization to Request Medical Information Form #6720-03 which is attached as the last page of the Evidence of Insurability Application. **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 an Evidence of Insurability Application and a signed Form #6720-03.

The premium for the buy-up options will be paid through a payroll deduction. This form must be signed to authorize your employer to make the payroll deduction.

**Caution:** If your answers on this Benefit Election Form are incorrect or untrue, we may have the right to deny benefits or rescind your insurance.

By signing below, you signify that you are participating in the Supplemental Life program, 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)

\_\_\_\_\_  
Employee's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Please sign and mail all required signature forms to UNUM,  
Attn: Margaret Fier, 3600 Minnesota Drive, #600, Edina, MN 55435.  
Retain a copy for your records. (A1)

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