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

บก๋บ๋ก๋า

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 Bir	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:						
benefit of \$1,500 for a 2 y coverage (PLAN 2, PLAN Election Form <i>does not</i>	ions below: Active employear duration as part of the N 3 or PLAN 4) may be puneed to be completed if the cerning Long Term Care	ne State's (irchased b he coverag	Group Supplemental y completing this Be ge under the State fu	Life Plan at nenefit Election nded Basic P	o additional cost Form. Please not lan 1 is the only c	. Additional te: This Benefit coverage
Plans (Check one)						
☐ Plan 1 (Funded Plan)	□ Plan 2		☐ Plan 3 <i>Partnership</i>		□ Plan 4 <i>Partnership</i>	
 Long Term Care Facility – 100% Assisted Living Facility – 60% Professional Home Care – 50% 	Assisted Living Facility – 60% Professional Home Care – 50%		 Long Term Care Facility – 100% Assisted Living Facility – 60% Professional Home Care – 50% Compound Inflation 		 Long Term Care Facility – 100% Assisted Living Facility – 60% Professional Home Care – 50% Total Home Care – 50% Compound Inflation 	
Plans 3 and 4 are "Partnership Qualified" for employees age 75 or younger. For employees 76 or older, <u>all plans</u> are "Partnership Qualified". Please refer to information on the Partnership program located in this enrollment kit.						
Facility Monthly Benefit	t Amount (Check one))				
□ \$1,500 (Funded Plan) □ \$2	2,000 🗆 \$3,000	□ \$4,00	0 🗆 \$5,000	□ \$6,000	□ \$7,000	□ \$8,000
· · · · · · · · · · · · · · · · · · ·		Ŧ /	. ,	_ +=,===	. ,	
Facility Benefit Duration	<u>'</u>		.	. ,	I	
Facility Benefit Duration 2 Years (Funded Plan)	n (Check one) (Duratio	on of benef	its may vary depend	ing on where	benefits are received ted Duration *	ved.)
Facility Benefit Duration 2 Years (Funded Plan) *EMPLOYEES: Selection of this of Insurance Application (Evidence is attached as the last page of the Hired Employees – who enroll af the be required to fill out an Evidence	Of Check one) (Duration of Insurability) and a sign of Insurability) and a sign of Insurability of Insurability of Insurability of Insurability of Insurability Application	rantee Iss gned Auth ty Applica enrollmer ttion and a	ue limits and requir norization to Requestion. NOTE TO EMP nt period or choose a signed Form #672	□ Unlimi es completio st Medical Inf PLOYEES: All benefits over 0-03.	ted Duration * n of the Long Te ormation Form # Active Employe r the Guarantee I	rm Care f6720-03 which es & Newly ssue limits will
Facility Benefit Duration 2 Years (Funded Plan) *EMPLOYEES: Selection of this of Insurance Application (Evidence is attached as the last page of the Hired Employees – who enroll af be required to fill out an Evidence The premium for the buy-up of	n (Check one) (Duration of Years) option exceeds the Guars of Insurability) and a sign of Insurability of Insurability ter the Guarantee Issue the Guarability Applications will be paid through	rantee Iss gned Auth ty Applica enrollmer ttion and a	ue limits and requir norization to Requestion. NOTE TO EMP nt period or choose a signed Form #672	□ Unlimi es completio st Medical Inf PLOYEES: All benefits over 0-03.	ted Duration * n of the Long Te ormation Form # Active Employe r the Guarantee I	rm Care f6720-03 which es & Newly ssue limits will
Facility Benefit Duration 2 Years (Funded Plan) *EMPLOYEES: Selection of this of Insurance Application (Evidence is attached as the last page of the Hired Employees – who enroll af the be required to fill out an Evidence	n (Check one) (Duration of Pears of Insurability) and a sign of Insurability) and a sign of Insurability of Insurability Applicate the Guarantee Issue the of Insurability Applicate of Insurability Applications will be paid through the Benefit Election Insurance. The characteristic of Insurability Applications of Insurability Applications will be paid through the Benefit Election Insurance. The characteristic of Insurability Applications of Insurability Applications will be paid through the Benefit Election Insurance. The characteristic of Insurability Applications will be paid through the Insurability Applications of Insurability Applications will be paid through the Insurability Applications will be paid th	rantee Iss gned Auth ty Applica enrollmer ation and a ugh a pay Form are g in the Solitive Imped and that	ue limits and require norization to Requestion. NOTE TO EMP a signed Form #672 roll deduction. This incorrect or untractions and the complemental Life pairment must occurat certain limitations	ue, we may	ted Duration * n of the Long Te formation Form # Active Employe the Guarantee I De signed to auti have the right the e read and under ffective date of come apply to you	rm Care f6720-03 which es & Newly ssue limits will horize your to deny erstand that coverage ur coverage.
Facility Benefit Duration 2 Years (Funded Plan) *EMPLOYEES: Selection of this of Insurance Application (Evidence is attached as the last page of the Hired Employees – who enroll af be required to fill out an Evidence of The premium for the buy-up of employer to make the payroll of Caution: If your answers on benefits or rescind your insurance of Activities of Daily Living under this Long Term Care play you also acknowledge that your insurance of the control of the	option exceeds the Guar of Insurability) and a sign of Insurability) and a sign of Insurability applications will be paid throudeduction. This Benefit Election Insurance. That you are participating (ADL) or Severe Cogran in order to be covered u have received the Poyour kit.	rantee Iss gned Auti ty Applica enrollmer ation and a ugh a pay Form are ag in the S nitive Imp ed and tha otential R	ue limits and require norization to Requestion. NOTE TO EMPORT 10 Period or choose a signed Form #672 roll deduction. This incorrect or untractions are incorrect or untractions are limited in the pairment must occur at certain limitations ate Increase Disc	Unlimi es completio st Medical Inf PLOYEES: All benefits ovel 0-03. s form must b ue, we may rogram, have r after your es and exclusi losure Form	ted Duration * n of the Long Te formation Form # Active Employe the Guarantee I be signed to auti have the right the e read and under ffective date of come apply to you and Personal V	rm Care 26720-03 which es & Newly ssue limits will horize your to deny erstand that coverage ur coverage. Worksheet.
Facility Benefit Duration 2 Years (Funded Plan) *EMPLOYEES: Selection of this of Insurance Application (Evidence is attached as the last page of the Hired Employees – who enroll affice the premium for the buy-up of employer to make the payroll of Caution: If your answers on benefits or rescind your insurance of Activities of Daily Living under this Long Term Care play You also acknowledge that yo All information is contained in	option exceeds the Guar of Insurability) and a sign of Insurability) and a sign of Insurability applications will be paid throudeduction. This Benefit Election Insurance. That you are participating (ADL) or Severe Cogran in order to be covered u have received the Poyour kit.	rantee Iss gned Auti ty Applica enrollmer ation and a ugh a pay Form are ag in the S nitive Imp ed and tha otential R	ue limits and require norization to Requestion. NOTE TO EMPORT 10 Period or choose a signed Form #672 roll deduction. This incorrect or untractions are incorrect or untractions are limited in the pairment must occur at certain limitations ate Increase Disc	Unlimi es completio st Medical Inf PLOYEES: All benefits ovel 0-03. s form must b ue, we may rogram, have r after your es and exclusi losure Form	ted Duration * n of the Long Te formation Form # Active Employe the Guarantee I be signed to auti have the right the e read and under ffective date of come apply to you and Personal V	rm Care 26720-03 which es & Newly ssue limits will horize your to deny erstand that coverage ur coverage. Worksheet.
Facility Benefit Duration 2 Years (Funded Plan) *EMPLOYEES: Selection of this of Insurance Application (Evidence is attached as the last page of the Hired Employees – who enroll after the Employees – who enroll after the premium for the buy-up of employer to make the payroll of Caution: If your answers on benefits or rescind your insurance of Activities of Daily Living under this Long Term Care play you also acknowledge that you All information is contained in Your Premium: \$	n (Check one) (Duration of Pears of Insurability) and a sign of Insurability) and a sign of Insurability Applicate the Guarantee Issue the of Insurability Applicate of Insurability Applications will be paid through the Benefit Election Insurance. The character of the Courance of ADL) or Severe Cogran in order to be covered under the Poyour kit. (Transfer the point of Transfer the point of the Poyour kit.	rantee Iss gned Auti ty Applica enrollmer ation and a ugh a pay Form are ag in the S nitive Imp ed and tha otential R	ue limits and require norization to Requestion. NOTE TO EMPORT 10 Period or choose a signed Form #672 roll deduction. This incorrect or untractions are incorrect or untractions are limited in the pairment must occur at certain limitations ate Increase Disc	Unlimi es completio st Medical Inf PLOYEES: All benefits over 0-03. s form must b ue, we may rogram, have r after your es and exclusi losure Form calculation	ted Duration * n of the Long Te formation Form # Active Employe the Guarantee I De signed to auti have the right the read and under ffective date of the ons apply to you and Personal the on the rate she	rm Care 26720-03 which es & Newly ssue limits will horize your to deny erstand that coverage ur coverage. Worksheet.
Facility Benefit Duration 2 Years (Funded Plan) *EMPLOYEES: Selection of this of Insurance Application (Evidence is attached as the last page of the Hired Employees – who enroll after the premium for the buy-up of employer to make the payroll of Caution: If your answers on benefits or rescind your insurance of Activities of Daily Living under this Long Term Care play you also acknowledge that you All information is contained in Your Premium: \$	option exceeds the Guar of Insurability) and a sign of Insurability) and a sign of Insurability applications will be paid throudeduction. This Benefit Election Insurance. That you are participating (ADL) or Severe Cogran in order to be covered u have received the Poyour kit.	rantee Iss gned Auth ty Applica enrollmention and augh a pay Form are gin the Spitive Imped and that tential R	ue limits and require norization to Requestion. NOTE TO EMP a signed Form #672 roll deduction. This incorrect or untractions are the control of the control	Unlimi es completio st Medical Inf PLOYEES: All benefits over 0-03. s form must b ue, we may rogram, have r after your es and exclusi losure Form calculation	ted Duration * n of the Long Te formation Form # Active Employe the Guarantee I be signed to auti have the right the e read and under ffective date of come apply to you and Personal V	rm Care 26720-03 which es & Newly ssue limits will horize your to deny erstand that coverage ur coverage. Worksheet.

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.