IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on 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
FAMILY Benefit Election Form
Long Term Care - Policy #295435

Applicant's 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:		

Complete the following only if applicant is not the employee:

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

Applicant Is: (This Benefit Election Form must be completed for any selection)

☐ Employee's Spouse	☐ Spouse's (Step) Parent or Grandparent	☐ Sibling (Step) (minimum age 18)	☐ Retiree
	☐ Employee's (Step) Parent or Grandparent	☐ Child (Step) (minimum age 18)	☐ Retiree's Spouse

For any of the plans listed below, the Long Term Care Application (Evidence of Insurability), this Benefit Election form and a signed Authorization to Request Medical Information Form #6720-03 (attached as the last page of the Evidence of Insurability application) must be completed and approved for coverage in order to enroll in the Long Term Care plan. Questions concerning Long Term Care coverage can be directed to Unum's toll-free number: 1-800-227-4165.

Plans *(Check one)*

☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3** ***Partnership***	☐ **Plan 4** ***Partnership***
• Long Term Care Facility – 100% • Assisted Living Facility – 60% • Professional Home Care – 50%	• Long Term Care Facility – 100% • Assisted Living Facility – 60% • Professional Home Care – 50% • Total 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 applicants age 75 or younger. For applicants 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)*

☐ $1,500	☐ $2,000	☐ $3,000	☐ $4,000	☐ $5,000	☐ $6,000	☐ $7,000	☐ $8,000

Facility Benefit Duration *(Check one)* ***(Duration of benefits may vary depending on where benefits are received.)***

☐ 2 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.

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 Unum: ☐ 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. You 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)***

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