IMPORTANT INSTRUCTIONS: Prior to submitting this form, all applicants must review the important disclosures and information found on www.unuminfo.com/upitt 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, ME 04122

UNIVERSITY OF PITTSBURGH
Benefit Election Form
Long Term Care – Policy: 215087

A separate Benefit Election Form is required for each person electing coverage.
Employees/Spouses/Domestic Partners/Family Members/Retirees: Please sign and mail all required signature forms to Unum:

Unum
Group Long Term Care
2211 Congress Street
Portland, ME 04122

Please retain a copy for your records.
Spouses/Domestic Partners: If you are making an election to cover for the FIRST time a spouse or domestic partner, documentation of the relationship is required. For a spouse, a copy of the marriage certificate must be submitted to the Office of Human Resources Benefits Department. Please retain a copy for your records. For a domestic partner, contact the Office of Human Resources Benefits Department to schedule an appointment for review of a completed Affidavit of Domestic Partnership. Must also complete and submit Form #1434-97 located in the enrollment kit. Please retain a copy for your records.

This Benefit Election Form is the only form required by an Applicant who fulfills the category of Guarantee Issue, as indicated in Section 4. All other applicants, as checked in Section 4, must submit both this Benefit Election Form and the Long Term Care Application Evidence of Insurability Form #7030-04 and a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit.

1.

Applicant Name: (Last Name, First, Middle Initial)	Social Security Number __ __ __ - __ __ - __ __ __ __	Date of Hire (MM/DD/YYYY) __ __/__ __/__ __ __ __
Street Address	Gender ☐ Male ☐ Female	Date of Birth (MM/DD/YYYY) __ __/__ __/__ __ __ __
City, State, Zip Code	Home Telephone # ( )	Work Telephone # ( )
Applicant Email Address: (notification of receipt of application will be supplied to applicants who submit an email address)		

2. APPLICANT IS:

☐ **Faculty or Staff**	☐ Faculty or Staff's Parent or Grandparent	☐ Sibling (minimum age 18)	☐ Retiree
☐ Faculty or Staff's Spouse	☐ Spouse or Domestic Partner's Parent or Grandparent	☐ Child (minimum age 18)	☐ Retiree's Spouse
☐ Faculty or Staff's Domestic Partner			

Affiliation of Applicant Who is Not Faculty or Staff

Faculty or Staff Name	Faculty or Staff Soc. Sec. # (Only needed if applicant is spouse of faculty or staff)

3. BENEFIT ELECTION:

Plans *(Check one)*

☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 4**
• Long Term Care Facility only	• Long Term Care Facility • Professional Home Care • Total Home Care	• Long Term Care Facility • Compound Uncapped	• Long Term Care Facility • Professional Home Care • Total Home Care • Compound Uncapped

Facility Monthly Benefit Amount *(Check one)*

☐ $1,000	☐ $2,000	☐ $3,000	☐ $4,000	☐ $5,000	☐ $6,000

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

☐ 3 Years	☐ 6 Years	☐ **Unlimited Duration ***

Form is Continued on Reverse Side

REQUEST FOR SIGNATURE: Must check either accept or reject. Please read this entire form carefully before signing below.

I have reviewed the Outline of Coverage with the graphs that compare the benefits and premiums of this insurance with and without the Compound Uncapped and I accept ☐ / reject ☐ this option.

4. APPLICANT ELIGIBILITY - GUARANTEE ISSUE / NON GUARANTEE ISSUE:

Check One and Review Form Requirements for Each Category

GUARANTEE ISSUE CATEGORY

☐ Active and Newly Hired Full-time Faculty, Post Doctoral Associates, Tenured/Tenure Stream Part-time Faculty, Full-time Research Associates, Regular Full-time Staff, and Regular Part-time Staff working 50% effort or greater and Union Eligible Employees.

**Form Requirements –*
If the Applicant is electing Facility Benefit Unlimited Duration, the Evidence of Insurability form #7030-04 must be submitted together with a signed Authorization to Request Medical Information Form #6720-03, and a Benefit Election form.

After the initial Open Enrollment, all forms are required by Applicant, regardless of the level of Facility Benefit Duration elected.

NON GUARANTEE ISSUE CATEGORY

☐ Non Tenured Part-time Faculty, Part-time Research Associates, Regular Part-time Staff working less than 50% effort, Retirees, Post Doctoral Scholars and any other Applicant (including Spouse, Domestic Partner) who is NOT Faculty or Staff. Part –Time Post Doctoral Associates.

Form Requirements –
All Applicants in the Non Guarantee Issue category, as indicated in Section #2, must submit the Evidence of Insurability together with the Benefit Election Form and a signed Form 6720-03.

5. PREMIUM CALCULATION AND PAYMENT METHOD:

$_____ / month from rate sheet calculation, subject to review.

Check One

Authorization for After Tax Payroll Deduction
_____ Faculty or Staff Applicant under Guarantee Issue
_____ Faculty or Staff Applicant under Guarantee Issue
Whose Spouse submitted separate Election Form and Evidence of Insurability

Acceptance of Quarterly Bill Directly by Unum
_____ Faculty or Staff Applicant under Non Guarantee Issue
_____ Spouse Applicant under Non Guarantee Issue
_____ Any Other Applicant under Non Guarantee Issue

6. CERTIFICATION/SIGNATURE:

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.

_____ _____/_____/_____
Applicant (Any Eligible Person Electing Coverage)

_____ _____/_____/_____
If Applicant is Spouse, Domestic Partner
Faculty or Staff Signature is Also Required

If you have questions about Long Term Care coverage, please call Unum's toll-free number: 1-800-227-4165. **(M0)**