LONG TERM CARE BENEFIT ELECTION FORM

Especially for Family and Retired Employees/Members

UNUM Life Insurance Company of America
LTC Department, 2211 Congress Street, Portland, Maine 04122, 1-800-227-4165
If you have questions, please call Specialists in Long Term Care at 1-800-764-6585

United Teachers Los Angeles -- Policy #561070

Applicant's Name:_____Telephone: (H)_____(W)_____
Address: _____ Date of Birth: _____
City: _____ State: _____ Zip: _____ Email: _____
Applicant's Social Security Number: _____ Sex: ( ) Male ( ) Female
Applicant is: (Check One)
( ) Employee's Spouse/ Registered Domestic Partner ( ) Employee's Parent or Grandparent ( ) Sibling ( ) Children
( ) Employee's Domestic Partner ( ) Spouse's/Domestic Partner's Parent or Grandparent ( ) Retiree ( ) Retiree's Spouse

Plan Options (Check One)

Nursing Facility & Home Care

Basic Plan	**Preferred Plan**	**Enhanced Plan**
3 year plan (Lifetime Max $144,000)	4 year plan (Lifetime Max $192,000)	6 year plan (Lifetime Max $360,000)
Monthly Benefit Amount	Monthly Benefit Amount	Monthly Benefit Amount
$4,000 Nursing Facility	$4,000 Nursing Facility	$5,000 Nursing Facility
$2,800 Residential Care Facility	$2,800 Residential Care Facility	$3,500 Residential Care Facility
$2,000 Home and Community-Based Care	$2,000 Home and Community-Based Care	$2,500 Home and Community-Based Care
With Compound Inflation ☐	With Compound Inflation ☐	With Compound Inflation ☐
Without Compound Inflation ☐	Without Compound Inflation ☐	Without Compound Inflation ☐

Important Note: You may choose any of the plans listed above. The Long Term Care Application (medical questionnaire), the Benefit Election form and a signed Authorization to Request Medical Information Form #6720-03-CA located in the enrollment kit, must be completed and you must be approved for coverage in order to enroll in the Long Term Care plan.

Your Premium: $_____ *(Transfer the premium amount from the rate sheet.)*

Your Insurance Age is your age as of the effective date of coverage.

Caution: if your answers on this Enrollment Form are incorrect or untrue, we may have the right to deny benefits or rescind your insurance.

Billing:

- If you are an Active Employee's Spouse/Domestic Partner, your premium will be paid through payroll deduction from the employee's paycheck. In this case, the employee must sign below to authorize the employer to make the payroll deduction.
- If you are an eligible Family Member or Retiree, please select a payment method:
  ☐ Monthly Automatic Payments (deducted from your checking account – complete Authorization/Agreement for Automatic Payments),
  OR
  Billed directly (paper) by the insurance company: ☐ Quarterly ☐ Semi-Annually ☐ Annually

By signing below, you signify that you have read and understand that Activities of Daily Living (ADL) loss or severe cognitive impairment must occur after your effective date of coverage in order to be covered by this Long Term Care plan, and that certain limitations and exclusions apply to your coverage.

All information is contained in your kit.

_____ _____ _____ _____
Applicants Signature **Date** **Employee's Signature** **Date**
(Required for Spouse/Registered Domestic Partner Coverage)

Employee Name:_____ **Telephone: (H):**_____
Employee Social Security #:_____ **Telephone: (W):**_____
Employee #:_____ **Employee Date of Birth**:_____

Applicants sign and mail all required forms to
Specialists in Long Term Care Insurance Services, Inc., P.O. Box 6630, Auburn, CA 95604-9904
in the postage paid envelope.
Retain a copy for your records. (K5)