



LONG TERM CARE BENEFIT ELECTION FORM  
Especially for Employees/Members Only

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 #561070-002**

Employee/Member's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of Hire: \_\_\_\_\_ Employee #: \_\_\_\_\_ Email: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Sex: ( ) Male ( ) Female

**Plan Options** (Check One)

**Nursing Facility & Home Care**

**Basic Plan**

3 year plan (Lifetime Max \$108,000)

Monthly Benefit Amount

\$3,000 Nursing Facility

\$2,100 Residential Care Facility

\$1,500 Home and Community-Based Care

With Compound Inflation

Without Compound Inflation

**Preferred Plan**

4 year plan (Lifetime Max \$144,000)

Monthly Benefit Amount

\$3,000 Nursing Facility

\$2,100 Residential Care Facility

\$1,500 Home and Community-Based Care

With Compound Inflation

Without Compound Inflation

**Enhanced Plan**

6 year plan (Lifetime Max \$288,000)

Monthly Benefit Amount

\$4,000 Nursing Facility

\$2,800 Residential Care Facility

\$2,000 Home and Community-Based Care

With Compound Inflation

Without Compound Inflation

**Important Note: Active Employees/Members who select a plan do NOT need to complete the Long Term Care Application (medical questionnaire) if enrolling during the Guarantee Issue enrollment period. If you enroll after the Guarantee Issue enrollment period, you will be required to fill out the application/evidence of insurability. ALL application/evidence of insurability must accompany a signed Authorization to Request Medical Information Form #6720-03-CA located in the enrollment kit.**

Your Premium: \$ \_\_\_\_\_ (Transfer the premium amount from the rate sheet.)

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

**Billing:**

Your premium will be paid through payroll deduction from your paycheck. You must sign below to authorize your employer to make the payroll deduction.

**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 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.

Employee/Member's Signature \_\_\_\_\_

Date \_\_\_\_\_

Please sign and send this original to:  
Specialists in Long Term Care Insurance Services, Inc.  
P.O. Box 6630  
Auburn, CA 95604-9904  
If there are any questions, please call: 1-800-764-6585  
Retain a copy for your records. (K5)