



**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 #561070-003**

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/Registered Domestic Partner's/Domestic Partner's Parent or Grandparent ( ) Retiree ( ) Retiree's Spouse

**Plan Options** (Check One)

**Nursing Facility & Home Care**

<u>Basic Plan</u>	<u>Preferred Plan</u>	<u>Enhanced Plan</u>
3 year plan (Lifetime Max \$108,000)	4 year plan (Lifetime Max \$144,000)	6 year plan (Lifetime Max \$216,000)
<u>Monthly Benefit Amount</u>	<u>Monthly Benefit Amount</u>	<u>Monthly Benefit Amount</u>
\$3,000 Nursing Facility	\$3,000 Nursing Facility	\$3,000 Nursing Facility
\$2,100 Residential Care Facility	\$2,100 Residential Care Facility	\$2,100 Residential Care Facility
\$1,500 Home and Community-Based Care	\$1,500 Home and Community-Based Care	\$1,500 Home and Community-Based Care
With Compound Inflation <input type="checkbox"/>	With Compound Inflation <input type="checkbox"/>	With Compound Inflation <input type="checkbox"/>
Without Compound Inflation <input type="checkbox"/>	Without Compound Inflation <input type="checkbox"/>	Without Compound Inflation <input type="checkbox"/>

**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/Registered Domestic Partner/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.

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