**IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/aerovironment 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

# *AEROVIRONMENT, INC.*
## Benefit Election Form
## Long Term Care - Policy #949209

| Your Name: (Last Name, First, Middle Initial) | Social Security Number<br>__ __ __ - __ __ - __ __ __ __ | Date of Birth (MM/DD/YYYY)<br>__ __/__ __/__ __ __ __ |
|---|---|---|
| Street Address | Gender<br>☐ Male ☐ Female | Date of Hire (MM/DD/YYYY)<br>__ __/__ __/__ __ __ __ |
| City, State, Zip Code | Home Telephone #<br>( ) | Work Telephone #<br>( ) |
| Applicant's Email Address: | | |

**Complete the following only if applicant is not the employee**

| Employee's Name | Employee Social Security No.<br>__ __ __ - __ __ - __ __ __ __ | Employee Date of Birth<br>__ __/__ __/__ __ __ __ | Employee Date of Hire<br>__ __/__ __/__ __ __ __ |
|---|---|---|---|

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

| | | |
|---|---|---|
| ☐ Employee | ☐ Employee's Parent or Grandparent | ☐ Sibling *(minimum age 18)* |
| ☐ Employee's Spouse/ Registered Domestic Partner | ☐ Spouse's/Registered Domestic Partner's Parent or Grandparent | ☐ Child *(minimum age 18)* |

**Plans – (Check one)**

| ☐ **Plan 1** | ☐ **Plan 2** | ☐ **Plan 3** | ☐ **Plan 4** |
|---|---|---|---|
| • Nursing Facility & 70% Residential Care Facility<br>• Home & Community-Based Care | • Nursing Facility & 70% Residential Care Facility<br>• Home, Community-Based & Immediate Family Member Care | • Nursing Facility & 70% Residential Care Facility<br>• Home & Community-Based Care<br>• Compound Inflation | • Nursing Facility & 70% Residential Care Facility<br>• Home, Community-Based & Immediate Family Member Care<br>• Compound Inflation |

**Facility Monthly Benefit Amount**

| *(Check one)* | ☐ $3,000 | ☐ $4,000 | ☐ $5,000 | ☐ $6,000 | ☐ **$7,000 *** | ☐ **$8,000 *** |
|---|---|---|---|---|---|---|

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

| *(Check one)* | ☐ 3 Years | ☐ 6 Years | ☐ **Unlimited Duration *** |
|---|---|---|---|

*** EMPLOYEES: Selection of this option exceeds the Guarantee Issue limits and requires completion of the Long Term Care Insurance Application (medical questionnaire). ALL OTHER APPLICANTS must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire) for any selection. ALL Medical Questionnaires must accompany a signed Authorization to Request Medical Information Form #6720-03-CA located in the enrollment kit. *NOTE TO EMPLOYEES:* All Active Employees & Newly Hired Employees – who enroll after the Guarantee Issue enrollment period or choose benefits over the Guarantee Issue limits will be required to fill out a medical questionnaire and signed Form #6720-03-CA.**

**Active Employee or Spouse/Registered Domestic Partner:** Your premium will be paid through the Employee's payroll deduction. Employee must sign below to authorize the Employer to make the payroll deduction.

**All other eligible Family Members:** Please select 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

**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 also acknowledge that you have received the **Potential Rate Increase Disclosure Form** and **Personal Worksheet**.

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

| _____ | __ __/__ __/__ __ __ __ | _____ | __ __/__ __/__ __ __ __ |
|---|---|---|---|
| *Applicant's Signature* | *Date* | *Employee's Signature (Required for Spouse/Registered Domestic Partner Coverage)* | *Date* |

**Employees & Spouses/Registered Domestic Partners: Please sign and mail all required signature forms to your employer.**
**Family Members: Please sign and mail all required signature forms to Unum (address at top of page).**
**Retain a copy for your records. (K5)**

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