

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

ARGUS CONSULTING, INC.
Employee/Spouse Benefit Election Form
Long Term Care - Policy #206559

(one form to be completed by each applicant)

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

Complete the following only if applicant is not the employee:

Employee Name	Employee Social Security No. ____ - ____ - ____	Employee Date of Birth ____ / ____ / ____	Employee Date of Hire ____ / ____ / ____
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Is this a change to existing coverage? Yes No

If yes, new elections made below will replace existing coverage upon underwriting approval, if applicable.

Funded Plan (Employer Paid)

Level of Care:	Long Term Care Facility and 100% Professional Home and Community Care
Monthly Benefit:	\$1,000 Long Term Care Facility / 100% Professional Home and Community Care
Benefit Duration:	3 Years Long Term Care Facility / 100% Professional Home and Community Care
Inflation Protection:	Compound Inflation

Employee - Your employer is funding Plan 1. You may purchase additional coverage. Please make your selections below.

Spouse - You may choose any plan listed below. **

Plans – Check one (this Benefit Election Form must be completed for any selection).

<input type="checkbox"/> Plan 1 (Funded for Employees Only)	<input type="checkbox"/> Plan 2
<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home and Community Care • Compound Inflation 	<ul style="list-style-type: none"> • Long Term Care Facility • 50% Total Choice Home Care • Compound Inflation

Facility Monthly Benefit Amount – Check one

<input type="checkbox"/> \$1,000 (Funded for Employees Only)	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$6,000	<input type="checkbox"/> \$7,000 *	<input type="checkbox"/> \$8,000 *	<input type="checkbox"/> \$9,000 *
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Facility Benefit Duration – Check one

Duration of benefits may vary depending on where benefits are received.

<input type="checkbox"/> 3 Years (Funded for Employees Only)	<input type="checkbox"/> 6 Years	<input type="checkbox"/> Lifetime *
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- *** Employees:** These options exceed the **Guarantee Issue limits** and their selection will require completion of the Long Term Care Insurance Application (medical questionnaire).
- **All active employees and newly hired employees** who enroll after the Guarantee Issue enrollment period must complete the Long Term Care Insurance Application (medical questionnaire).
- **** Spouses** must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire) for any selection.
- A signed Authorization to Request Medical Information (form #6720-03 in the kit) must accompany all medical questionnaires.

Form is continued on reverse side.

Calculate Your Premium:

Please refer to rate sheet in your kit to determine the rate for the plan chosen.

	X		÷	\$1,000	=		(A)
Rate for plan chosen		Monthly benefit amount				Your premium	
For Employees Only:					=		(B)
		Rate for funded Plan 1 (3 Year duration)				Employer Paid Amount	
				A MINUS B			
						EMPLOYEE'S COST	

Disclosures:

Note: We may have the right to deny benefits or rescind insurance if any of the information provided on this enrollment form is incorrect.

REQUEST FOR SIGNATURE: Please read this entire form carefully before signing below.

I certify that all statements are true to the best of my knowledge and belief. I have read and understand that, for coverage that does not require me to submit evidence of insurability, loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after my effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to my coverage.

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

Active Employees & Spouses: Your signature below authorizes your employer to deduct the required premium from your paycheck. Final cost of coverage will be based on your Insurance Age. If you enroll for coverage on or before the group policy effective date, Insurance Age is your age on the group policy effective date. If you enroll for coverage after the group policy effective date, Insurance Age is your age on the date you sign this enrollment form.

Your premium: \$ _____ (transfer from calculation above)

	/	/				/	/	
<i>Applicant's Signature</i>			<i>Date</i>		<i>Employee's Signature</i>			<i>Date</i>
					(Required for Spouse Coverage)			

**Please sign and mail all required signature forms to your employer.
Retain a copy for your records. (M4)**

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