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

CUPERTINO ELECTRIC, INC.

FAMILY Benefit Election Form
Long Term Care – Policy: 220661

Your Name: (Last Name, First, Middle Initial)				Soc	Social Security Number		oer	Date of Birth (MM/DD/YYYY)				
Street Address				Hor (Home Telephone #			Work Telephone #				
City, State, Zip Code				1 \	Gender ☐ Male ☐ Fei			Female	emale			
Applicant's Email Address:												
Employee's Name		Employee Social Security I		/ No.	No. Employee Date of B		rth	th Employee Date of Hire				
Applicant Is: (This Benefit Election Form must be completed for any selection)												
			ouse's/ Registered Domestic Partn nt or Grandparent			tner's			t or Grandparent			
You may choose any of the plans listed below. 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.												
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Plans – (Ch		арргочес	Tior coverage	in order to	emonim	the Long	Term Care	ріан.				
		□ Pla	_	in order to	□ Plar		Term Care	-	Plan 4			
Plans – (Ch	eck one)	□ Pla • Nurs	_		□ Plar • Nursir	n 3		• N	lursing Fa	cility & ntial Care Facility		
Plans – (Che	eck one)	□ Pla • Nurs 70% F	an 2		□ Plar • Nursir 70% Re • Home	n 3 ng Facility esidential (&	• N 70	lursing Fac % Resider			
Plans – (Che	eck one)	□ Pla • Nurs 70% F	an 2 sing Facility & Residential Care		□ Plar • Nursir 70% Re • Home	n 3 ng Facility esidential (& Care Facility ity-Based &	• N 70 • H are Im	lursing Fac % Resider	ntial Care Facility nmunity-Based & amily Member Care		
Plans – (Che	eck one) / & Care Facility	• Nurs 70% F	an 2 sing Facility & Residential Care	e Facility	□ Plar • Nursir 70% Re • Home	n 3 ng Facility esidential (& Care Facility ity-Based &	• N 70 • H are Im	Nursing Factorial Resider Number Come, Commediate Factorial Residue Re	ntial Care Facility nmunity-Based & amily Member Care		
Plans – (Che	eck one) / & Care Facility	□ Pla • Nurs 70% F • Simp	an 2 sing Facility & Residential Caro ole Inflation	e Facility	□ Plar • Nursir 70% Re • Home Immedia	n 3 ng Facility esidential (& Care Facility ity-Based & Member Ca	• N 70 • H are Im	Nursing Factorial Resider Nome, Commediate Factorial Resider	ntial Care Facility nmunity-Based & amily Member Care		
Plans – (Che ☐ Plan 1 • Nursing Facility 70% Residential	eck one) A Care Facility Facility M	• Nurs 70% F • Simp	an 2 sing Facility & Residential Caro ole Inflation Benefit Ar	e Facility mount	□ Plar • Nursir 70% Re • Home Immedia	ng Facility esidential (, Commur ate Family	& Care Facility ity-Based & Member Ca	• N 70 • H Im	Nursing Fac % Resider Home, Com mediate Fac Simple Infla	ntial Care Facility nmunity-Based & amily Member Care ation		
Plans – (Che ☐ Plan 1 • Nursing Facility 70% Residential	eck one) / & Care Facility Facility M	• Nurs 70% F • Simp	an 2 sing Facility & Residential Care ole Inflation Benefit Ar \$2,000 \$2,500	e Facility mount □ \$3,000	□ Plar • Nursir 70% Re • Home Immedia	n 3 ng Facility esidential (c, Commur ate Family	& Care Facility lity-Based & Member Ca	• N 70 • H Im • S	Nursing Factorial Resider Fact	ntial Care Facility nmunity-Based & amily Member Care ation		

Form is continued on reverse side.

Active Employee's Spouse: Your pr			mployee's payroll dedu	ction. Employ	ee must sign					
below to authorize the Employer to make the payroll deduction.										
All other eligible Family Members: checking account – complete Authoriz		•		ayments (dedu	ucted from your					
Billed directly (paper) by the insurance	e company:	☐ Quarterly	☐ Semi-Annually ☐ Annually		,					
<u>Caution:</u> 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. All information is contained in your kit.										
Your Premium: \$ (Transfer the premium amount from the calculation on the rate sheet)										
				/						
Applicant's Signature	Date	(Require	mployee's Signature ed for Spouse/ Registered estic Partner Coverage)		Date					
Spouses/Registered Domes										
Family Members/Retirees: Please sign and mail all required signature forms to Unum (address at top of page).										

Retain a copy for your records. (K6)

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