IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/desertradiologists002 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

RADIOLOGY PARTNERS dba DESERT RADIOLOGISTS
Benefit Election Form
Long Term Care - Policy #140612-002

Your Name: (Last Name, First, Middle Initial)	Social Security Number __ __ __ - __ __ - __ __ __ __	Date of Birth (MM/DD/YYYY) __ __/__ __/__ __ __ __
Street Address	Gender ☐ Male ☐ 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's Name	Employee Social Security No. __ __ __ - __ __ - __ __ __ __	Employee Date of Birth __ __/__ __/__ __ __ __	Employee Date of Hire __ __/__ __/__ __ __ __

All applicants must complete this form. Applicant is:

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

Plans – Check one

☐ **Plan 1**	☐ **Plan 2 ***	☐ **Plan 3**	☐ **Plan 4 ***
• Long Term Care Facility • 100% Professional Home & Community Care	• Long Term Care Facility • 100% Total Choice Home Care	• Long Term Care Facility • 100% Professional Home & Community Care • Simple Inflation	• Long Term Care Facility • 100% Total Choice Home Care • Simple Inflation

Facility Monthly Benefit Amount – Check one

☐ $1,000	☐ $2,000	☐ $3,000	☐ $4,000	☐ $5,000	☐ $6,000	☐ **$7,000 ***	☐ **$8,000 ***

Facility Benefit Duration – Check one.

☐ 3 Years	☐ 6 Years	☐ **Lifetime ***

- ***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 or choose benefits over the Guarantee Issue limits must complete 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.
- 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 =**	_____
Rate for plan chosen		Monthly benefit amount		Your premium

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.

Active Employees & Spouses or Domestic Partners: I authorize my employer to make the necessary payroll deduction to pay the premium when my insurance becomes effective.

All 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

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

Your premium: $_____ (transfer from calculation above)

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

<u>Employees & Spouses/Domestic Partners:</u> Please sign and mail all required signature forms to your employer.

<u>Domestic Partners</u> must also complete and submit Form #1434-97 provided in kit.

<u>Family Members</u>: Please sign and mail all required signature forms to Unum (address at top of page).

Retain a copy for your records. (G2)

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