IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/fairleighdickinsonu or in a paper enrollment kit. You can request a paper enrollment kit by calling 1-877-286-2852. 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

FAIRLEIGH DICKINSON UNIVERSITY
Benefit Election Form
Long Term Care - Policy #580551

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 # ( )
Work Email Address:	Personal 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 __ __/__ __/__ __ __ __

EMPLOYEE PAYCYCLE: (Check one)

DIVISION 001: ☐ 22 OR ☐ 24	***DIVISION 002:*** ☐ 18 OR ☐ 20

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

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

(Check one)	☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 4**
	• Long Term Care Facility • 100% Professional Home Care	• Long Term Care Facility • 100% Professional Home Care • Accelerated Payment	• Long Term Care Facility • 100% Professional Home Care •5% Compound Inflation	• Long Term Care Facility • 100% Professional Home Care • Accelerated Payment • 5% Compound Inflation

	Facility Monthly Benefit Amount					
(Check one)	☐ $1,000	☐ $2,000	☐ $3,000	☐ $4,000	☐ $5,000	☐ $6,000

	Facility Benefit Duration		
(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 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.**

This form is continued on the reverse side.

Active Employee or Spouse/Civil Union Partner/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.**

This information is contained in your kit.

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

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

Employees & Spouses/Civil Union Partner/Domestic Partners/Family Members: Please sign and return all required signature forms to LTC Solutions, Inc. 14715 NE 95th Street, Suite 200, Redmond, WA 98052
Domestic Partners must also complete and submit Form #1434-97 located in kit.
Retain a copy for your records. (M5)

If you have questions about Long Term Care coverage, please call LTC Solutions' toll-free number: 1-877-286-2852 or email info@ltc-solutions.com.