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

FERNDALE PHARMA GROUP

Employee/Spouse/Domestic Partner

Benefit Election Form

Long Term Care - Policy #125002-002

(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 ☐ Male ☐ Female	Date of Hire (MM/DD/YYYY) __ __/__ __/__ __ __ __
City, State, Zip Code	Home Telephone # ( )	Work Telephone # ( )
Applicant's Email Address:		

Spouses/Domestic Partner's complete the following:

Employee's Name	Employee Social Security No. __ __ __ - __ __ - __ __ __ __	Employee Date of Birth __ __/__ __/__ __ __ __	Employee Date of Hire __ __/__ __/__ __ __ __

Funded Plan (Employer Paid)

Level of Care:	Long Term Care Facility and 100% Professional Home & Community Care
Monthly Benefit:	$2,000 Long Term Care Facility/ 100% Professional Home & Community Care
Benefit Duration:	3 Years Long Term Care Facility/ 100% Professional Home & Community Care

☐ **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. **** ☐ **Domestic Partner - You may choose any plan listed below. ****

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

☐ **Plan 1** **(Funded for Employees Only)**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 4**
• Long Term Care Facility • 100% Professional Home & Community Care	• Long Term Care Facility • 100% Professional Home & Community Care • 5% Simple Inflation	• Long Term Care Facility • 100% Professional Home & Community Care • 10 Year APO	• Long Term Care Facility • 100% Professional Home & Community Care • 5% Simple Inflation • 10 Year APO

Employee Facility Monthly Benefit Amount – Check one

☐ $2,000 **(Funded for Employees Only)**	☐ $3,000	☐ $4,000	☐ $5,000	☐ $6,000	☐ **$7,000 ***	☐ **$8,000 ***	☐ **$9,000 ***

Spouse/Domestic Partner Facility Monthly Benefit Amount – Check one

☐ $1,000	☐ $2,000	☐ $3,000	☐ $4,000	☐ $5,000	☐ $6,000	☐ $7,000	☐ $8,000	☐ $9,000

Facility Benefit Duration – Check one **Duration of benefits may vary depending on where benefits are received.**

☐ 3 Years **(Funded for Employees Only)**	☐ 6 Years	☐ **Lifetime ***

- *** 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 or choose benefits over the Guarantee Issue limits must complete the Long Term Care Insurance Application (medical questionnaire).
- **** Spouses and Domestic Partners** 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.

_____ Rate for plan chosen	**X**	_____ Monthly benefit amount	**÷ $1,000**	**=** _____ **(A)** Your premium
For Employees Only:		_____ Rate for funded Plan 1 (3 Year duration)		**=** _____ **(B)** 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**. I acknowledge receipt of the Outline of Coverage and understand that it is mine to keep.

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.

Your premium: $_____ (Transfer from calculation above)

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

Please sign and mail all required signature forms to your employer.
Domestic Partners must also complete and submit Form #1434-97 provided in kit.
Retain a copy for your records. (J7)

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

FOR ADDITIONAL INFORMATION ABOUT LONG-TERM CARE COVERAGE WRITE TO THE INSURANCE BUREAU, P.O. BOX 30220, LANSING, MI 48909 OR CALL THE AREA AGENCY ON AGING IN YOUR COMMUNITY