

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
Family Benefit Election Form
Long Term Care - Policy #125002-002

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

All applicants must complete this form. Applicant is:

<input type="checkbox"/> Employee's Parent or Grandparent	<input type="checkbox"/> Sibling (<i>minimum age 18</i>)
<input type="checkbox"/> Spouse's/Domestic Partner's Parent or Grandparent	<input type="checkbox"/> Child (<i>minimum age 18</i>)

Plans – Check one

<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4
<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home & Community Care 	<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home & Community Care • 5% Simple Inflation 	<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home & Community Care • 10 Year APO 	<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home & Community Care • 5% Simple Inflation • 10 Year APO

Facility Monthly Benefit Amount – Check one

<input type="checkbox"/> \$1,000	<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	<input type="checkbox"/> 6 Years	<input type="checkbox"/> Lifetime
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- **All 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.

$$\begin{array}{ccccccc}
 \underline{\hspace{2cm}} & \times & \underline{\hspace{2cm}} & \div & \$1,000 & = & \underline{\hspace{2cm}} \\
 \text{Rate for plan chosen} & & \text{Monthly benefit amount} & & & & \text{Your premium}
 \end{array}$$

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 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.

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

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

Applicant's Signature

____/____/_____
Date

Employee's Signature

____/____/_____
Date

**Please sign and mail all required signature forms to Unum (address at top of page).
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**