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

# *FLORIDA STATE UNIVERSITY*
## Benefit Election Form (FL)
## Long Term Care - Policy #025320

| Your Name: (Last Name, First, Middle Initial) | Social Security Number<br>__ __ __ - __ __ - __ __ __ __ | Date of Birth (MM/DD/YYYY)<br>__ __/__ __/__ __ __ __ |
|---|---|---|
| Street Address | Gender<br>☐ Male ☐ Female | Date of Hire (MM/DD/YYYY)<br>__ __/__ __/__ __ __ __ |
| City, State, Zip Code | Home Telephone #<br>( ) | Work Telephone #<br>( ) |
| Applicant's Email Address: | | |

**Complete the following only if applicant is not the employee:**

| Employee's Name | Employee Social Security No.<br>__ __ __ - __ __ - __ __ __ __ | Employee Date of Birth<br>__ __/__ __/__ __ __ __ | Employee Date of Hire<br>__ __/__ __/__ __ __ __ |
|---|---|---|---|

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

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

**Plans** *(Check one)*

| ☐ **Plan 1** | ☐ **Plan 2** | ☐ **Plan 3** | ☐ **Plan 4** |
|---|---|---|---|
| • Long Term Care Facility<br>• Professional Home Care | • Long Term Care Facility<br>• Professional Home Care<br>• Total Home Care | • Long Term Care Facility<br>• Professional Home Care<br>• Simple Inflation | • Long Term Care Facility<br>• Professional Home Care<br>• Total Home Care<br>• Simple Inflation |

**Facility Monthly Benefit Amount** *(Check one)*

| ☐ $1,000 | ☐ $2,000 | ☐ $3,000 | ☐ $4,000 | ☐ **$5,000 *** | ☐ **$6,000 *** |
|---|---|---|---|---|---|

**Facility Benefit Duration** ***(Duration of benefits may vary depending on where benefits are received.)*** *(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 sign Form #6720-03.**

**Active Employee or Spouse/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 or Retirees:** 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: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

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.** All 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/Domestic Partner Coverage)* | *Date* |

**Employees & Spouses/Domestic Partners: Please sign and mail all required signature forms to your employer.**
**Domestic Partners must also complete and submit Form #1434-97 located in kit.**
**Family Members/Retirees: Please sign and mail all required signature forms to Unum (address at top of page).**
**Retain a copy for your records. (J1)**

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