

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

**PUBLIC UTILITY DISTRICT NO. 2 OF  
 GRANT COUNTY, WASHINGTON  
 Benefit Election Form  
 Long Term Care - Policy #556888**

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: \_\_\_\_\_

**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 ____/____/____
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**Applicant Is:**

<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Parent or Grandparent	<input type="checkbox"/> Sibling/Child ( <i>minimum age 18</i> )	<input type="checkbox"/> Retiree
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<i>(Check one)</i>	<b>Plans</b>							
	<input type="checkbox"/> <b>Plan 1</b> • Long Term Care Facility • Professional Home Care	<input type="checkbox"/> <b>Plan 2</b> • Long Term Care Facility • Professional Home Care • Total Home Care	<input type="checkbox"/> <b>Plan 3</b> • Long Term Care Facility • Professional Home Care • Compound Inflation	<input type="checkbox"/> <b>Plan 4</b> • Long Term Care Facility • Professional Home Care • Total Home Care • Compound Inflation				
<i>(Check one)</i>	<b>Facility Monthly Benefit Amount</b>							
	<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"/> <b>\$7,000*</b>	<input type="checkbox"/> <b>\$8,000*</b>
<i>(Check one)</i>	<b>Facility Benefit Duration</b> ( <i>Duration of benefits may vary depending on where benefits are received.</i> )							
	<input type="checkbox"/> 3 Years		<input type="checkbox"/> 6 Years			<input type="checkbox"/> <b>Unlimited Duration *</b>		

**\*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:** 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:** 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**. 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 Coverage)	Date

**Employees & Spouses:** Please sign and mail all required signature forms to your employer.  
**Family Members/Retirees:** Please sign and mail all required signature forms to Unum (address at top of page).  
 Retain a copy for your records. (M5)

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