



Underwritten by:
 Unum Life Insurance Company of America
 2211 Congress Street
 Portland, Maine 04122

**LONG TERM CARE
 ELIGIBLE FAMILY MEMBER OF SURVIVING SPOUSE/RDP***

BENEFIT ELECTION FORM

**Los Angeles Police Relief Association, Inc.
 Policy Number: 096797-003**

IMPORTANT: You must complete this form and a Long Term Care Insurance Application for any long-term care coverage you select.

| | | |
|---|---|---|
| Your Name: (Last Name, First Name, 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 | | |

**Relationship to
 Surviving Spouse:**

Parent or Grandparent Sibling Child

The minimum age for a sibling or child is 18.

| | | |
|----------------------------|---|--------------------------------------|
| Surviving Spouse/RDP* Name | Social Security Number ____ - ____ - _____ | Date of Birth ____ / ____ / _____ |
|----------------------------|---|--------------------------------------|

| Choose a Plan (Check One) | | |
|---|---|---|
| <input type="checkbox"/> Plan 1 100% Facility, Home and Community-Based Care, No Inflation Protection | <input type="checkbox"/> Plan 2 100% Facility, Home and Community-Based Care, 5% Simple Inflation | <input type="checkbox"/> Plan 3 100% Facility, Home and Community-Based Care, 5% Compound Inflation |

| Choose a Benefit Duration (Check One) | | |
|---------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> 2 Years | <input type="checkbox"/> 5 Years | <input type="checkbox"/> Lifetime |

| Choose a Facility Monthly Benefit Amount (Check One) | | | | | | | |
|--|----------------------------------|----------------------------------|----------------------------------|----------------------------------|----------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> \$1,500 | <input type="checkbox"/> \$2,500 | <input type="checkbox"/> \$3,500 | <input type="checkbox"/> \$4,500 | <input type="checkbox"/> \$5,500 | <input type="checkbox"/> \$6,500 | <input type="checkbox"/> \$7,500 | <input type="checkbox"/> \$8,500 |

Full Medical Underwriting is required for this coverage: The eligible family member must complete a Long Term Care Insurance Application and a signed Authorization to Request Medical Information Form #6720-03-CA included as part of the Application.

(continued on reverse side)

* Registered Domestic Partner



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Calculate Your Premium

To calculate your premium using the formula below:

1. Refer to the Rate Sheet available at <http://w3.unum.com/enroll/LAPRA> or call Unum at 1-800-227-4165 to request an enrollment kit, which includes the Rate Sheet.
2. Fill in the numbers below.

$$\underline{\hspace{2cm}} \quad \times \quad \underline{\hspace{2cm}} \quad / \quad \$1,000 \quad = \quad \underline{\hspace{2cm}}$$

Rate per \$1,000 for Plan Chosen Monthly Benefit Amount Monthly Premium

You can also use the online premium calculator on the Unum long-term care insurance website for LAPRA members at <http://w3.unum.com/enroll/LAPRA>.

Payment Method

Eligible Family Members: Please select a payment method for long-term care insurance premiums:

- Monthly Automatic Payment (deducted from your checking account – complete Authorization/Agreement for Automatic Payments)
- Billed Directly (Paper Bill) by the Insurance Company: Quarterly Semi-Annually Annually

Your Premium: \$_____ (transfer monthly premium from calculation above)

Request for Signature (Please read this entire form carefully before signing below.)

Your premium is based on your insurance age. Insurance age is your age on the plan effective date. If you enroll for coverage on or after the plan effective date, insurance age is your age on the date this election form is signed. Please verify your name, Social Security number and date of birth before signing. **Please Note: Your signature is required. Retain a copy for your records.**

Caution: If your answers on this Benefit Election Form are incorrect or untrue, we may have the right to deny benefits or rescind your insurance.

 Applicant Signature

 Date

If you have any questions about long-term care coverage, please call Unum at 1-800-227-4165. Please sign and return all forms that require a signature to Unum at the address listed on the Long Term Care Insurance Application. Keep a copy of the forms for your records.