



LONG TERM CARE LAPRA EMPLOYEE BENEFIT ELECTION FORM

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

Los Angeles Police Relief Association, Inc.
Policy Number: 096797-005

IMPORTANT: Complete this form ONLY if you are electing an LTC coverage amount over the Core Benefit that is funded by LAPRA.

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 # ()
Email Address		

LAPRA is paying for the following Core Benefit

Level of Care:	100% Facility, Home and Community-Based Care
Benefit Duration:	2 Years Facility / 100% Home and Community-Based Care
Monthly Benefit:	\$1,500 Facility/ 100% Home and Community-Based Care
Inflation Protection:	None
Elimination Period:	90 Days

Choose a Plan (Check One)

<input type="checkbox"/> Plan 1 (Funded by LAPRA) 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
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Choose a Benefit Duration (Check One)

<input type="checkbox"/> 2 Years (Funded by LAPRA)	<input type="checkbox"/> 5 Years	<input type="checkbox"/> Lifetime*
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Choose a Facility Monthly Benefit Amount (Check One)

<input type="checkbox"/> \$1,500 <small>(Funded by LAPRA)</small>	<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*
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* **Note to LAPRA Employees:** Selection of this LTC option exceeds the Guarantee Issue limits and requires completion of a Long Term Care Insurance Application and a signed Authorization to Request Medical Information Form #6720-03-CA. You can download a Long Term Care Insurance Application from the LAPRA website (www.lapra.org), or you can call **LAPRA at 888-252-7721 to request that a Long Term Care Insurance Application be mailed to you.** All LAPRA employees and who enroll after the initial enrollment period or choose benefits over the Guarantee Issue limits will be required to fill out a Long Term Care Insurance Application and signed Form #6720-03-CA.

(continued on reverse side)



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Calculate Your Premium

To calculate your premium, please refer to the rate sheet in your kit and use the calculation below.

$$\frac{\text{Rate per \$1,000 for Plan Chosen}}{\text{Rate per \$1,000 for Plan Chosen}} \times \frac{\text{Monthly Benefit Amount}}{\text{Monthly Benefit Amount}} / \$1,000 = \frac{\text{Per Pay Period Premium}}{\text{Per Pay Period Premium}} \quad \text{(A)}$$

Core LTC Benefit Paid by LAPRA

$$\frac{\text{Rate per \$1,000 for Plan One}}{\text{Rate per \$1,000 for Plan One}} \times \frac{\$1,500}{\text{Monthly Benefit Amount}} / \$1,000 = \frac{\text{LAPRA Paid Per Pay Period Premium}}{\text{LAPRA Paid Per Pay Period Premium}} \quad \text{(B)}$$

$$\text{(A) MINUS (B) = EMPLOYEE'S Per Pay Period Premium}$$

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

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

Your signature below authorizes LAPRA to deduct premium from your paycheck, if applicable. 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 you sign the enrollment form. Please verify your name, Social Security number and date of birth before signing. **Please Note: Member signature is required. Retain a copy for your records.**

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

MA Residents Only: You also signify that you have received and read the MassHealth eligibility notice entitled "For Massachusetts Residents Only" – Form #7650-04.

LAPRA Employee 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:

LAPRA
600 North Grand Ave
Los Angeles, CA 90012

Keep a copy of the forms for your records.