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

LONG TERM CARE
ELIGIBLE FAMILY MEMBER OF LAPRA EMPLOYEE
BENEFIT ELECTION FORM
Los Angeles Police Relief Association, Inc.
Policy Number: 096797-005

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 ☐ Male ☐ Female	Date of Hire (MM/DD/YYYY) __ __ / __ __/ __ __ __ __
City, State, Zip Code	Home Telephone # ( )	Work Telephone # ( )
Email Address		

Relationship to LAPRA Employee: ☐ Spouse/RDP* ☐ Parent or Grandparent ☐ Sibling ☐ Child | The minimum age for a sibling or child is 18.

LAPRA Employee's Name	Social Security Number __ __ __ - __ __ - __ __ __ __	Date of Birth __ __ / __ __/ __ __ __ __

Choose a Plan (Check One)		
☐ **Plan 1** 100% Facility, Home and Community-Based Care, No Inflation Protection	☐ **Plan 2** 100% Facility, Home and Community-Based Care, 5% Simple Inflation	☐ **Plan 3** 100% Facility, Home and Community-Based Care,5% Compound Inflation

Choose a Benefit Duration (Check One)		
☐ 2 Years	☐ 5 Years	☐ Lifetime

Choose a Facility Monthly Benefit Amount (Check One)							
☐ $1,500	☐ $2,500	☐ $3,500	☐ $4,500	☐ $5,500	☐ $6,500	☐ $7,500	☐ $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 the premium for your coverage:

1. Use the Rate Sheet included in your enrollment packet to find the rate per $1,000 of coverage based on your age and the plan and benefit duration you select.
2. Fill in the numbers below.

_____	X	_____	/ $1,000 =	_____
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

Note to LAPRA Employee: Your signature below authorizes LAPRA to deduct premiums from your paycheck for spouse/RDP* coverage.

Eligible Family Members (Except Spouse/RDP*): 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 you 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.

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 (only required for spouse/RDP* coverage) **Date**

_____ _____

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 for your records.

* Registered Domestic Partner