



**LONG TERM CARE  
ELIGIBLE FAMILY MEMBER OF LAPRA RETIRED EMPLOYEE**

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

**BENEFIT ELECTION FORM  
Los Angeles Police Relief Association, Inc.  
Policy Number: 096797-006**

**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<br>____ - ____ - _____                           | Date of Birth (MM/DD/YYYY)<br>__ / __ / ____ |
| Street Address                              | Gender<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Hire (MM/DD/YYYY)<br>__ / __ / ____  |
| City, State, Zip Code                       | Home Telephone #<br>(   )   | Work Telephone #<br>(   )                    |
| Email Address                               |   |  |

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

| Information About the LAPRA Member |  |  |
|------------------------------------|--|--|
| Member's Name                      | Member's Social Security Number<br>____ - ____ - _____ | Member's Date of Birth<br>__ / __ / ____ |

| Choose a Plan (Check One)   |   |   |
|---|---|---|
| <input type="checkbox"/> <b>Plan 1</b><br>100% Facility, Home and Community-Based Care, No Inflation Protection | <input type="checkbox"/> <b>Plan 2</b><br>100% Facility, Home and Community-Based Care, 5% Simple Inflation | <input type="checkbox"/> <b>Plan 3</b><br>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 the Premium for LTC Coverage**

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.

$$\begin{array}{ccccccc}
 \underline{\hspace{2cm}} & & \text{X} & & \underline{\hspace{2cm}} & / \$1,000 = & \underline{\hspace{2cm}} \\
 \text{Rate per \$1,000 for Plan Chosen} & & & & \text{Monthly Benefit Amount} & & \text{Monthly Premium}
 \end{array}$$

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 Retired LAPRA Employee:** Your signature below authorizes LAPRA to deduct premiums from your pension check 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.

\_\_\_\_\_  
**Retired 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