

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

**LOS RIOS COMMUNITY COLLEGE DISTRICT  
 CLASS 002 CERTIFICATED EMPLOYEES  
 EQUAL TO 50% OF A FULL TIME EMPLOYEE  
 Benefit Election Form  
 Long Term Care - Policy #145431-002**

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 # (____) _____

Email Address: \_\_\_\_\_

**Complete the following only if applicant is not the employee**

Employee Name	Employee Social Security No. ____-____-____	Employee Date of Birth ____/____/____	Employee Date of Hire ____/____/____
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Is this a change to existing coverage?    Yes     No  
 If yes, new elections made below will replace existing coverage upon underwriting approval, if applicable.

**Applicant is: (please circle)** \_\_\_\_\_      The Minimum age for a sibling or child is 18.

Employee;    Spouse/ Domestic Partner;    Parent or Grandparent;    Sibling;    Child

**Plans – Check one**

<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4
<ul style="list-style-type: none"> <li>• Facility</li> <li>• 50% Home and Community Based Care</li> </ul>	<ul style="list-style-type: none"> <li>• Facility</li> <li>• 50% Home and Community Based and Immediate Family Member Care</li> </ul>	<ul style="list-style-type: none"> <li>• Facility</li> <li>• 50% Home and Community Based Care</li> <li>• 5% Simple Inflation</li> </ul>	<ul style="list-style-type: none"> <li>• Facility</li> <li>• 50% Home and Community Based and Immediate Family Member Care</li> <li>• 5% Simple Inflation</li> </ul>

**Facility Monthly Benefit Amount – Check one**

\$3,000     \$4,000     \$5,000     \$6,000     \$7,000 \*     \$8,000 \*     \$9,000 \*

**Facility Benefit Duration – Check one.**    Note: Duration of benefits may vary depending on where benefits are received.

<input type="checkbox"/> 2 Years	<input type="checkbox"/> 5 Years	<input type="checkbox"/> Lifetime *
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➤ **\*These options exceed the Guarantee Issue limits** and their selection will require completion of the Long Term Care Insurance Application (medical questionnaire).

➤ **All active employees and newly hired employees** who enroll after the Guarantee Issue enrollment period must complete 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.

➤ A signed Authorization to Request Medical Information (form #6720-03-CA in the kit) must accompany all medical questionnaires.

Form is continued on reverse side.

**Calculate Your Premium:**

Please refer to rate sheet in your kit to determine the rate for the plan chosen.

$$\begin{array}{ccccccc}
 \underline{\hspace{2cm}} & \times & \underline{\hspace{2cm}} & \div & \$1,000 & = & \underline{\hspace{2cm}} \\
 \text{Rate for plan chosen} & & \text{Monthly benefit amount} & & & & \text{Your premium}
 \end{array}$$

**Disclosures:**

**Note: We may have the right to deny benefits or rescind insurance if any of the information provided on this enrollment form is incorrect.**

I am declining coverage at this time.

**REQUEST FOR SIGNATURE:** Please read this entire form carefully before signing below.

I certify that all statements are true to the best of my knowledge and belief. I have read and understand that, for coverage that does not require me to submit evidence of insurability, loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after my effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to my coverage.

**Active Employees & Spouse/Domestic Partners:** Your signature below authorizes your employer to deduct the required premium from your paycheck. Final cost of coverage will be based on your Insurance Age. If you enroll for coverage on or before the group policy effective date, Insurance Age is your age on the group policy effective date. If you enroll for coverage after the group policy effective date, Insurance Age is your age on the date you sign this enrollment form.

**All eligible Family Members:** 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

**Your premium:** \$ \_\_\_\_\_ (transfer from calculation above)

_____ <i>Applicant's Signature</i>	____/____/_____ <i>Date</i>	_____ <i>Employee's Signature</i> (Required for Spouse/ Domestic Partner Coverage)	____/____/_____ <i>Date</i>
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**Employee & Spouse/ Domestic Partner:** Please sign and mail all required signature forms to your employer.

**Family Members:** Please sign and mail all required signature forms to Unum (address at top of page).

**Retain a copy for your records. (K6)**

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