

IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on 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 004 RETIREES
Benefit Election Form
Long Term Care - Policy #145431-004

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 Retiree

Retiree Name	Retiree Social Security No. _____-_____-_____	Retiree Date of Birth ____/____/____	Retiree 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.	
<input type="checkbox"/> Retiree	<input type="checkbox"/> Sibling (<i>minimum age 18</i>)	<input type="checkbox"/> Retiree's Parent or Grandparent	
<input type="checkbox"/> Retiree's Spouse/ Domestic Partner	<input type="checkbox"/> Child (<i>minimum age 18</i>)	<input type="checkbox"/> Retiree's Spouse's/ Domestic Partner's Parent or Grandparent	

Plans – Check one

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

<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$6,000	<input type="checkbox"/> \$7,000	<input type="checkbox"/> \$8,000	<input type="checkbox"/> \$9,000
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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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- **All 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.

$$\frac{\text{Rate for plan chosen}}{\text{Monthly benefit amount}} \times \text{\$1,000} = \text{Your premium}$$

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
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.

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)

Applicant's Signature ____/____/_____
Date

**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.**