IMPORTANT INSTRUCTIONS: Prior to submitting this form, all applicants must review the important disclosures and information found on www.unuminfo.com/MAPMG 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

MID-ATLANTIC PERMANENTE MEDICAL GROUP P.C.

Benefit Election Form

Long Term Care - Policy #088575

Your Name: (Last Name, First, Middle 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 # ( )
Applicant's Email Address:		

Complete the following only if applicant is not the employee

Employee's Name	Employee Social Security No. __ __ __ - __ __ - __ __ __ __	Employee Date of Birth __ __/__ __/__ __ __ __	Employee Date of Hire __ __/__ __/__ __ __ __

Applicant Is: (This Benefit Election Form must be completed for any selection)

☐ Employee	☐ Spouse	☐ Domestic Partner	☐ Parent or Grandparent	☐ Sibling *(minimum age 18)*	☐ Child *(minimum age 18)*

Plan

- Long Term Care Facility
- Professional Home Care
- Total Home Care
- Simple Inflation
- Accelerated Payment
- Non Forfeiture
- 90 Day Elimination Period

Facility Monthly Benefit Amount

(Check one)

☐ $3,000	☐ $4,000	☐ $5,000	☐ **$6,000 ***	☐ **$7,000 ***	☐ **$8,000 ***

Facility Benefit Duration is 5 Years *Duration of benefits may vary depending on where benefits are received.*

NOTE TO EMPLOYEES: **All Active Employees & Newly Hired Employees – who enroll after the Guarantee Issue enrollment period will be required to fill out a medical questionnaire and signed Form #6720-03. SPOUSES, DOMESTIC PARTNERS AND ALL OTHER FAMILY MEMBERS must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire) for any selection. ALL Medical Questionnaires must accompany a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit.**

Active Employee or Spouse/Domestic Partner: Your premium will be paid through the Employee's payroll deduction. Employee must sign below to authorize the Employer to make the payroll deduction.
All other 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
Caution: if your answers on this Enrollment Form are incorrect or untrue, we may have the right to deny benefits or rescind your insurance. By signing below, you signify that you have read and understand that loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after your effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to your coverage. You acknowledge that you have received the **Potential Rate Increase Disclosure Form** and **Personal Worksheet**. All information is contained in your kit.

Your Premium: $_____ ***(Transfer the premium amount from the calculation on the rate sheet)***

_____	__ __/__ __/__ __ __ __	_____	__ __/__ __/__ __ __ __
Applicant's Signature	*Date*	*Employee's Signature (Required for Spouse/ Domestic Partner Coverage)*	*Date*

Employees & Spouses/Domestic Partners: Please sign and mail all required signature forms to your employer.
Domestic Partners must also complete and submit Form #1434-97 located in kit.
Family Members: Please sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (L3)

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