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

OREGON PUBLIC EMPLOYEES' BENEFIT BOARD
Benefit Election Form
Long Term Care - Policy #025758

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 __ __/__ __/__ __ __ __

AGENCY NAME [1]	**AGENCY #** [1]	**AGENCY SIGNATURE** [1]

[1] **Required only if applicant is an Employee, Employee's Spouse or Employee's Domestic Partner**

Coverage Information – Applicant is:

(Check one)

- ☐ Employee [2]
- ☐ Employee's Spouse [2]
- ☐ Employee's Domestic Partner [2]
- ☐ Employee's Parents/Grandparents [2]
- ☐ Spouse's Parents/Grandparents [2]
- ☐ Domestic Partner's Parents/Grandparents [2]
- ☐ Sibling [2]
- ☐ Adult Children [2]
- ☐ Retiree [2]
- ☐ Retiree's Spouse [2]
- ☐ Retiree's Domestic Partner [2]

[2] **Requires Completion of an Insurance Application (Evidence of Insurability). For Employees, evidence of insurability is only required if enrolling after your initial eligibility period or if enrolling for coverage that exceeds the guarantee issue limits.**

Facility Benefit Duration

(Check one) ☐ 3 Years ☐ 6 Years ☐ **Unlimited Duration** [3]

NOTE: Duration of benefits may vary according to where benefits are received.

Plans

(Check one)

☐ Plan 1	☐ Plan 2	☐ Plan 3	☐ Plan 4
▪ Long Term Care Facility	▪ Long Term Care Facility	▪ Long Term Care Facility	▪ Long Term Care Facility
▪ Professional Home Care	▪ Professional Home Care	▪ Professional Home Care	▪ Professional Home Care
	▪ Total Home Care	▪ Simple Inflation Uncapped	▪ Total Home Care
			▪ Simple Inflation Uncapped

Facility Monthly Benefit Amount

(Check one) ☐ $1,000 ☐ $2,000 ☐ $3,000 ☐ $4,000 ☐ **$5,000** [3] ☐ **$6,000** [3]

[3] **EMPLOYEES: Selection of this option exceeds the Guarantee Issue limits and requires completion of the Long Term Care Insurance Application (medical questionnaire) and signed Form #6720-03. ALL OTHER APPLICANTS must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire) and signed Form # 6720-03. ALL Medical Questionnaires must accompany a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment Kit. *NOTE TO EMPLOYEES:* All Active Employees & Newly Hired Employees – who enroll after the Guarantee Issue enrollment period or choose benefits over the Guarantee Issue limits will be required to fill out a medical questionnaire and signed Form #6720-03.**

Form is Continued on Reverse Side

If you are an Active Employee, Spouse or 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 or Retirees: 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

<u>Caution:</u> 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 also 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*

<u>Employees & Spouses/Domestic Partners:</u> Please sign and mail all required signature forms to your employer.
<u>Domestic Partners</u> must also complete and submit Form #1434-97 located in kit.
<u>Family Members/Retirees</u>: Please sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (Q4)

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