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

PLEASANTON UNIFIED SCHOOL DISTRICT
FAMILY Benefit Election Form
Long Term Care - Policy #220354

Your Name: (Last Name, First, Middle Initial)	Social Security Number __ __ __ - __ __ - __ __ __ __	Date of Birth (MM/DD/YYYY) __ __/__ __/__ __ __ __
Street Address	Home Telephone # ( )	Work Telephone # ( )
City, State, Zip Code		Gender ☐ Male ☐ Female
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)

☐ Spouse/ Registered Domestic Partner	☐ Parent or Grandparent

You may choose any of the plans listed below. The Long Term Care Application (medical questionnaire), the Benefit Election form and a signed Authorization to Request Medical Information Form #6720-03-CA located in the enrollment kit, must be completed and you must be approved for coverage in order to enroll in the Long Term Care plan.

Plans			
• Nursing Facility & 60% Residential Care Facility	• Nursing Facility & 60% Residential Care Facility • Home and Community Based Care	• Nursing Facility & 60% Residential Care Facility • Simple Inflation	• Nursing Facility & 60% Residential Care Facility • Home and Community Based Care • Simple Inflation

Facility Monthly Benefit Amount

(Check one)

☐ $1,000	☐ $1,500	☐ $2,000	☐ $2,500	☐ $3,000	☐ $3,500	☐ $4,000	☐ $4,500	☐ $5,000

2 Years Facility Benefit Duration ***(Duration of benefits may vary depending on where benefits are received.)***

Calculate your Premium:

_____ (Rate for plan chosen) X _____ (Facility Monthly Benefit Amount) ÷ $1,000 = _____ (Your Premium)

Active Employee's Spouse/Registered 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. All information is contained in your kit.

_____ *Applicant's Signature* __ __/__ __/__ __ __ __ *Date*

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

Spouses: Please sign and mail all required signature forms to the 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.