

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

SCHOOL SPECIALTY, INC.
Benefit Election Form
Long Term Care - Policy #931976

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 # ()

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 ____/____/____
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All applicants must complete this form. Applicant is:

<input type="checkbox"/> Employee	<input type="checkbox"/> Employee's Parent or Grandparent	<input type="checkbox"/> Sibling (<i>minimum age 18</i>)
<input type="checkbox"/> Employee's Spouse	<input type="checkbox"/> Spouse's Parent or Grandparent	<input type="checkbox"/> Child (<i>minimum age 18</i>)

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"> • Long Term Care Facility • 100% Professional Home & Community Care 	<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home & Community Care • CPI Inflation 	<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home & Community Care • To Age 65 APO 	<ul style="list-style-type: none"> • Long Term Care Facility • 100% Professional Home & Community Care • CPI Inflation • To Age 65 APO

Facility Monthly Benefit Amount – Check one

<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,000	<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"/> 3 Years	<input type="checkbox"/> 6 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 or choose benefits over the Guarantee Issue limits 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 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.

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

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 additional 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.

I acknowledge that I have received the **Potential Rate Increase Disclosure Form** and **Personal Worksheet**.

Active Employees & Spouses: I authorize my employer to make the necessary payroll deduction to pay the premium when my insurance becomes effective.

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>	<i>Date</i>
		(Required for Spouse Coverage)	

Employees & Spouses: Please sign and mail all required signature forms to:
 Kris McCourt, Unum, 500 Elm Grove Road, Elm Grove, WI 53122.
Family Members: Please sign and mail all required signature forms to Unum (address at top of page).
 Retain a copy for your records. (M3)

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