IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/UniversityofHartford or in a paper enrollment kit. You can request a paper enrollment kit by calling 1-877-286-2852. 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

UNIVERSITY OF HARTFORD
Benefit Election Form
Long Term Care - Policy # 581270

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 # ( )
Work Email Address:	Personal 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 __ __/__ __/__ __ __ __

EMPLOYEE PAYCYCLE: (Check one)

DIVISION 001: **26 OR 12** | ***DIVISION 002:*** **20 (9 months)**

(Check one) **ARE YOU A PART-TIME EMPLOYEE WORKING AT LEAST 20 HOURS OR MORE:** ☐ **YES** ☐ **NO**

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

Employee	Parent or Grandparent	Sibling *(minimum age 18)*	Retiree
Employee's Spouse		Child *(minimum age 18)*	Retiree's Spouse

Plans

(Check one)

Plan 1	**Plan 2**
• Long Term Care Facility • Non Forfeiture • 100% Professional Home Care	• Long Term Care Facility • Non Forfeiture • 100% Professional Home Care • 5% Compound Inflation

Facility Monthly Benefit Amount

(Check one)

$1,000	$2,000	$3,000	$4,000	$5,000	$6,000	$7,000	$8,000

Facility Benefit Duration

(Check one)

3 Years	6 Years	**Unlimited Duration ***

***EMPLOYEES EXCEPT PART-TIME EMPLOYEES: Selection of this option exceeds the Guarantee Issue limits and requires completion of the Long Term Care Insurance Application (medical questionnaire). PART-TIME EMPLOYEES (working at least 20 hours or more) and ALL OTHER APPLICANTS 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.**

REQUEST FOR SIGNATURE: You must check either accept or reject. Please read this entire form carefully before signing below. I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this insurance with and without the Uncapped Compound Growth Inflation Protection Option and I accept ☐ / reject ☐ this option.

Active Employee or Spouse: 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

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 receipt of the Outline of Coverage and understand that it is yours to keep. All information is contained in your kit.

Your Premium FROM RATE SHEET: $______________

____________________ *Applicant's Signature*	__ __/__ __/__ __ __ __ *Date*	____________________ *Employee's Signature* *(Required for Spouse Coverage)*	__ __/__ __/__ __ __ __ *Date*

Employees & Spouses: Please sign and mail all required signature forms to LTC Solutions, 14715 NE 95th Street, Suite 200, Redmond, WA 98052.
Family Members: Please sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (M5)

If you have questions about Long Term Care coverage, please call LTC Solutions' toll-free number 1-877-286-2852 or email info@ltc-solutions.com.

Voluntary