Underwritten by:
Unum Life Insurance Company of America
LTC Department
2211 Congress Street,
Portland, Maine 04122

LOS RIOS COMMUNITY COLLEGE DISTRICT
CLASS 001 FULL TIME EMPLOYEES WORKING A MINIMUM OF 20 HOURS PER WEEK
Benefit Election Form
Long Term Care - Policy #145431-001

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 # ( )
Email Address:		

Complete the following only if applicant is not the employee

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

Is this a change to existing coverage? □ Yes □ No
If yes, new elections made below will replace existing coverage upon underwriting approval, if applicable.

Applicant is: (please circle) The Minimum age for a sibling or child is 18.

Employee; Spouse/ Domestic Partner; Parent or Grandparent; Sibling; Child

Plans – Check one

□ **Plan 1**	□ **Plan 2**	□ **Plan 3**	□ **Plan 4**
• Facility • 50% Home and Community Based Care	• Facility • 50% Home and Community Based and Immediate Family Member Care	• Facility • 50% Home and Community Based Care • 5% Simple Inflation	• Facility • 50% Home and Community Based and Immediate Family Member Care • 5% Simple Inflation

Facility Monthly Benefit Amount – Check one

□ $3,000	□ $4,000	□ $5,000	□ $6,000	□ **$7,000 ***	□ **$8,000 ***	□ **$9,000 ***

Facility Benefit Duration – Check one. **Note: Duration of benefits may vary depending on where benefits are received.**

□ 2 Years	□ 5 Years	□ **Lifetime ***

- ***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 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-CA 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.

_____	X	_____	÷ $1,000 =	_____
Rate for plan chosen		Monthly benefit amount		Your premium

Disclosures:

Massachusetts Residents: You also signify that you have received and read the MassHealth eligibility notice entitled "For Massachusetts Residents Only"- Form #7650-04. The notice is contained in your kit.

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 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.
Active Employees & Spouse/ Domestic Partners: Your signature below authorizes your employer to deduct the required premium from your paycheck. Final cost of coverage will be based on your Insurance Age. If you enroll for coverage on or before the group policy effective date, Insurance Age is your age on the group policy effective date. If you enroll for coverage after the group policy effective date, Insurance Age is your age on the date you sign this enrollment form.

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)

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

<u>Employee & Spouse/ Domestic Partner:</u> Please sign and mail all required signature forms to your employer.
<u>Family Members</u>: 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.**