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

ATKINS
Benefit Election Form (FL)
Long Term Care - Policy #220758

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 # ( )

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)

☐ Employee	☐ Employee's Parent or Grandparent	☐ Sibling *(minimum age 18)*
☐ Employee's Spouse / Domestic Partner	☐ Spouse's / Domestic Partner's Parent or Grandparent	☐ Child *(minimum age 18)*

(Check one)	☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 4**
	• Long Term Care Facility • Professional Home Care	• Long Term Care Facility • Professional Home Care • Total Home Care	• Long Term Care Facility • Professional Home Care • Simple Inflation	• Long Term Care Facility • Professional Home Care • Total Home Care • Simple Inflation

Facility Monthly Benefit Amount

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

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

(Check one)	☐ 3 Years	☐ 5 Years

***Note*: All Active Employees, Newly Hired Employees, Spouses or Domestic Partners – who enroll after the Guarantee Issue enrollment period will be required to fill out a medical questionnaire. ALL OTHER APPLICANTS must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire) for any selection. ALL Medical Questionnaire must accompany a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit.**

Calculate your Premium:

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

Active Employee or Spouse/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: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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. This information is contained in your kit.

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

Employees & Spouses/ Domestic Partners: Please sign and mail all required signature forms to your employer.
Domestic Partners must also complete and submit Form #1434-97 located in kit.
Family Members: Please sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (J1)

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