UNUMPROVIDENT

LONG TERM CARE

Underwritten by:
Unum Life Insurance Company of America
LTC Department – A238
2211 Congress Street, Portland, Maine 04122

NAGLE HARTRAY DANKER KAGAN MCKAY PENNEY ARCHITECTS LTD.

EMPLOYEE Benefit Election Form

Long Term Care Policy #220185

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 # ( )

Funded Plan (Employer Paid) (This Benefit Election Form must be completed for any selection)	
Level of Care:	Long Term Care Facility
Monthly Benefit:	$1,000 Long Term Care Facility
Benefit Duration:	Unlimited Long Term Care Facility

Your employer is funding Plan 1: You may purchase additional coverage. Please make your selections below:

	Plans	
(Check one)	☐ **Plan 1 (Funded Plan)**	☐ **Plan 2***
	• Long Term Care Facility • Simple Inflation	• Long Term Care Facility • Simple Inflation • Professional Home Care

	Facility Monthly Benefit Amount				
(Check one)	☐ $1,000 **(Funded Plan)**	☐ **$2,000 ***	☐ **$3,000 ***	☐ **$4,000 ***	☐ **$5,000 ***

Facility Benefit Duration is Unlimited

*** EMPLOYEES: Selection of this option exceeds the Guarantee Issue limits and requires completion of the Long Term Care Insurance Application (medical questionnaire) and a signed return of the Authorization to request Medical Information Form #6720-03 located in the kit. *Note to Employees:* All Active Employees & Newly Hired Employees – who enroll after the Guarantee Issue enrollment period or choose benefits over the Guarantee Issue limits will be required to fill out a medical questionnaire and signed Form #6720-03..**

Calculate your Premium:

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

FOR EMPLOYEES ONLY: _____ = _____**(B)**
Rate for Funded Plan 1 (Unlimited Duration) — Employer Paid Amount

A MINUS B = _____
EMPLOYEE'S COST

Your premium for the buy-up options will be paid through payroll deduction from your paycheck. You must sign below to authorize your employer to make the payroll deduction.

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. This information is contained in your kit.

_____ *Employee's Signature*

__ __/__ __/__ __ __ __ *Date*

Please sign and mail all required signature forms to UnumProvident (address at top of page).
Retain a copy for your records. (J5)

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