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.

FAMILY 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	Home Telephone # ( )	Work Telephone # ( )
City, State, Zip Code	Gender ☐ Male ☐ Female	

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's Spouse	☐ Spouse's Parent or Grandparent
	☐ Employee's Parent or Grandparent

You may choose any of the plans listed below. The Long Term Care Application (medical questionnaire), the Benefit Election form and a signed return of the Authorization to request Medical Information Form #6720-03 located in the kit, must be completed and you must be approved for coverage in order to enroll in the Long Term Care plan.

Plans

(Check one)

☐ **Plan 1**	☐ **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	☐ $2,000	☐ $3,000	☐ $4,000	☐ $5,000

Facility Benefit Duration is Unlimited

Calculate your Premium:

____________ X ____________ ÷ $1,000 = ____________

Rate for plan chosen — Facility Monthly Benefit Amount — Your Premium

If you are an Active Employee's Spouse your premium will be paid through the employee's payroll deduction, please sign below. Employee must sign below to authorize the employer to make the payroll deduction.
All other eligible family members will be billed directly by the insurance company.
Family members or how would you like to be billed? ☐ 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. This information is contained in your kit.

Your Premium: $____________ ***(Transfer the premium amount from the calculation on the rate sheet.)***

____________________	___ ___/___ ___/___ ___ ___ ___	____________________	___ ___/___ ___/___ ___ ___ ___
Applicant's Signature	*Date*	*Employee's Signature*	*Date*

All applicants, 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.