



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

STATE OF SOUTH DAKOTA
FAMILY Benefit Election Form
Long Term Care - Policy #295435

Applicant's 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	

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

<input type="checkbox"/> Employee's Spouse	<input type="checkbox"/> Spouse's (Step) Parent or Grandparent	<input type="checkbox"/> Sibling (Step) (minimum age 18)	<input type="checkbox"/> Retiree
	<input type="checkbox"/> Employee's (Step) Parent or Grandparent	<input type="checkbox"/> Child (Step) (minimum age 18)	<input type="checkbox"/> Retiree's Spouse

For any of the plans listed below, the Long Term Care Application (Evidence of Insurability), this Benefit Election form and a signed Authorization to Request Medical Information Form #6720-03 (attached as the last page of the Evidence of Insurability application) must be completed and approved for coverage in order to enroll in the Long Term Care plan. Questions concerning Long Term Care coverage, can be directed to Unum's toll-free number: 1-800-227-4165.

Plans (Check one)					
<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<u>Partnership</u>	<input type="checkbox"/> Plan 4	<u>Partnership</u>
<ul style="list-style-type: none"> Long Term Care Facility – 100% Assisted Living Facility – 60% Professional Home Care – 50% 	<ul style="list-style-type: none"> Long Term Care Facility – 100% Assisted Living Facility – 60% Professional Home Care – 50% Total Home Care – 50% 	<ul style="list-style-type: none"> Long Term Care Facility – 100% Assisted Living Facility – 60% Professional Home Care – 50% Compound Inflation 		<ul style="list-style-type: none"> Long Term Care Facility – 100% Assisted Living Facility – 60% Professional Home Care – 50% Total Home Care – 50% Compound Inflation 	

Plans 3 and 4 are "Partnership Qualified" for applicants age 75 or younger. For applicants 76 or older, all plans are "Partnership Qualified". Please refer to information on the Partnership program located in this enrollment kit.

Facility Monthly Benefit Amount (Check one)							
<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$6,000	<input type="checkbox"/> \$7,000	<input type="checkbox"/> \$8,000

Facility Benefit Duration (Check one)			(Duration of benefits may vary depending on where benefits are received.)		
<input type="checkbox"/> 2 Years	<input type="checkbox"/> 6 Years	<input type="checkbox"/> Unlimited Duration			

Active Employee's 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.

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

I acknowledge that I have received the **Potential Rate Increase Disclosure Form** and **Personal Worksheet**.

Your Premium: \$_____ (Transfer the premium amount from the calculation on the rate sheet)

_____	____/____/____	_____	____/____/____
Applicant's Signature	Date	Employee's Signature (Required for Spouse Coverage)	Date

**Please sign and mail all required signature forms to UNUM,
 Attn: Margaret Fier, 3600 Minnesota Drive, #600, Edina, MN 55435.
 Retain a copy for your records. (A1)**