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

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

Employee 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 # ( )
Applicant's Email Address:		

Please make your selections below: Active employees automatically receive a Basic Plan (PLAN 1) with a facility monthly benefit of $1,500 for a 2 year duration as part of the State's Group Supplemental Life Plan at no additional cost. Additional coverage (PLAN 2, PLAN 3 or PLAN 4) may be purchased by completing this Benefit Election Form.

Please note: This Benefit Election Form *does not* need to be completed if the coverage under the State funded Basic Plan 1 is the only coverage desired.

Questions concerning Long Term Care coverage can be directed to Unum's toll-free number: 1-800-227-4165.

Plans *(Check one)*

☐ **Plan 1 (Funded Plan)**	☐ **Plan 2**	☐ **Plan 3**	***Partnership***	☐ **Plan 4**	***Partnership***
• Long Term Care Facility – 100% • Assisted Living Facility – 60% • Professional Home Care – 50%	• Long Term Care Facility – 100% • Assisted Living Facility – 60% • Professional Home Care – 50% • Total Home Care – 50%	• Long Term Care Facility – 100% • Assisted Living Facility – 60% • Professional Home Care – 50% • Compound Inflation		• 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 employees age 75 or younger. For employees 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)*

☐ $1,500 **(Funded Plan)**	☐ $2,000	☐ $3,000	☐ $4,000	☐ $5,000	☐ $6,000	☐ $7,000	☐ $8,000

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

☐ 2 Years **(Funded Plan)**	☐ 6 Years	☐ **Unlimited Duration ***

***EMPLOYEES: Selection of this option exceeds the Guarantee Issue limits and requires completion of the Long Term Care Insurance Application (Evidence of Insurability) and a signed Authorization to Request Medical Information Form #6720-03 which is attached as the last page of the Evidence of Insurability Application. 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 an Evidence of Insurability Application and a signed Form #6720-03.**

The premium for the buy-up options will be paid through a payroll deduction. This form must be signed to authorize your employer to make the payroll deduction.

Caution: If your answers on this Benefit Election Form are incorrect or untrue, we may have the right to deny benefits or rescind your insurance.

By signing below, you signify that you are participating in the Supplemental Life program, 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.

You also acknowledge that you have received the **Potential Rate Increase Disclosure Form** and **Personal Worksheet.**

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

_____ *Employee's Signature*	__ __/__ __/__ __ __ __ *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)

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