<u>IMPORTANT INSTRUCTIONS</u>: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on <u>www.unuminfo.com/hsta</u> or in a paper enrollment kit. You can request a paper enrollment kit by calling 1-800-227-4165. DO NOT submit this form if you have not reviewed those materials.



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

## HSTA VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION TRUST MEMBER Benefit Election Form Long Term Care - Policy #536134-002

Your Name: (I	Last Name, Firs	t, Middle Initial)			Socia	cial Security Number		Date of Birth (MM/DD/YYYY)		
Street Address					Gend			Date of Hire (MM/DD/YYYY)		
City, State, Zi	p Code	F		Hom (	ne Telephone # )		Work Telephone #			
Applicant's Er	nail Address:									
Funded Plan (Employer Paid) (This Benefit Election Form must be completed for any selection)										
Level of Care:			Long Term Care Facility and 50% Professional Home Care							
Monthly Ben	efit:	\$1,000 Long Term Care Facility/ 50% Professional Home Care								
Benefit Dura	ition:	3 Years Long Term Care Facility/ 50% Professional Home Care								
Your employer is funding <u>Plan 1</u> . You may purchase additional coverage. Please make your selections below:										
(Check one)	☐ Plan 1 (Fur		☐ Plan 2			☐ Plan 3		☐ Plan 4		
	Long Term Care Facility		<ul> <li>Long Term Care Facility</li> </ul>			Long Term Care Facility		Long Term Care Facility		
	Professional Home Care		Professional Home Care			Professional Home Care		Professional Home Care		
			Total Home Care			• Simple Inflation		Non Forfeiture Benefit		
	□ Plan 5		Plan 6			□ Plan 7		□ Plan 8		
	Long Term Care Facility      Description of Library Care		<ul><li>Long Term Care Facility</li><li>Professional Home Care</li></ul>			Long Term Care Facility     Professional Home Care			Long Term Care Facility     Professional Home Care	
	<ul><li>Professional Home Care</li><li>Total Home Care</li></ul>		Total Home Care			Simple Inflation			Total Home Care	
	Simple Inflation		Non Forfeiture Benefit			Non Forfeiture Benefit			Simple Inflation	
	Jp. 3							Non Forfeit		
	Facility Monthly Benefit Amount									
(Check one)	□ \$1,000 (Funded)	□ \$1,500	□ \$2,500	□ \$3,500		□\$4,500	□\$5,500	□\$6,500	□\$7,500	
		□\$2,000	□\$3,000	□\$4,000		□\$5,000	□\$6,000	□\$7,000	□\$8,000	
	Facility Be	enefit Durat	ion (Duration	of benefits m	ay va	ry depending o	on where ber	efits are receiv	ed.)	
(Check one)	☐ 3 Years (Fu	□ 3 Years (Funded) □ 4 Years □ 6 Years								
								sue enrollment		
		arantee issue iii Authorization to						Application (menrollment kit.	edicai	
Calculate y	our Premiu		-							
		X		11 5 6 4		÷ -	\$500 =		(A)	
Your Rate for plan chosen Facility Monthly Benefit Amount Your Premium									nium	
FOR EMPL	OYEES ONL	_Y:					=		(B)	
		Rate for Funded Plan 1					Employer Paid			
			(3	3 Year Duration	1)	A MINU	JSB =			
	EMPLOYEE'S COST							S COST		
								,		

Form is continued on reverse side

Your premium for the buy-up of authorize your employer to ma		roll deduction from your paycheck.	You must sign below to							
, ,	. ,	orrect or untrue, we may have th	e right to deny benefits or							
rescind your insurance.		,	o ,							
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. You also acknowledge that you have received the <b>Potential Rate Increase Disclosure Form</b> and <b>Personal Worksheet</b> . All information is contained in your kit.										
Your Premium: \$	(Transfer the premium amou	unt from the calculation on the ra	ate sheet.)							
	//									
Applicant's Signature	Date	Employee's Signature (Required for Spouse Coverage)	Date							
Please sign and submit this form to HSTA Voluntary Employees Beneficiary Trust.										

Retain a copy for your records. (K6)

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