

**IMPORTANT INSTRUCTIONS:** Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on [www.unuminfo.com/hsta](http://www.unuminfo.com/hsta) 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  
Benefit Election Form  
Long Term Care – Policy: 536134-004**

Your Name: (Last Name, First, Middle Initial)	Social Security Number - - - - -	Date of Birth (MM/DD/YYYY) / /
Street Address	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Hire - N/A / /
City, State, Zip Code	Home Telephone # ( )	Work Telephone # ( )

Applicant's Email Address:

**Complete the following only if applicant is not the Retiree**

Retiree's Name	Retiree Social Security No. - - - - -	Retiree Date of Birth / /	Date of Hire - N/A / /
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**Applicant Is: (This Benefit Election Form must be completed for any selection)**

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

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

(Check one)

<input type="checkbox"/> <b>Plan 1</b> • Long Term Care Facility • Professional Home Care	<input type="checkbox"/> <b>Plan 2</b> • Long Term Care Facility • Professional Home Care • Total Home Care	<input type="checkbox"/> <b>Plan 3</b> • Long Term Care Facility • Professional Home Care • Simple Inflation	<input type="checkbox"/> <b>Plan 4</b> • Long Term Care Facility • Professional Home Care • Non Forfeiture
<input type="checkbox"/> <b>Plan 5</b> • Long Term Care Facility • Professional Home Care • Total Home Care • Simple Inflation	<input type="checkbox"/> <b>Plan 6</b> • Long Term Care Facility • Professional Home Care • Total Home Care • Non Forfeiture	<input type="checkbox"/> <b>Plan 7</b> • Long Term Care Facility • Professional Home Care • Simple Inflation • Non Forfeiture	<input type="checkbox"/> <b>Plan 8</b> • Long Term Care Facility • Professional Home Care • Total Home Care • Simple Inflation • Non Forfeiture

**Facility Monthly Benefit Amount**

(Check one)

<input type="checkbox"/> \$1,000	<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
<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$3,500	<input type="checkbox"/> \$4,500	<input type="checkbox"/> \$5,500	<input type="checkbox"/> \$6,500	<input type="checkbox"/> \$7,500	

(Check one)

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

<input type="checkbox"/> 2 Years	<input type="checkbox"/> 3 Years	<input type="checkbox"/> 5 Years
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**Calculate your Premium:**

$$\frac{\text{Rate for plan chosen} \times \text{Facility Monthly Benefit Amount}}{\$500} = \text{Your Premium}$$

If you are an HSTA VEBA Trust Participant or Spouse your premium will be deducted from Participant's payroll or retirement check. Trust Participant must sign below to authorize deduction.

If you are not an HSTA VEBA Trust Participant or Spouse, please select payment method: ☐ Monthly Automatic Payments (deducted from your checking account – complete Authorization/ Agreement for Automatic Payments), **OR**

Billed directly (paper) by the insurance company: ☐ 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. You also acknowledge that you have received the **Potential Rate Increase Disclosure Form** and **Personal Worksheet**. This information is contained in your kit.

_____ Applicant's Signature	_____ Date	_____ Retiree's Signature (Required for Spouse Coverage)	_____ Date
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**Please sign and submit this form to HSTA-VEBA Trust. Other applicants, sign and mail all required signature forms to Unum (address at top of page). Retain a copy for your records. (K6)**

If you have questions about Long Term Care coverage, please call HSTA-VEBA Trust at (808)-440-6940.