<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/UniversityofHartford</u> or in a paper enrollment kit. You can request a paper enrollment kit by calling 1-877-286-2852. DO NOT submit this form if you have not reviewed those materials.



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

## UNIVERSITY OF HARTFORD Benefit Election Form Long Term Care - Policy # 581270

Your Name: (Last Name, First, Middle Initial)				Social Se	Social Security Number			Date of Birth (MM/DD/YYYY)			
Street Address				Gender	Gender		Date of Hire (MM/DD/YYYY)				
				Male			/ /				
City, State, Zip Code			Home Te	e Telephone # Work Telephone #			ne #				
				(							
Work Email Address: Personal Email Address:											
Complete the fol	lowing only if	applicant is not	the employee	•							
Employee's Name			Employee Social Security N		o. Employee Date of Birth		n Employee Date of Hire				
			<u> </u>		!!		//				
EMPLOYEE PA	YCYCLE: (C	heck one)									
<b>DIVISION 001:</b>	26	OR	12	DI	VISION 002:	20 (9 m	nonths)				
(Check one) ARE YOU A PART-TIME EMPLOYEE WORKING AT LEAST 20 HOURS OR MORE:											
Applicant Is: (This Benefit Election Form must be completed for any selection)											
Employee Parent or Grandparent					Sibling (minimum age 18) Retiree						
Employee's S	pouse	Child (mir.	Child (minimum age 18) Retiree's Spouse			e					
, ,	Plans			•		•	-				
(Check one)	Plan 1				Plan 2						
	• Long Term	•			Long Term Care Facility						
	Non Forfeit				Non Forfeiture						
	100% Professional Home Care				<ul><li>100% Professional Home Care</li><li>5% Compound Inflation</li></ul>						
	Eacility Mo	nthly Benefit A	mount		5% Compound iniiai	lion					
(Check one)	\$1,000	\$2,000		\$4,000	\$5,000 \$6,0	00	\$7,000	\$8,000			
		enefit Duratio		ψ+,000	ψο,οοο   ψο,ο	00	Ψ1,000	ψο,σσσ			
(Check one)	3 Years	mont Baratio	6 Yea	ars	Unlimited Duration *						
*EMPLOYEES EXCEPT PART-TIME EMPLOYEES: Selection of this option exceeds the Guarantee Issue limits and requires											
completion of the Long Term Care Insurance Application (medical questionnaire). PART-TIME EMPLOYEES (working at least 20 hours or more) and ALL OTHER APPLICANTS must complete this Benefit Election Form and the Long Term Care Insurance											
					ection Form and th naires must accom						
Request Medical					naires must accom	ipany a s	ignea Autho	rization to			
					read this entire fo	rm carefu	ully before si	gning below.			
			REQUEST FOR SIGNATURE: You must check either accept or reject. Please read this entire form carefully before signing below. I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this insurance with and								
	without the Uncapped Compound Growth Inflation Protection Option and I accept 🔲 / reject 🗀 this option.										
Active Employee or Spouse: Your premium will be paid through the Employee's payroll deduction. Employee must sign											
	ee or Spous	e: Your premiur	n will be paid thr	<b>Option and I ac</b> ough the Emp	cept 🛛 / reject 🗀	this opt	ion.	nust sign			
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Employees & Spouses: Please sign and mail all required signature forms to LTC Solutions, 14715 NE 95<sup>th</sup> Street, Suite 200, Redmond, WA 98052.

<u>Family Members</u>: Please sign and mail all required signature forms to Unum (address at top of page).

Retain a copy for your records. (M5)