**IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/LAHealthServiceExisting 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 Company of America
LTC Department
2211 Congress Street,
Portland, Maine 04122

# *LA HEALTH SERVICE & INDEMNITY CO*
# *DBA BCBS OF LA*
## Benefit Election Form
## Long Term Care – Policy: 094733-002

| Your Name: (Last Name, First, Middle Initial) | Social Security Number<br>__ __ __ - __ __ - __ __ __ __ | Date of Birth (MM/DD/YYYY)<br>__ __/__ __/__ __ __ __ |
|---|---|---|
| Street Address | Gender<br>☐ Male ☐ Female | Date of Hire (MM/DD/YYYY)<br>__ __/__ __/__ __ __ __ |
| City, State, Zip Code | Home Telephone #<br>( ) | Work Telephone #<br>( ) |
| Applicant's Email Address: | | |

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

| Employee Name | Employee Social Security No.<br>__ __ __ - __ __ - __ __ __ __ | Employee Date of Birth<br>__ __/__ __/__ __ __ __ | Employee Date of Hire<br>__ __/__ __/__ __ __ __ |
|---|---|---|---|

**Applicant is: (please circle)** The Minimum age for a sibling or child is 18.

Employee; Spouse; Parent or Grandparent; Sibling; Child

### Plans – Check one

| ☐ **Plan 1** | ☐ **Plan 2** | ☐ **Plan 3** | ☐ **Plan 4** |
|---|---|---|---|
| • Long Term Care Facility<br>• 50% Professional Home and Community Care<br>• 3 Year SBP | • Long Term Care Facility<br>• 50% Total Choice Home Care<br>• 3 Year SBP | • Long Term Care Facility<br>• 50% Professional Home and Community Care<br>• Simple Inflation<br>• 3 Year SBP | • Long Term Care Facility<br>• 50% Total Choice Home Care<br>• Simple Inflation<br>• 3 Year SBP |

### Facility Monthly Benefit Amount – Check one

| ☐ $2,000 | ☐ $3,000 | ☐ $4,000 | ☐ **$5,000 *** | ☐ **$6,000 *** | ☐ **$7,000 *** | ☐ **$8,000 *** | ☐ **$9,000 *** |
|---|---|---|---|---|---|---|---|

### Facility Benefit Duration – Check one.

**Note: Duration of benefits may vary depending on where benefits are received.**

| ☐ 3 Years | ☐ 6 Years | ☐ **Lifetime *** |
|---|---|---|

- ***These options exceed the Guarantee Issue limits** and their selection will require completion of the Long Term Care Insurance Application (medical questionnaire).
- **All active employees and newly hired employees** who enroll after the Guarantee Issue enrollment period or choose benefits over the Guarantee Issue limits must complete the Long Term Care Insurance Application (medical questionnaire).
- **All other applicants** must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire) for any selection.
- A signed Authorization to Request Medical Information (form #6720-03 in the kit) must accompany all medical questionnaires.

**Form is continued on reverse side.**

## Calculate Your Premium:

Please refer to rate sheet in your kit to determine the rate for the plan chosen.

| _____ | X | _____ | ÷ $1,000 = | _____ |
|---|---|---|---|---|
| Rate for plan chosen | | Monthly benefit amount | | Your premium |

## Disclosures:

**Note: We may have the right to deny benefits or rescind insurance if any of the information provided on this enrollment form is incorrect.**

**REQUEST FOR SIGNATURE:** Please read this entire form carefully before signing below.

I certify that all statements are true to the best of my knowledge and belief. I have read and understand that, for coverage that does not require me to submit evidence of insurability, loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after my effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to my coverage. I acknowledge that I have received the **Potential Rate Increase Disclosure Form** and **Personal Worksheet.**

**Active Employees & Spouses:** Your signature below authorizes your employer to deduct the required premium from your paycheck. Final cost of coverage will be based on your Insurance Age. If you enroll for coverage on or before the group policy effective date, Insurance Age is your age on the group policy effective date. If you enroll for coverage after the group policy effective date, Insurance Age is your age on the date you sign this enrollment form.

**All eligible Family Members:** 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

**Your premium:** $_____ (transfer from calculation above)

| _____ | __ __/__ __/__ __ __ __ | _____ | __ __/__ __/__ __ __ __ |
|---|---|---|---|
| *Applicant's Signature* | *Date* | *Employee's Signature* (Required for Spouse Coverage) | *Date* |

**Employee & Spouse: Please sign and mail all required signature forms to your employer.**
**Family Members: Please sign and mail all required signature forms to Unum (address at top of page).**
**Retain a copy for your records. (G6)**

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