SPOUSE/DOMESTIC PARTNER & FAMILY BENEFIT ELECTION FORM

IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/Permanente 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

THE PERMANENTE MEDICAL GROUP, INC.
Long Term Care Insurance
Policy #586474

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

Sr. Physician's Name	Sr. Physician's Social Security No. __ __ __ - __ __ - __ __ __ __	Sr. Physician's Date of Birth __ __/__ __/__ __ __ __	Sr. Physician's Date of Hire __ __/__ __/__ __ __ __

Applicant Is: (This Benefit Election Form must be completed for any selection)

☐ Senior Physician's Spouse / Registered Domestic Partner (Payroll Deducted)	☐ Senior Physician's Parent or Grandparent (Direct Billed)	☐ Sibling *(minimum age 18)* (Direct Billed)
☐ Senior Physician's Domestic Partner (Payroll Deducted)	☐ Spouse's / Domestic Partner's Parent or Grandparent (Direct Billed)	☐ Child *(minimum age 18)* (Direct Billed)

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-CA 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.

☐ Plan 1	☐ Plan 2	☐ Plan 3	☐ Plan 4
• Nursing Facility & Residential Care Facility • 100% Home & Community-Based Care	• Nursing Facility & Residential Care Facility • 100% Home, Community-Based & Immediate Family Member Care	• Nursing Facility & Residential Care Facility • 100% Home & Community-Based Care • Compound Inflation	• Nursing Facility & Residential Care Facility • 100% Home, Community-Based & Immediate Family Member Care • Compound Inflation

Facility Monthly Benefit Amount

(Check one)

☐ $1,500	☐ $2,500	☐ $3,500	☐ $4,000	☐ $5,000	☐ $6,000

Facility Benefit Duration

(Check one)

☐ 3 Years	☐ 6 Years

IMPORTANT INFORMATION FOR APPLICANT:
Premium and Payments:

1. **Spouse/Domestic Partner** premiums paid by physician's payroll deduction only. Senior Physician must sign below to authorize TPMG to make the payroll deduction.
2. All eligible family members will be billed directly by the insurance company.
   Please select payment method:
   ☐ Monthly Automatic Payments (deducted from your checking account – complete Authorization/Agreement for Automatic Payments), **OR**
3. ☐ 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.

All information is contained in your kit.

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

_____ *Applicant's Signature*	__ __/__ __/__ __ __ __ *Date*	_____ *Senior Physician's Signature (Required for Spouse/Domestic Partner Coverage)*	__ __/__ __/__ __ __ __ *Date*

Spouses/Registered Domestic Partners/Domestic Partners: Please sign and mail all required signature forms to Unum.
Family Members: Please sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (Q4)

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