IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on 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
FAMILY Benefit Election Form
Long Term Care – Policy: 536134-002

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

Employee's Name	Employee Social Security No. ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Employee Date of Birth ___ ___/___ ___/___ ___ ___ ___	Employee Date of Hire ___ ___/___ ___/___ ___ ___ ___

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

☐ Member's Spouse	☐ Member's Parent/Grandparent	☐ Member's Sibling (minimum age 18)
	☐ Spouse's Parent/Grandparent	☐ Member's 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)

☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 4**
• Long Term Care Facility • Professional Home Care	• Long Term Care Facility • Professional Home Care • Total Home Care	• Long Term Care Facility • Professional Home Care • Simple Inflation	• Long Term Care Facility • Professional Home Care • Non Forfeiture Benefit
☐ **Plan 5**	☐ **Plan 6**	☐ **Plan 7**	☐ **Plan 8**
• Long Term Care Facility • Professional Home Care • Total Home Care • Simple Inflation	• Long Term Care Facility • Professional Home Care • Total Home Care • Non Forfeiture Benefit	• Long Term Care Facility • Professional Home Care • Simple Inflation • Non Forfeiture Benefit	• Long Term Care Facility • Professional Home Care • Total Home Care • Simple Inflation • Non Forfeiture Benefit

Facility Monthly Benefit Amount

(Check one)

☐ $1,000	☐ $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 Benefit Duration *(Duration of benefits may vary depending on where benefits are received.)*

(Check one)

☐ 3 Years	☐ 4 Years	☐ 6 Years

Calculate your Premium:

_______________ X _______________ ÷ $500 = _______________

Rate for plan chosen   Facility Monthly Benefit Amount   Your Premium

Form is continued on reverse side.

I certify that the information provided is true and complete. Applicant must sign below.

Note: If you are an HSTA VEBA Trust **participant** or **spouse,** your premium will be deducted from the participant's salary, wages, pension or other compensation.

VEBA Participant (member):
I authorize HSTA-VEBA Trust to set the effective date of coverage and to make the deductions, adjustments or cancellations from my salary, wages, pension or other compensation for the monthly premium.

If you are not an HSTA VEBA Trust Spouse, the insurance company will bill you directly. 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.**

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

____________________	__ __/__ __/__ __ __ __	____________________	__ __/__ __/__ __ __ __
Applicant's Signature	*Date*	*Employee's Signature (Required for Spouse Coverage)*	*Date*

Spouses: Please sign and submit this form to HSTA Voluntary Employees Beneficiary Trust.
Family Members: Please 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 Unum's toll-free number: 1-800-227-4165.