

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



**STATE OF GEORGIA EMPLOYEE
BENEFIT PLAN COUNCIL
Benefit Election Form
Long Term Care - Policy #513565**

Your 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	
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)

<input type="checkbox"/> Employee's Spouse	<input type="checkbox"/> Employee's Parent	<input type="checkbox"/> Employee's Parent-In-Law
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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.

Plans (Check One)			
<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4
<ul style="list-style-type: none"> • Nursing Home Facility Care • Professional Home Care • Total Home Care • Return of Premium 	<ul style="list-style-type: none"> • Nursing Home Facility Care • Professional Home Care • Total Home Care • Return of Premium • Compound Inflation 	<ul style="list-style-type: none"> • Nursing Home Facility Care • Professional Home Care • Total Home Care • Return of Premium • Paid Up 	<ul style="list-style-type: none"> • Nursing Home Facility Care • Professional Home Care • Total Home Care • Return of Premium • Compound Inflation • Paid Up

Facility Daily Benefit Amount			
(Check one)	Nursing Home Facility Care	Assisted Living Facility & Home Care	Lifetime Maximum
	<input type="checkbox"/> \$75.00	\$ 45.00	\$136,875.00
	<input type="checkbox"/> \$100.00	\$ 60.00	\$182,500.00
	<input type="checkbox"/> \$125.00	\$ 75.00	\$228,125.00
Facility Benefit Duration is 5 Years			
<i>Duration of benefits may vary depending on where benefits are received</i>			

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

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 Monthly Premium: \$ _____ (Transfer the premium amount from the Enrollment Workbook rate page).

_____	____/____/____	_____	____/____/____
Applicant's Signature	Date	Employee's Signature (Required for Spouse Coverage)	Date

Spouses & Family Members: Please sign and mail all required signature forms to Unum (address at top of page). **Retain a copy for your records. (K2)**

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