

IMPORTANT INSTRUCTIONS: Prior to submitting this form, all applicants must review the important disclosures and information found on <http://unuminfo.com/RomanCatholicBishopWorcester> 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

ROMAN CATHOLIC BISHOP OF WORCESTER
Benefit Election Form
Long Term Care - Policy #588055

| | | | | | |
|---|--|--|--|---|--|
| Your Name: (Last Name, First, Middle Initial) | | Social Security Number | | Date of Birth (MM/DD/YYYY) | |
| Street Address | | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | | Date of Hire (MM/DD/YYYY) | |
| City, State, Zip Code | | Home Telephone # () | | Work Telephone # () | |
| Complete the following only if applicant is not the employee | | | | | |
| 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 | | <input type="checkbox"/> Employee's Parent or Grandparent | | <input type="checkbox"/> Sibling (minimum age 18) | |
| <input type="checkbox"/> Employee's Spouse | | <input type="checkbox"/> Spouse's Parent or Grandparent | | <input type="checkbox"/> Child (minimum age 18) | |
| (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"> • Long Term Care Facility • Professional Home & Community Care Services | <ul style="list-style-type: none"> • Long Term Care Facility • Professional Home & Community Care Services • Total Home Health Care | <ul style="list-style-type: none"> • Long Term Care Facility • Professional Home & Community Care Services • Compound Inflation | | <ul style="list-style-type: none"> • Long Term Care Facility • Professional Home & Community Care Services • Total Home Health Care • Compound Inflation |
| Facility Monthly Benefit Amount | | | | | |
| (Check one) | <input type="checkbox"/> \$4,000 | <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$6,000 | <input type="checkbox"/> \$7,000 * | <input type="checkbox"/> \$8,000 * |
| | Facility Benefit Duration (Duration of benefits may vary depending on where benefits are received) | | | | |
| (Check one) | <input type="checkbox"/> 3 Years | | <input type="checkbox"/> 6 Years | | <input type="checkbox"/> Unlimited Duration * |

Form is continued on reverse side.

* **EMPLOYEES:** Selection of this option exceeds the Guarantee Issue limits and requires completion of 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. **ALL** Medical Questionnaire must accompany a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit.
NOTE TO EMPLOYEES: All Active Employees & Newly Hired Employees – who enroll after the Guarantee Issue enrollment period or choose benefits over the Guarantee Issue limits will be required to fill out a medical questionnaire and signed Form #6720-03.

Active Employee or Spouse: Your premium will be paid through the Employee's payroll deduction. Employee must sign below to authorize the Employer to make the payroll deduction.

All other 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.

All information is contained in your kit.

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

Employees & Spouses: 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. (M7)

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