UNUMPROVIDENT

LONG TERM CARE

Underwritten by:
Unum Life Insurance Company of America
LTC Department – A207
2211 Congress Street, Portland, Maine 04122

MANN FINANCIAL, INC.

EMPLOYEE Benefit Election Form

Long Term Care - Policy #589512

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 # ( )

Funded Plan (Employer Paid) (This Benefit Election Form must be completed for any selection)

Level of Care:	Long Term Care Facility and Professional Home Care
Monthly Benefit:	$2,000 Long Term Care Facility/$1,000 Professional Home Care
Benefit Duration:	3 Years Long Term Care Facility/6 Years Professional Home Care
Non Forfeiture:	Shortened Benefit Period

Your employer is funding Plan 1. You may purchase additional coverage. Please make your selections below:

Plans

(Check one)	☐ **Plan 1 (Funded Plan)**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 4**
	• Long Term Care Facility • Non Forfeiture • Professional Home Care	• Long Term Care Facility • Non Forfeiture • Professional Home Care • Total Home Care	• Long Term Care Facility • Non Forfeiture • Professional Home Care • Compound Inflation	• Long Term Care Facility • Non Forfeiture • Professional Home Care • Total Home Care • Compound Inflation

Facility Monthly Benefit Amount

(Check one)	☐ $2,000 **(Funded Plan)**	☐ $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 **(Funded Plan)**	☐ 6 Years	☐ **Unlimited Duration ***

*** EMPLOYEES: Selection of this option exceeds the Guarantee Issue limits and requires completion of the Long Term Care Insurance Application (medical questionnaire) and a signed return of the Authorization to request Medical Information Form #6720-03 located in the 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 a signed Form #6720-03.

Your premium for the buy-up options will be paid through payroll deduction from your paycheck. You must sign below to authorize your employer to make the payroll deduction.

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. This information is contained in your kit.

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

_____ *Employee's Signature*

___/___/____ *Date*

Please sign and submit to your employer. **Retain a copy for your records.**

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