UnumProvident

LONG TERM CARE

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

MANN FINANCIAL, INC.

FAMILY 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	Home Telephone # ( )	Work Telephone # ( )
City, State, Zip Code	Gender ☐ Male ☐ Female	

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)

☐ Employee's Spouse	☐ Spouse's Parent or Grandparent	☐ Sibling (minimum age 18)	☐ Retiree
	☐ Employee's Parent or Grandparent	☐ Child (minimum age 18)	☐ Retiree's Spouse

You may choose any of the plans listed below. The Long Term Care Application (medical questionnaire), the Benefit Election form and a signed return of the Authorization to request Medical Information Form #6720-03 located in the kit, must be completed and you must be approved for coverage in order to enroll in the Long Term Care plan.

Plans

(Check one)

☐ Plan 1	☐ 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)

☐ $1,000	☐ $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	☐ 6 Years	☐ Unlimited Duration

If you are an Active Employee's Spouse your premium will be paid through the employee's payroll deduction, please sign below. Employee must sign below to authorize the employer to make the payroll deduction.
All other eligible family members or retirees will be billed directly by the insurance company.
Family members or retirees, how would you like to be billed? ☐ 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. This 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*	*Date*

Spouses, sign and submit this form to the employee's employer. Other applicants, sign and mail to UnumProvident (address at top of page). **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.