GROUP LONG TERM CARE INSURANCE APPLICATION

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

The policy for long term care insurance is intended to be a federally qualified long term care insurance policy and may qualify you for federal and state tax benefits.

THE COVERAGE YOU ARE APPLYING FOR IS PROVIDED UNDER AN APPROVED LONG TERM CARE INSURANCE POLICY UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THE POLICY WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG TERM CARE. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE CALIFORNIA PARTNERSHIP FOR LONG TERM CARE, CALL THE HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM AT THE TOLL-FREE NUMBER, 1-800-434-0222.

Please advise if you have received the following documents with this application:

- **Outline of Coverage** ❑ Yes ❑ No
- **HICAP Notice (Item 13 in the Outline of Coverage)** ❑ Yes ❑ No
- **A Consumer's Guide to Long Term Care** ❑ Yes ❑ No
- **Things You Should Know Before You Buy Long Term Care** ❑ Yes ❑ No
- **Long Term Care Insurance Personal Worksheet** ❑ Yes ❑ No
- **Notice to Applicant Regarding Replacement of Accident and Sickness, Nursing Home or Long Term Care Insurance** ❑ Yes ❑ No

7600-04

FILL IN ALL SECTIONS. PROCESSING MAY BE DELAYED IF INCOMPLETE.

Applicant, answer all questions and sign.
Alterations to the pre-printed text will void this Application.

SEND ORIGINAL TO: **Unum Life Insurance Company of America**
Attn: Group Long Term Care Client Service Center
2211 Congress Street, Portland, ME 04122-2295

Policyholder's (i.e. association, employer) Name	Policyholder's ID or Policy No.

I. General Information

Your Name:

(First) (Initial) (Last)

Complete Address:

(Street/PO Box) (City) (State) (Zip Code)

Social Security Number:	Date of Birth: Month Day Year	Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widowed

Are you presently working? ❑ Yes ❑ No If yes, list occupation:	Daytime Telephone Number: ( )
Primary Physician's Name:	Date of Last Physical Exam: Month Day Year
Primary Physician's Address:	Primary Physician's Telephone Number: ( )

REJECTION OF INFLATION PROTECTION OPTION:
I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this insurance with and without inflation protection and I reject this option. ❑ Yes ❑ No

II. Statement of Health - Part 1

Do you use a:

❑ Yes ❑ No	Wheelchair	❑ Yes ❑ No	Walker	❑ Yes ❑ No	Quad Cane
❑ Yes ❑ No	Crutches	❑ Yes ❑ No	Hospital Bed	❑ Yes ❑ No	Dialysis Machine
❑ Yes ❑ No	Oxygen	❑ Yes ❑ No	Stairlift	❑ Yes ❑ No	Hoyer Lift

II. Statement of Health - Part 2

Do you currently need or receive help in doing any of the following:

❑ Yes ❑ No	Bathing	❑ Yes ❑ No	Eating	❑ Yes ❑ No	Dressing
❑ Yes ❑ No	Toileting	❑ Yes ❑ No	Transferring	❑ Yes ❑ No	Maintaining Continence

If you checked "Yes" to any of the questions in Part 2 above, please provide the appropriate details as requested below (include both prescribed and over the counter medications).

Physician (Name & Specialty):	Address (Street, City, State, Zip Code):
Clinic/Office Name:	Telephone Number: ( )
Condition checked in Statement of Health-Part 1 and/or Part 2:	Medication(s) you are taking for the condition:
Date you last visited this physician:	

III. Medical Profile - Part 1

	Your Height: _____ Your Weight: _____
❑ Yes ❑ No	Have you had a weight gain of 10 or more pounds in the last 12 months?
❑ Yes ❑ No	Have you had a weight loss of 10 or more pounds in the last 12 months?
❑ Yes ❑ No	Was the weight change due to a medical condition?
In the next 6 months, do you plan to:	
❑ Yes ❑ No	be hospitalized?
❑ Yes ❑ No	have surgery?
❑ Yes ❑ No	have any diagnostic tests (e.g. EKG, MRI, x-ray)?
In the last 12 months, have you:	
❑ Yes ❑ No	experienced episodes of falling, fainting, dizziness or imbalance?
❑ Yes ❑ No	used tobacco products (smoked, chewed, or used a nicotine delivery system), including pipes and cigars?

In the last 36 months, have you:

❑ Yes ❑ No been advised by a physician to limit, reduce, discontinue or seek counseling for the use of alcohol or drugs?

Have you:

❑ Yes ❑ No been confined to any hospital or facility in the past 5 years?

❑ Yes ❑ No been diagnosed or treated by a member of the medical profession for AIDS or the AIDS Related Complex (ARC)?

III. Medical Profile - Part 2

Within the past five (5) years, have you been diagnosed with, treated or consulted with a licensed physician or been referred to another licensed physician for any of the following conditions?

Yes	No		Yes	No		Yes	No	
❑	❑	Alzheimer's Disease	❑	❑	Ambulation Problems	❑	❑	Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
❑	❑	Ataxia	❑	❑	Blindness	❑	❑	Cardiomyopathy
❑	❑	Catheter use	❑	❑	Cerebral Palsy	❑	❑	Chronic Obstructive Pulmonary Disease
❑	❑	Cirrhosis of the Liver	❑	❑	Confusion	❑	❑	Crohn's Disease
❑	❑	Defibrillator use	❑	❑	Dementia	❑	❑	Drug Abuse
❑	❑	Hairy Cell Leukemia	❑	❑	Hodgkin's Disease	❑	❑	Huntington's Chorea
❑	❑	Hydrocephalus	❑	❑	Incontinence, bowel or bladder	❑	❑	Memory Loss
❑	❑	Mental Retardation	❑	❑	Multiple Myeloma	❑	❑	Multiple Sclerosis
❑	❑	Muscular Dystrophy	❑	❑	Myasthenia Gravis	❑	❑	Organ Transplant (except cornea)
❑	❑	Organic Brain Syndrome	❑	❑	Ostomy	❑	❑	Paraplegia
❑	❑	Paralysis	❑	❑	Parkinson's Disease	❑	❑	Poliomyelitis (Polio)
❑	❑	Polycythemia Vera	❑	❑	Progressive Muscular Atrophy	❑	❑	Post Polio Syndrome
❑	❑	Pulmonary Fibrosis	❑	❑	Quadriplegia	❑	❑	Schizophrenia
❑	❑	Scleroderma	❑	❑	Sjogren's Syndrome	❑	❑	Systemic Lupus Erythematosis
❑	❑	Temporal Arteritis	❑	❑	Thrombocytopenia	❑	❑	Wilson's Disease

If you checked "Yes" to any of the questions in Medical Profile-Part 2 above, please provide the appropriate details as requested below (include both prescribed and over the counter medications).

Physician (Name & Specialty):	Address (Street, City, State, Zip Code):
Clinic/Office Name:	Telephone Number: ( )
Condition checked in Medical Profile-Part 2:	Medication(s) you are taking for the condition:
Date you last visited this physician:	

III. Medical Profile - Part 3

Within the past five (5) years, have you been diagnosed with, treated or consulted with a licensed physician or been referred to another licensed physician for any of the following conditions?

Yes	No		Yes	No		Yes	No	
❑	❑	Amputation	❑	❑	Anemia	❑	❑	Aneurysm
❑	❑	Angina	❑	❑	Anxiety	❑	❑	Arrhythmia/ Irregular Heart Beat
❑	❑	Arthritis	❑	❑	Asthma/ Bronchitis	❑	❑	Atrial Fibrillation
❑	❑	Back Disorder	❑	❑	Barrett's Esophagus	❑	❑	Cancer
❑	❑	Carotid Artery Disease/ Stenosis	❑	❑	Cataracts	❑	❑	Chronic Fatigue Syndrome
❑	❑	Chronic Pain	❑	❑	Colitis/Irritable Bowel Syndrome/Ulcerative Colitis	❑	❑	Congestive Heart Failure
❑	❑	Coronary Heart/Artery Disease	❑	❑	Depression	❑	❑	Diabetes
❑	❑	Emphysema	❑	❑	Endocarditis	❑	❑	Epilepsy/Seizures
❑	❑	Eye Disorders	❑	❑	Fibromyalgia	❑	❑	Fractures, including compression fractures of the spine
❑	❑	Gout	❑	❑	Head Injury	❑	❑	Heart Attack (Myocardial Infarction)
❑	❑	Hemophilia	❑	❑	Hepatitis	❑	❑	Hip Fractures/ Disorders/ Replacement
❑	❑	Hyperglycemia	❑	❑	Hypertension	❑	❑	Hypoglycemia
❑	❑	Joint Disease	❑	❑	Kidney Disease/ Renal Failure	❑	❑	Knee Replacement
❑	❑	Leukemia	❑	❑	Lymphoma	❑	❑	Neuropathy
❑	❑	Osteoarthritis	❑	❑	Osteoporosis	❑	❑	Paget's Disease of Bone
❑	❑	Pancreatitis	❑	❑	Peripheral Vascular Disease	❑	❑	Prostatic Hypertrophy, Benign (BPH)
❑	❑	Polymyalgia Rheumatica	❑	❑	Rheumatoid Arthritis	❑	❑	Sarcoidosis
❑	❑	Sleep Apnea	❑	❑	Spinal Stenosis	❑	❑	Steroid Therapy
❑	❑	Stroke/ Transient Ischemic Attack/ Cerebral Vascular Accident	❑	❑	Tic/ Tremor	❑	❑	Transient Global Amnesia
❑	❑	Thrombophlebitis/ Phlebitis	❑	❑	Valvular Heart Disease			

If you checked "Yes" to any of the questions in Medical Profile-Part 3 above, please provide the appropriate details as requested below (include both prescribed and over the counter medications).

Physician (Name & Specialty):	Address (Street, City, State, Zip Code):
Clinic/Office Name:	Telephone Number: ( )
Condition checked in Medical Profile-Part 3:	Medication(s) you are taking for the condition:
Date you last visited this physician:	

IV. Insurance History (Required by Law)		
A.	❑ Yes ❑ No	Do you have another long term care insurance policy in force, including health care service contract, or health maintenance organization contract?
B.	❑ Yes ❑ No	Have you had another long term care insurance policy or certificate in force during the last 12 months? If so, with which company? _____ If it has lapsed, when did it lapse? _ _/_ _/_ _ _ _
C.	❑ Yes ❑ No	Are you covered by Medicaid (not Medicare)?
D.	❑ Yes ❑ No	Are you receiving Disability, Worker's Compensation, or Social Security Disability Benefits?
E.	❑ Yes ❑ No	Do you intend to replace any of your medical or health coverage with the coverage applied for?
F.	❑ Yes ❑ No	Have you signed a Power of Attorney authorizing another individual to manage your personal affairs?

V. Authorization to Obtain Information

I authorize any **medical related personnel or organization** to give Unum Life Insurance Company of America, or its subsidiaries or representatives, if any, any of the following:

- information about any injury or illness I have or I have had, including mental illness or drug or alcohol abuse;
- information about my medical history including any consultations, prescriptions, treatments or benefits; and
- copies of all records that may be requested concerning me.

The term **medical related personnel or organization**, which is used above, means any of the following:

- a medical professional;
- a medical care institution; or
- Medical Information Bureau

I understand that the information obtained by use of this authorization will be used by Unum Life Insurance Company of America or its subsidiaries or representatives, if any, to determine eligibility for insurance. Unum Life Insurance Company of America will not release any of the obtained information to any other person or organization except:

- reinsuring companies; or
- persons or organizations performing business or legal services in connection with my application as may be otherwise lawfully required or, as I may further authorize.

I understand that I have the right to ask for and get a copy of this authorization. I agree that a copy of this authorization will be as valid as the original and will remain valid for two and a half years from the date shown on the application.

VI. Applicant's Signature

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE MISSTATED OR UNTRUE, UNUM LIFE INSURANCE COMPANY OF AMERICA MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR INSURANCE.

X_____ Date: _____
Applicant's Signature Month Day Year

_____
Signed at (City/State)

Printed Name of Applicant: _____
(First Name) (MI) (Last Name)

Social Security Number: _____

Policy Number: _____

NOTE: The Health Insurance Policy and Accountability Act (HIPAA) requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or process your application. Please sign and return this authorization to: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory or other medically related facility or service; insurance company; insurance service provider; third party administrator; producer; and employer that has information about my health; employment; or other insurance coverage, claims and benefits to disclose any and all of this information to persons who evaluate and process applications for, Unum, Unum Life Insurance Company of America, and duly authorized representatives ("Unum"). Information about my health may relate to any disorder of the immune system including, but not limited to, AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information Unum obtains pursuant to this authorization will be used for evaluating and processing my application for coverage. I further understand that the information is subject to redisclosure and might not be protected by HIPAA.

This authorization is valid for two (2) years from the date below. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Unum has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Unum may not be able to evaluate or process my application and this may be the basis for denying my application. I may revoke this authorization by sending written notice to: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or process my application and this may be the basis for denying my application.

_____ _____
(Applicant Signature) (Date Signed)

I, _____, signed on behalf of the applicant as the applicant's Personal Representative. Please circle the type of Personal Representative: Power of Attorney Designee, Guardian, Conservator; and attach a copy of the document granting authority.

Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

GROUP LONG TERM CARE INSURANCE APPLICATION

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

The policy for long term care insurance is intended to be a federally qualified long term care insurance policy and may qualify you for federal and state tax benefits.

THE COVERAGE YOU ARE APPLYING FOR IS PROVIDED UNDER AN APPROVED LONG TERM CARE INSURANCE POLICY UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THE POLICY WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG TERM CARE. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE CALIFORNIA PARTNERSHIP FOR LONG TERM CARE, CALL THE HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM AT THE TOLL-FREE NUMBER, 1-800-434-0222.

Please advise if you have received the following documents with this application:

- **Outline of Coverage** ❑ Yes ❑ No
- **HICAP Notice (Item 13 in the Outline of Coverage)** ❑ Yes ❑ No
- **A Consumer's Guide to Long Term Care** ❑ Yes ❑ No
- **Things You Should Know Before You Buy Long Term Care** ❑ Yes ❑ No
- **Long Term Care Insurance Personal Worksheet** ❑ Yes ❑ No
- **Notice to Applicant Regarding Replacement of Accident and Sickness, Nursing Home or Long Term Care Insurance** ❑ Yes ❑ No

7600-04

FILL IN ALL SECTIONS. PROCESSING MAY BE DELAYED IF INCOMPLETE.

Applicant, answer all questions and sign.
Alterations to the pre-printed text will void this Application.

SEND ORIGINAL TO: **Unum Life Insurance Company of America**
Attn: Group Long Term Care Client Service Center
2211 Congress Street, Portland, ME 04122-2295

Policyholder's (i.e. association, employer) Name	Policyholder's ID or Policy No.

I. General Information

Your Name:

(First) (Initial) (Last)

Complete Address:

(Street/PO Box) (City) (State) (Zip Code)

Social Security Number:	Date of Birth: Month Day Year	Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widowed

Are you presently working? ❑ Yes ❑ No If yes, list occupation:	Daytime Telephone Number: ( )
Primary Physician's Name:	Date of Last Physical Exam: Month Day Year
Primary Physician's Address:	Primary Physician's Telephone Number: ( )

REJECTION OF INFLATION PROTECTION OPTION:
I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this insurance with and without inflation protection and I reject this option. ❑ Yes ❑ No

II. Statement of Health - Part 1

Do you use a:

❑ Yes ❑ No	Wheelchair	❑ Yes ❑ No	Walker	❑ Yes ❑ No	Quad Cane
❑ Yes ❑ No	Crutches	❑ Yes ❑ No	Hospital Bed	❑ Yes ❑ No	Dialysis Machine
❑ Yes ❑ No	Oxygen	❑ Yes ❑ No	Stairlift	❑ Yes ❑ No	Hoyer Lift

II. Statement of Health - Part 2

Do you currently need or receive help in doing any of the following:

❑ Yes ❑ No	Bathing	❑ Yes ❑ No	Eating	❑ Yes ❑ No	Dressing
❑ Yes ❑ No	Toileting	❑ Yes ❑ No	Transferring	❑ Yes ❑ No	Maintaining Continence

If you checked "Yes" to any of the questions in Part 2 above, please provide the appropriate details as requested below (include both prescribed and over the counter medications).

Physician (Name & Specialty):	Address (Street, City, State, Zip Code):
Clinic/Office Name:	Telephone Number: ( )
Condition checked in Statement of Health-Part 1 and/or Part 2:	Medication(s) you are taking for the condition:
Date you last visited this physician:	

III. Medical Profile - Part 1

	Your Height: _____ Your Weight: _____
❑ Yes ❑ No	Have you had a weight gain of 10 or more pounds in the last 12 months?
❑ Yes ❑ No	Have you had a weight loss of 10 or more pounds in the last 12 months?
❑ Yes ❑ No	Was the weight change due to a medical condition?
In the next 6 months, do you plan to:	
❑ Yes ❑ No	be hospitalized?
❑ Yes ❑ No	have surgery?
❑ Yes ❑ No	have any diagnostic tests (e.g. EKG, MRI, x-ray)?
In the last 12 months, have you:	
❑ Yes ❑ No	experienced episodes of falling, fainting, dizziness or imbalance?
❑ Yes ❑ No	used tobacco products (smoked, chewed, or used a nicotine delivery system), including pipes and cigars?

In the last 36 months, have you:

❑ Yes ❑ No been advised by a physician to limit, reduce, discontinue or seek counseling for the use of alcohol or drugs?

Have you:

❑ Yes ❑ No been confined to any hospital or facility in the past 5 years?

❑ Yes ❑ No been diagnosed or treated by a member of the medical profession for AIDS or the AIDS Related Complex (ARC)?

III. Medical Profile - Part 2

Within the past five (5) years, have you been diagnosed with, treated or consulted with a licensed physician or been referred to another licensed physician for any of the following conditions?

Yes	No		Yes	No		Yes	No	
❑	❑	Alzheimer's Disease	❑	❑	Ambulation Problems	❑	❑	Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
❑	❑	Ataxia	❑	❑	Blindness	❑	❑	Cardiomyopathy
❑	❑	Catheter use	❑	❑	Cerebral Palsy	❑	❑	Chronic Obstructive Pulmonary Disease
❑	❑	Cirrhosis of the Liver	❑	❑	Confusion	❑	❑	Crohn's Disease
❑	❑	Defibrillator use	❑	❑	Dementia	❑	❑	Drug Abuse
❑	❑	Hairy Cell Leukemia	❑	❑	Hodgkin's Disease	❑	❑	Huntington's Chorea
❑	❑	Hydrocephalus	❑	❑	Incontinence, bowel or bladder	❑	❑	Memory Loss
❑	❑	Mental Retardation	❑	❑	Multiple Myeloma	❑	❑	Multiple Sclerosis
❑	❑	Muscular Dystrophy	❑	❑	Myasthenia Gravis	❑	❑	Organ Transplant (except cornea)
❑	❑	Organic Brain Syndrome	❑	❑	Ostomy	❑	❑	Paraplegia
❑	❑	Paralysis	❑	❑	Parkinson's Disease	❑	❑	Poliomyelitis (Polio)
❑	❑	Polycythemia Vera	❑	❑	Progressive Muscular Atrophy	❑	❑	Post Polio Syndrome
❑	❑	Pulmonary Fibrosis	❑	❑	Quadriplegia	❑	❑	Schizophrenia
❑	❑	Scleroderma	❑	❑	Sjogren's Syndrome	❑	❑	Systemic Lupus Erythematosis
❑	❑	Temporal Arteritis	❑	❑	Thrombocytopenia	❑	❑	Wilson's Disease

If you checked "Yes" to any of the questions in Medical Profile-Part 2 above, please provide the appropriate details as requested below (include both prescribed and over the counter medications).

Physician (Name & Specialty):	Address (Street, City, State, Zip Code):
Clinic/Office Name:	Telephone Number: ( )
Condition checked in Medical Profile-Part 2:	Medication(s) you are taking for the condition:
Date you last visited this physician:	

III. Medical Profile - Part 3

Within the past five (5) years, have you been diagnosed with, treated or consulted with a licensed physician or been referred to another licensed physician for any of the following conditions?

Yes	No		Yes	No		Yes	No	
❑	❑	Amputation	❑	❑	Anemia	❑	❑	Aneurysm
❑	❑	Angina	❑	❑	Anxiety	❑	❑	Arrhythmia/ Irregular Heart Beat
❑	❑	Arthritis	❑	❑	Asthma/ Bronchitis	❑	❑	Atrial Fibrillation
❑	❑	Back Disorder	❑	❑	Barrett's Esophagus	❑	❑	Cancer
❑	❑	Carotid Artery Disease/ Stenosis	❑	❑	Cataracts	❑	❑	Chronic Fatigue Syndrome
❑	❑	Chronic Pain	❑	❑	Colitis/Irritable Bowel Syndrome/Ulcerative Colitis	❑	❑	Congestive Heart Failure
❑	❑	Coronary Heart/Artery Disease	❑	❑	Depression	❑	❑	Diabetes
❑	❑	Emphysema	❑	❑	Endocarditis	❑	❑	Epilepsy/Seizures
❑	❑	Eye Disorders	❑	❑	Fibromyalgia	❑	❑	Fractures, including compression fractures of the spine
❑	❑	Gout	❑	❑	Head Injury	❑	❑	Heart Attack (Myocardial Infarction)
❑	❑	Hemophilia	❑	❑	Hepatitis	❑	❑	Hip Fractures/ Disorders/ Replacement
❑	❑	Hyperglycemia	❑	❑	Hypertension	❑	❑	Hypoglycemia
❑	❑	Joint Disease	❑	❑	Kidney Disease/ Renal Failure	❑	❑	Knee Replacement
❑	❑	Leukemia	❑	❑	Lymphoma	❑	❑	Neuropathy
❑	❑	Osteoarthritis	❑	❑	Osteoporosis	❑	❑	Paget's Disease of Bone
❑	❑	Pancreatitis	❑	❑	Peripheral Vascular Disease	❑	❑	Prostatic Hypertrophy, Benign (BPH)
❑	❑	Polymyalgia Rheumatica	❑	❑	Rheumatoid Arthritis	❑	❑	Sarcoidosis
❑	❑	Sleep Apnea	❑	❑	Spinal Stenosis	❑	❑	Steroid Therapy
❑	❑	Stroke/ Transient Ischemic Attack/ Cerebral Vascular Accident	❑	❑	Tic/ Tremor	❑	❑	Transient Global Amnesia
❑	❑	Thrombophlebitis/ Phlebitis	❑	❑	Valvular Heart Disease			

If you checked "Yes" to any of the questions in Medical Profile-Part 3 above, please provide the appropriate details as requested below (include both prescribed and over the counter medications).

Physician (Name & Specialty):	Address (Street, City, State, Zip Code):
Clinic/Office Name:	Telephone Number: ( )
Condition checked in Medical Profile-Part 3:	Medication(s) you are taking for the condition:
Date you last visited this physician:	

IV. Insurance History (Required by Law)		
A.	❑ Yes ❑ No	Do you have another long term care insurance policy in force, including health care service contract, or health maintenance organization contract?
B.	❑ Yes ❑ No	Have you had another long term care insurance policy or certificate in force during the last 12 months? If so, with which company? _____ If it has lapsed, when did it lapse? _ _/_ _/_ _ _ _
C.	❑ Yes ❑ No	Are you covered by Medicaid (not Medicare)?
D.	❑ Yes ❑ No	Are you receiving Disability, Worker's Compensation, or Social Security Disability Benefits?
E.	❑ Yes ❑ No	Do you intend to replace any of your medical or health coverage with the coverage applied for?
F.	❑ Yes ❑ No	Have you signed a Power of Attorney authorizing another individual to manage your personal affairs?

V. Authorization to Obtain Information

I authorize any **medical related personnel or organization** to give Unum Life Insurance Company of America, or its subsidiaries or representatives, if any, any of the following:

- information about any injury or illness I have or I have had, including mental illness or drug or alcohol abuse;
- information about my medical history including any consultations, prescriptions, treatments or benefits; and
- copies of all records that may be requested concerning me.

The term **medical related personnel or organization**, which is used above, means any of the following:

- a medical professional;
- a medical care institution; or
- Medical Information Bureau

I understand that the information obtained by use of this authorization will be used by Unum Life Insurance Company of America or its subsidiaries or representatives, if any, to determine eligibility for insurance. Unum Life Insurance Company of America will not release any of the obtained information to any other person or organization except:

- reinsuring companies; or
- persons or organizations performing business or legal services in connection with my application as may be otherwise lawfully required or, as I may further authorize.

I understand that I have the right to ask for and get a copy of this authorization. I agree that a copy of this authorization will be as valid as the original and will remain valid for two and a half years from the date shown on the application.

VI. Applicant's Signature

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE MISSTATED OR UNTRUE, UNUM LIFE INSURANCE COMPANY OF AMERICA MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR INSURANCE.

X_____ Date: _____
Applicant's Signature Month Day Year

_____
Signed at (City/State)

Printed Name of Applicant: _____
(First Name) (MI) (Last Name)

Social Security Number: _____

Policy Number: _____

NOTE: The Health Insurance Policy and Accountability Act (HIPAA) requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or process your application. Please sign and return this authorization to: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory or other medically related facility or service; insurance company; insurance service provider; third party administrator; producer; and employer that has information about my health; employment; or other insurance coverage, claims and benefits to disclose any and all of this information to persons who evaluate and process applications for, Unum, Unum Life Insurance Company of America, and duly authorized representatives ("Unum"). Information about my health may relate to any disorder of the immune system including, but not limited to, AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information Unum obtains pursuant to this authorization will be used for evaluating and processing my application for coverage. I further understand that the information is subject to redisclosure and might not be protected by HIPAA.

This authorization is valid for two (2) years from the date below. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Unum has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Unum may not be able to evaluate or process my application and this may be the basis for denying my application. I may revoke this authorization by sending written notice to: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or process my application and this may be the basis for denying my application.

_____ _____
(Applicant Signature) (Date Signed)

I, _____, signed on behalf of the applicant as the applicant's Personal Representative. Please circle the type of Personal Representative: Power of Attorney Designee, Guardian, Conservator; and attach a copy of the document granting authority.

Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS, NURSING HOME OR LONG-TERM CARE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to the information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with long-term care insurance coverage to be issued by Unum Life Insurance Company of America. Your new coverage provides thirty (30) days within which you may decide, without cost, whether you desire to keep the coverage. For your own information and protection, you should be aware of and seriously consider certain factors, which may affect the insurance protection available to you under the new coverage.

(1) Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new coverage. This could result in denial or delay in payment of benefits under the new coverage, whereas a similar claim might have been payable under your present coverage.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

Unum Life Insurance Company of America
Mail to: Long Term Care Operations
2211 Congress Street
Portland, ME 04122
Phone – 1-800-227-4165
Fax – 207-541-7606

Authorization and Agreement for Monthly Automatic Payments

Drawn By and Payable To: Unum Life Insurance Company of America
(Hereinafter referred to as "the Company")

Please Print

Policy Number	Insured's Name: Last, First, Middle Initial	Social Security Number
_____	_____	_____

1. **Check all that apply:**

   New authorized payment request Change in bank Change in account number

2. **Tape Voided Check Here**

   If you do not use checks, have starter checks, or you are providing savings account information, you will need to include a letter from your bank reflecting routing transit and account numbers.

3. **Please sign and date.** I authorize the above named bank to pay and charge my account monthly debit entries for the above insured, including checks, drafts and other orders by electronic or paper means, made by and payable to the Company. Your signature confirms that you have read and agree to the terms and conditions that are reflected on the reverse side of this form.

➧ _____ ➧ _____

Signature of Account Holder **Date of Signature**

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL
Please retain a copy of this form for your records

Unum Life Insurance Company of America
Mail to: Long Term Care Operations
2211 Congress Street
Portland, ME 04122
Phone – 1-800-227-4165
Fax – 207-541-7606

Terms and Conditions

I (premium payor whose signature appears on the previous page) have **carefully read** the terms of this authorization, and I **understand** and **agree** that:

1) This Authorization applies to coverage provided under the policy listed above and to any coverage subsequently added.

2) My signature on the previous page reflects my intent that my account be debited by the Company in the amount necessary to pay premium.

3) No notice of premium due will be furnished while the Authorization is in effect, except, if any check or other debit entry made pursuant to this Authorization is not paid, the Company will send notice of premium past due.

4) It is my responsibility to fund my account in an amount sufficient to pay premium when due and failure to do so may result in lapse of coverage. Payments are typically drawn on the 1st of the month.

5) This Authorization does not waive, alter or amend any provision of coverage under the above policy.

6) No premium shall be deemed paid until the Company receives payment at its Home Office.

7) The Company shall incur no liability as a result of the dishonor of any debit entry or any check, draft or other instrument drawn pursuant to this Authorization Agreement.

8) This Authorization shall remain in effect unless and until the bank, the insured person or premium payor presents written notice of termination to the Company.

   Exception: The Company may terminate this Agreement, by providing written notice thereof, in the event that, within any period of twelve consecutive months, two or more premium debits are not paid upon presentation, or if any time the Company is required to refund to the bank any amount paid pursuant to this Authorization.

9) Upon termination of this Agreement, premiums will be payable at the rate (amount) and mode (frequency) required under the Company's usual rate and mode for coverages not enrolled in the Automatic Payment Plan.

10) Funds must be paid in U.S. dollars and withdrawn from a U.S. bank.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
(207) 575-2211

PROTECTION AGAINST UNINTENTIONAL LAPSE OF LONG TERM CARE INSURANCE ADDITIONAL DESIGNATION TO BE COMPLETED IF YOU ARE BILLED DIRECTLY

You will receive notice if any coverage for which you are required to pay the cost is about to terminate because you have not paid the required premiums.

You are required to provide Unum with a written designation of at least one person, in addition to you, who is to receive the notice of cancellation of your coverage for nonpayment of premium OR sign a waiver electing not to designate a person. You have the right to change these designations. Designation does not constitute acceptance of any liability on the part of the designated person or persons for services provided to you. The notice will not be sent until 30 days after the premium is due and unpaid.

Instructions

If you are electing a designee, please complete, sign and date **Sections 1 and 2**.

Section 3 must be completed by your designee only if you are a resident of New Jersey or New York, and are age 62 or older.

If you are not electing a designee, please complete, sign and date **Sections 1 and 4**.

SECTION 1- Applicant / Insured - Please Print Legibly

Policy Number _____

Policyholder's/Company's Name:_____

Your Name:_____

Your Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

SECTION 2- Designations - Please Print Legibly

My Designations are as follows:

Name:_____

Address:Street/PO Box _____

City, State, Zip Code:_____

Name:_____

Address:Street/PO Box _____

City, State, Zip Code:_____

Applicant/Insured's Signature:_____Date:_____

PLEASE RETURN THIS FORM TO LTC SERVICE OPERATIONS AT THE ADDRESS LISTED ABOVE

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
(207) 575-2211

Section 3- For New Jersey or New York Residents Age 62 or Older

Per New Jersey Insurance code C.17:29C-1.2 and §3111 of the New York Insurance Laws, this form shall be delivered to Unum by certified mail, return receipt requested along with the completed Designee Acceptance below. Your Designee(s) must accept in writing that they are willing to receive copies of notices of cancellation, non-renewal and conditional renewal from us.

DESIGNEE ACCEPTANCE LONG TERM CARE INSURANCE

This section needs to be completed by the Designee, if the named applicant/insured is age 62 or over and a resident of ***New Jersey or New York.***

Applicant / Insured: Please complete this section prior to providing this form to your Designee for signature.

Applicant/Insured's name _____

Policy Number: ___ ___ ___ ___ ___ ___

Prior to issuing a long term care certificate, the applicant/insured is required to provide Unum with a written designation of at least one person, who is to receive the notice of cancellation of insurance coverage for nonpayment of premium, in addition to the applicant/insured OR sign a waiver electing not to designate a person. You have been listed as one of the designees. Designation does not constitute acceptance of any liability on the part of the designated person or persons for services provided to the applicant/insured.

You must accept in writing that you are willing to receive copies of notices of cancellation, non-renewal and conditional renewal from Unum. Should you desire to terminate the status as a third party designee, you shall provide written notice to both Unum and the policyholder.

⇨ Designee's signature_____

Print name: _____ Date: _____

SECTION 4-Waiver Electing Not To Name An Additional Designation

Protection against Unintentional Lapse. I understand that I have the right to designate at least one person, other than myself, to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. **I elect NOT to designate any person to receive such notice.**

⇨ Applicant/Insured's signature:_____ Date _____

PLEASE RETURN THIS FORM TO LTC SERVICE OPERATIONS AT THE ADDRESS LISTED ABOVE

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

LONG TERM CARE INSURANCE PERSONAL WORKSHEET

Applicant Name: _____
Social Security Number: _____
Group Policy Number: _____

People buy long term care insurance for many reasons. Some don't want to use their own assets to pay for long term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. However, long term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this long term care insurance coverage.

Premium Information

The premium for the coverage you are considering will be $ _____ per month, or $ _____ per year.

A rate guide is available, that compares the policies sold by different insurers, the benefits provided in those policies, sample premiums, and the history of rate increases, if any, for those policies. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free number (1-800-434-0222) or by accessing the Department of Insurance's Internet web site (www.insurance.ca.gov).

Type of Policy - guaranteed renewable.

The Company's Right to Increase Premiums: The company has the right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History: Unum Life Insurance Company of America has sold long term care insurance since 1988; the B.LTC policy series has been sold since 1990, the GLTC95 policy series has been sold since 1998. The company has not raised its rates on these or similar policy forms in the last ten years.

Questions Related to Your Income

How will you pay each year's premium? (check one)
❒ From My Income ❒ From My Savings/Investments ❒ My Family Will Pay ❒ Other

Have you considered whether you could afford to keep this coverage if the premiums went up, for example, by 20%?

What is your annual income? (check one) ❒ Under $20,000 ❒ $20-29,999 ❒ $30-50,000
❒ Over $50,000

How do you expect your income to change over the next 10 years? ❒ No change ❒ Increase
❒ Decrease

If you will be paying premiums with money received only from your income, a rule of thumb is that you may not be able to afford this coverage if the premiums will be more than 7% of your income.

Will you buy inflation protection? * ❒ Yes ❒ No
* Please refer to your enrollment form to determine if inflation protection is available.

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? ❒ My Income ❒ My Savings/Investments ❒ My Family Will Pay

Long Term Care Personal Worksheet Continued

Please consider your elimination period. The elimination period is selected by the policyholder. Refer to your enrollment form to determine what the elimination period is.
Number of days: _____ Approximate cost $_____ for that period of care.

How are you planning to pay for your care during the elimination period?
❒ From My Income ❒ From My Savings/Investments ❒ My Family Will Pay

Questions Related to Your Savings and Investments
Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one) ❒ Under $20,000 ❒ $20-29,999 ❒ $30-50,000 ❒ Over $50,000

How do you expect your assets to change over the next ten years? (check one)
❒ No change ❒ Increase ❒ Decrease

If you are buying this coverage to protect your assets and your assets are less then $30,000, you may wish to consider other options for financing your long term care.

In order for us to process your application, if applicable, and enrollment form, please sign and return this form to Unum Life Insurance Company of America. We may contact you to verify your answers. Employees and their spouses need not sign and return this form to us.

Disclosure Statement

Please check one

❒ The answers to the questions above describe my financial situation.
OR
❒ I choose not to complete this information. I have reviewed and signed the **Verification of Non-Disclosure of Financial Information** below.

This box must be checked

❒ I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history, and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**

Signature of Applicant: _____ Date: _____

Applicant's Printed Name: _____ Social Security No. _____

Group Policy Number (if available): _____

Name of Employer (complete if applying through Employer offer): _____
_____

Verification of Non-Disclosure of Financial Information

Complete if applicable

❒ Yes. I choose not to provide any financial information. I wish to purchase this coverage. Please resume review of my application.

❒ No. I have decided not to buy long term care insurance coverage at this time.

Signature of Applicant: _____ Date: _____

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

THIS FORM IS REQUIRED TO BE COMPLETED AND RETURNED BEFORE COVERAGE WILL BE EFFECTIVE

California regulations require Unum Life Insurance Company of America to provide you with the following forms. Please advise if you have received these forms by signing, dating and returning this form to Unum Life Insurance Company of America.

- **Outline of Coverage** ☐ Yes ☐ No
- **HICAP Notice (Item 13 in the Outline of Coverage)** ☐ Yes ☐ No
- **A Consumer's Guide to Long Term Care** ☐ Yes ☐ No
- **Things You Should Know Before You Buy Long Term Care** ☐ Yes ☐ No
- **Long Term Care Insurance Personal Worksheet** ☐ Yes ☐ No
- **Notice to Applicant Regarding Replacement of Accident and Sickness, Nursing Home or Long Term Care Insurance** ☐ Yes ☐ No

Signed:_____ _____
(Applicant) (Social Security Number)

_____ _____
(Please Print Name) (Date)

_____ _____
(Name of Employer) (Group Policy Number, if available)
Complete if applying through Employer offer

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

Things You Should Know Before You Buy Long-Term Care

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should not buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does not pay for most of long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local and state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a booklet called the "Guide to Long-Term Care". Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state department on aging for more information about the senior health insurance counseling program in your state.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

(For long term care policies providing both nursing home and non-institutional coverage)

Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.

- This is long term care insurance that provides benefits for covered nursing home and home care services.
- In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most long term care expenses.

Before You Buy This Insurance

✔ Check the coverage in **all** health insurance policies you already have.

✔ For more information about long term care insurance, review the Shopper's Guide to Long Term Care Insurance, available at http://w3.unum.com/enroll/booklets. To have a printed copy mailed to you, call 1-877-678-6040.

✔ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available at http://w3.unum.com/enroll/booklets. To have a printed copy mailed to you, call 1-877-678-6040.

✔ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

(For long term care policies providing nursing home only coverage)

Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.

- This insurance provides benefits primarily for covered nursing home services.
- In some situations Medicare pays for short periods of skilled nursing home care and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most nursing home expenses.

Before You Buy This Insurance

✔ Check the coverage in **all** health insurance policies you already have.

✔ For more information about long term care insurance, review the Shopper's Guide to Long Term Care Insurance, available at http://w3.unum.com/enroll/booklets. To have a printed copy mailed to you, call 1-877-678-6040.

✔ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, at http://w3.unum.com/enroll/booklets. To have a printed copy mailed to you, call 1-877-678-6040.

✔ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

DISCLOSURE

NOTICE OF INSURANCE INFORMATION PRACTICES

Thank you for applying to Unum Life Insurance Company of America. As part of our normal underwriting procedure, we need to obtain information to determine an Applicant's eligibility for insurance. Much of that information will come from you; however, we often obtain additional information or verify information through other sources.

Collection
Your application, including the medical questionnaire and any exams, is our main source of information. However, Unum Life Insurance Company of America may need to obtain additional information from other sources about your age, physical condition, occupation, other insurance coverage, and health history.

Unum Life Insurance Company of America may obtain this information from physicians, hospitals, clinics or other medical professionals or medical care facilities. We may collect information in person, by telephone, or by exchanges of correspondence.

Disclosures
Unum Life Insurance Company of America will not disclose to others the information, which we obtain about you without your prior authorization except as necessary to conduct our business (and then only if disclosure is permitted by law).

For example, if necessary, Unum Life Insurance Company of America may disclose information to:
- persons and organizations that perform insurance, or business or professional services for us;
- other insurance companies to which you have applied for coverage or benefits;
- insurance companies, agents, or insurance support organizations to help detect or prevent insurance fraud or misrepresentation;
- a medical professional or facility so it can properly notify you of a medical condition of which you may not be aware;
- our reinsurers;
- insurance departments or commissions in connection with audits or examinations of our company;
- law enforcement agencies to help prevent or prosecute fraud or to alert them that unlawful activity may have occurred; or
- a research or actuarial organization.

These are disclosures that Unum Life Insurance Company of America is permitted to make- not disclosures that we make often. In fact most disclosures made by us are to identify you for collection of information, for reinsurance or other services, or to help detect or prevent fraud and misrepresentation.

Applicant should retain a copy of this page for their records.

Access to Information
You have a right to recorded personal information about you, which is in Unum Life Insurance Company of America's files and is reasonably locatable. To ensure security of information in our files, we will require positive identification before we allow access to that information. To obtain access to recorded personal information about you, send a signed, written request to the address on the front page of this Application. Give your full name, address, telephone number, and policy number if a policy has been issued.

Within 30 business days after we receive your request, we will inform you of the nature and substance of the information in our files, which is reasonably locatable and retrievable. We will also tell you to whom we have disclosed this information within the last two years. If you wish we can show you the information at our Home Office or we will mail copies to you. However, we reserve the right to disclose medical information only through a medical professional chosen by you. You may have to pay a reasonable charge to cover the cost of the copies.

Correction of Information
If you believe any of Unum Life Insurance Company of America's information is not correct, please notify us and explain why you believe it is inaccurate or incomplete. We will review it. If we agree with you, we will correct the information and notify any person designated by you to whom we have disclosed the information within the preceding two years.

If we disagree with you, we will tell you that we will not make the requested change. Then you may submit to us information and your reasons for disagreeing with our decision not to change the information. We will then furnish your statement to any person designated by you to whom we disclosed the information in the prior two years and to anyone else who may receive the information from us in the future.

Underwritten by:
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

NOTICE TO APPLICANT –

A CONSUMER'S GUIDE TO LONG TERM CARE

"A CONSUMER'S GUIDE TO LONG TERM CARE" (listed on Form 7600-04) is a booklet that has been provided to your Plan Administrator.

Please contact your Plan Administrator if you would like a copy to review prior to making your selection for Long Term Care.