IMPORTANT INSTRUCTIONS: Prior to submitting this form, all applicants must review the important disclosures and information found 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

MILPITAS CHRISTIAN SCHOOL
EMPLOYEE Benefit Election Form
Long Term Care - Policy #578655-001

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 # ( )
Applicant's Email Address:		

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

Level of Care:	Nursing Facility & 70% Residential Care Facility and 50% Home & Community-Based Care
Monthly Benefit:	$3,000 Nursing Facility & 70% Residential Care Facility/ 50% Home & Community-Based Care
Benefit Duration:	3 Years Nursing Facility & 70% Residential Care Facility/ 50% Home & Community-Based Care

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
• Nursing Facility & 70% Residential Care Facility • Home & Community-Based Care	• Nursing Facility & 70% Residential Care Facility • Home, Community-Based & Immediate Family Member Care	• Nursing Facility & 70% Residential Care Facility • Home & Community-Based Care • Compound Inflation	• Nursing Facility & 70% Residential Care Facility • Home, Community-Based & Immediate Family Member Care • Compound Inflation

Facility Monthly Benefit Amount

(Check one)	☐ $3,000 **(Funded Plan)**	☐ $4,000	☐ $5,000	☐ $6,000

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 Authorization to Request Medical Information Form #6720-03-CA 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-CA.**

Transfer your premium amount from the calculation on the rate sheet: = _____ (A)

_____ **X** 3 **=** _____ **(B)**
Rate for Funded Base Plan 1 (3 year duration) (based on funded amount) Employer Paid Amount

A MINUS B = _____
EMPLOYEE'S COST

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. All 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 mail all required signature forms to your employer.
Retain a copy for your records. (K6)

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

IMPORTANT INSTRUCTIONS: Prior to submitting this form, all applicants must review the important disclosures and information found 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.

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LTC Department
2211 Congress Street
Portland, Maine 04122

MILPITAS CHRISTIAN SCHOOL
FAMILY Benefit Election Form
Long Term Care - Policy #578655-001

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	
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)

☐ Employee's Spouse/Registered Domestic Partner	☐ Spouse's/Registered Domestic Partner's Parent or Grandparent	☐ Sibling (minimum age 18)
	☐ Employee's Parent or Grandparent	☐ Child (minimum age 18)

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-CA 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)

☐ Plan 1	☐ Plan 2	☐ Plan 3	☐ Plan 4
• Nursing Facility & 70% Residential Care Facility • Home & Community-Based Care	• Nursing Facility & 70% Residential Care Facility • Home, Community-Based & Immediate Family Member Care	• Nursing Facility & 70% Residential Care Facility • Home & Community-Based Care • Compound Inflation	• Nursing Facility & 70% Residential Care Facility • Home, Community-Based & Immediate Family Member Care • Compound Inflation

Facility Monthly Benefit Amount

(Check one)

☐ $3,000	☐ $4,000	☐ $5,000	☐ $6,000

Facility Benefit Duration ***(Duration of benefits may vary depending on where benefits are received.)***

(Check one)

☐ 3 Years	☐ 6 Years	☐ Unlimited Duration

Active Employee's Spouse/Registered Domestic Partner: 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/ Registered Domestic Partner Coverage)*	*Date*

Spouses/Registered Domestic Partners: Please sign and mail all required signature forms to the employer.
Family Members: Please sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (K6)

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