Long term care insurance

Everything you need to apply for coverage for yourself and your family members

What you need to know

This booklet provides information you need to understand the long term care (LTC) insurance coverage the employer is offering through Unum including detailed plan information. Be sure to review this information before enrolling.

How to enroll in the plan

Review the Benefit Election Form, Rates, Long Term Care Insurance Applications (medical questionnaire), replacement forms, and other forms that require a signature. Refer to the grid below to determine which forms you need to complete.

	Employee*	Spouse	Other family members	Retired employee & spouse
Benefit Election Form	✔	✔	✔	✔
Long Term Care Application (medical questions)	✔ *	✔	✔	✔
Protection Against Unintentional Lapse			✔	✔
Authorization & Agreement for Automatic Payment			✔ †	✔ †
Personal Worksheet			✔	✔

* Employees: Complete the Long Term Care Application (medical questionnaire) only if you are choosing coverage over the guarantee issue limit or if you are enrolling after your initial guarantee issue enrollment period.

† This form is only required if you wish to have your payment automatically deducted from your checking account.

State forms to review

Please be sure to review all other forms. The state where the group policy was issued requires that this information be included for all consumers.

To review the Shopper's Guide to Long Term Care or the Guide to Health Insurance for People with Medicare, visit http://w3.unum.com/enroll/booklets. To obtain a paper copy of either of these booklets please contact us at the number below.

Call 1-800-227-4165 if you have any questions or need additional forms.

AE-1217 (01/16)

Underwritten by:
Unum Life Insurance Company of America

Long Term Care Insurance

The purpose of this communication is the solicitation of insurance. Contact will be made by an insurance agent or insurance company.

Long Term Care Insurance coverage can help protect your finances

If you need long term care for a period of time, this policy may help you be prepared for the financial impact. This coverage can also help you maintain control of some important decisions, such as:

- Who would take care of me?
- Where can I choose to receive care?

What is long term care?

It is the type of care you may need if — due to a chronic illness* — you are unable to perform, without substantial assistance from another individual, two or more Activities of Daily Living** such as:

- Eating
- Bathing
- Continence
- Dressing
- Toileting
- Transferring

Or if you require substantial supervision by another individual to protect you from threats to your health and safety due to severe cognitive impairment, such as alzheimer's disease or mental Illness.

How does this coverage help?

Group Comprehensive Long Term Care Insurance provides benefits to help you pay for care provided by:

- Adult day care
- Home health care
- Homemaker services
- Hospice services
- Personal care
- Respite care
- Adult day care facility
- Alzheimer's facility
- Nursing facility
- Residential care facility
- Hospice facility
- Rehabilitation facility

Why buy now?

People often buy long term care insurance at an early age, because the younger you are, the more affordable the rates.

Why buy coverage at work?

1. You may get more affordable rates when you buy this coverage through your employer and you can apply for coverage for your parents and spouse.
2. Depending on your plan, you may be able to pay your premium through convenient payroll deduction.

How to apply

Your benefit enrollment is coming soon. To learn more, watch for information from your employer.

"Chronic illness"* means:

- You are unable to perform, without substantial assistance from another individual, two or more Activities of Daily Living; or
- You require substantial supervision by another individual to protect you from threats to your health and safety due to severe cognitive impairment or mental illness.

"Activities of Daily Living (ADLs)" are:**

- Eating means feeding oneself by getting food into the body from a receptacle (such as a plate or cup) or by a feeding tube or intravenously.
- Bathing means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence means the ability to maintain control of bowel or bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- Dressing means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Toileting means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring means the ability to move into and out of a bed, a chair, or wheelchair.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form B.LTC, GLTC95, RGLTC04, or GLTC04 or contact your Unum representative.

Underwritten by: Unum Life Insurance Company of America, Portland, Maine

unum.com

MILPITAS CHRISTIAN SCHOOL - #578655-001
SCHEDULE OF BENEFITS / PLAN HIGHLIGHTS

Your Long Term Care (LTC) insurance plan is listed below.

Elimination Period: Your plan's Elimination Period of 90 consecutive days is the amount of time you must wait before benefits become payable. This time period must be satisfied only once during the life of your plan.

Newly Hired Employees – once eligible for the plan, will have 30 days to sign up for Guarantee Issue coverage. Please check with your employer for your effective date.

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.

Medical Underwriting Effective Date – The effective date for those applicants passing medical underwriting between the 1st and 15th of the month is the first of the month following their date of approval. For those approved between the 16th and the end of the month, their effective date is the first of the second month following their date of approval.
Medical Underwriting means that you must answer all questions on a medical questionnaire. In some cases, an interview may also be necessary.

Delayed Effective Date – If you are absent from work because you are injured, sick, temporarily laid off or on a leave of absence, your coverage will not begin on your otherwise expected effective date.

Medical Underwriting for Employees and Family: (Completion of the Benefit Election Form is required for enrollment). **EMPLOYEES:** Your employer funded basic plan, as well as additional benefit amounts of up to and including $6,000 and a Facility Benefit Duration of 3 or 6 years, is being offered on a Guarantee Issue basis. This does not require completion of the Long Term Care Insurance Application (medical questionnaire) if you apply during your initial eligibility period. The Long Term Care Insurance Application (medical questionnaire) is required if enrolling after your initial eligibility period or if you choose to buy the Unlimited Duration coverage. All **Family Members** must complete the Benefit Election Form and Long Term Care Insurance Application (medical questionnaire) and must be approved for coverage in order to enroll in the Long Term Care plan. **All** Medical Questionnaires must accompany a signed Authorization to Request Medical Information Form #6720-03-CA located in the enrollment kit.

Benefit Duration	3 Years	6 Years	Unlimited Duration
Nursing Facility Benefit Amount **Per $1,000 Increments**	$3,000 to $6,000	$3,000 to $6,000	$3,000 to $6,000
Residential Care Facility	70%	70%	70%
Home and Community-Based Care	50%	50%	50%
Home, Community-Based and Immediate Family Member Care - **Option**	50%	50%	50%
Inflation Protection - **Option**	Compound Uncapped	Compound Uncapped	Compound Uncapped

Lifetime Maximum: The Lifetime Maximum is the maximum benefit dollar amount Unum will pay over the life of your coverage. This dollar amount is based on the Facility Benefit Amount and Benefit Duration.
For Example: If you choose $3,000 Facility Monthly Benefit Amount & 3 Year Duration, your Lifetime Maximum is calculated as follows, $3,000 per Month X 12 Months X 3 Years = $108,000 Lifetime Maximum.

Insurance Age: Insurance Age is used to determine the cost of your coverage. Insurance Age is your age on the plan effective date if you enroll for coverage prior to the plan effective date. If you enroll for coverage on or after the plan effective date, insurance age is your age on the date you sign the enrollment form.

Questions: Please call 1-800-227-4165 with questions regarding your Long Term Care Insurance.

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

LONG TERM CARE INSURANCE - OUTLINE OF COVERAGE

FOR THE EMPLOYEES OF

MILPITAS CHRISTIAN SCHOOL

(the Policyholder)

Group Master Policy/Certificate Form Number **578655**

This policy for Long Term Care Insurance is intended to be a federally qualified Long Term Care Insurance contract and may qualify you for federal and state tax benefits.

NOTICE TO BUYER: This policy may not cover all costs associated with Long Term Care incurred by you during the period of coverage. You are advised to review carefully all policy limitations.

THIS POLICY IS AN APPROVED LONG-TERM CARE INSURANCE POLICY UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THIS 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.

IMPORTANT CAUTION ABOUT INFORMATION YOU PROVIDED

Caution: If you must complete an Application for Long Term Care Insurance, the issuance of a Long Term Care insurance certificate will be based on your response to the questions in your application. A copy of your Application for Long Term Care Insurance was retained by you when you applied. If your answers are incorrect or untrue, Unum may have the right to deny benefits or rescind your coverage. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact Unum at this address: Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122.

1. This policy is a group policy of insurance which was issued in **California**.

2. PURPOSE OF OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the plan. You should compare this outline of coverage to outlines of coverage for other policies available to you.

This is not an insurance contract, but only a summary of coverage. Only the group policy contains governing contractual provisions. This means that the group policy sets forth in detail the rights and obligations of both you and us (Unum Life Insurance Company of America). Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY CAREFULLY!**

3. TERMS UNDER WHICH THE CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED

- You have a 30-day right to examine the certificate. If, after examining the certificate, you are not satisfied for any reason, you may withdraw your enrollment in the plan by returning your certificate within 30 days of its delivery to you. The certificate, together with a written request for withdrawal must be sent to the Plan Administrator or Unum. Upon receipt, your insurance will be deemed void from its effective date and any premium contributions paid will be returned.
- Premiums for additional, increased or terminated insurance may cause a pro-rata adjustment on the next premium due date.

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Unum. You may obtain a copy of the Guide by calling 1-800-227-4165. Unum Life Insurance Company of America is not representing Medicare, the federal government or any state government.

5. LONG TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered Long Term Care expenses, if you are **Chronically Ill** and you are receiving care while confined in a **Nursing Facility** or a **Residential Care Facility**. If you purchase **Home, Community-Based and Immediate Family Member Care** coverage, we will pay you a benefit if you elect to receive care other than in a **Nursing Facility** or a **Residential Care Facility**. Coverage is subject to policy limitations, benefit maximums and **Elimination Periods**.

6. BENEFITS PROVIDED BY THIS POLICY

REFER TO THE ATTACHED SUMMARY OF BENEFITS FOR THE BENEFITS AVAILABLE UNDER THE POLICYHOLDER'S PLAN.

You are eligible for a Monthly Benefit if, after the effective date of your coverage and while your coverage is in effect,:

a. you suffer the loss of 2 or more **Activities of Daily Living (ADLs)**; or
b. you suffer **Severe Cognitive Impairment**; and
c. you are receiving services in a **Nursing Facility** or a **Residential Care Facility** or you are receiving a **Home Care Benefit**.

A monthly benefit will become payable once:

a. you have satisfied your **Elimination Period**; and
b. a **Physician** has certified that you are unable to perform (without **Substantial Assistance** from another individual) two or more **ADLs** for a period that is expected to last at least 90 days, or that you require **Substantial Supervision** by another individual to protect you or others from threats to health or safety due to **Severe Cognitive Impairment**. You will be required to submit a **Physician** certification every 12 months.

The treatment and services you receive for your **Chronic Illness** must be provided pursuant to a written **Plan of Care.**

Facility Benefit

We will pay you:

a. the **Nursing Facility** benefit amount if you receive care while confined in a **Nursing Facility**. Your confinement must be because you need either: (1) the **Substantial Assistance** of another person to perform 2 or more **Activities of Daily Living (ADLs)**; or (2) **Substantial Supervisio**n because you suffer from **Severe Cognitive Impairment**, or
b. the **Residential Care Facility** benefit amount if you are **Chronically Ill** and are receiving services in a **Residential Care Facility**.

   The **Residential Care Facility** benefit amount will be the greater of:
   (1) 70% of the **Nursing Facility** benefit amount; or
   (2) the **Home Care Benefit** shown on the SUMMARY OF BENEFITS, if **Home Care** is purchased.

The benefit paid is subject to the **Lifetime Maximum Amount**. Benefits are not paid during the **Elimination Period**.

IMPORTANT TERMS YOU SHOULD KNOW

"Activities of Daily Living" (ADLs) are:

- eating – feeding oneself by getting food in the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- bathing - washing oneself by sponge bath; or in either a tub or shower, including the act of getting into or out of the tub or shower.
- continence - the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- dressing - putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- toileting - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- transferring - the ability to move into and out of a bed, a chair, or wheelchair, or ability to walk or move around inside or outside the home, regardless of the use of a cane, crutches, or braces.

"Chronic Illness and Chronically Ill" mean:

- you are unable to perform, without **Substantial Assistance** from another individual, at least two **Activities of Daily Living**; or
- you require **Substantial Supervision** by another individual to protect you from threats to health and safety due to **severe impairment of cognitive ability**.

"Elimination Period" is the number of consecutive days, specific to your plan, during which you must be eligible for benefits before benefits become payable.

"Lifetime Maximum Amount" is the total dollar amount of benefits that will be paid under the policy. Your **Lifetime Maximum Amount** is based on the level of coverage and benefit duration you select.

"Plan of Care" means a program of treatment or care. It must be developed by your Physician, multi-disciplinary team or Licensed Health Care Practitioner and approved, in writing, by your Physician before the start of **Home Care Services**.

"Respite Care" means care provided to you for a short period of time to allow your informal caregiver a break from their caregiving responsibilities. If you are eligible for a **Home Care Benefit** but benefits have not yet become payable, payments will be made to you for each day you receive **Respite Care** for up to 15 days each calendar year. The amount of your payment will equal 1/30th of your **Home Care** monthly benefit for each day that you receive **Respite Care**.

"Severe Cognitive Impairment" means a severe deterioration or loss, as reliably measured by clinical evidence and standardized tests, in your short or long term memory; your orientation as to person, place, and time; and your deductive or abstract reasoning.

Such deterioration or loss requires **Substantial Supervision** by another individual for the purpose of protecting yourself. Such loss can result from a **Chronic Illness**, Alzheimer's disease, or similar form of dementia.

Unum will make payments to you for conditions that are psychological, psychiatric or mental in nature, including Alzheimer's disease, organic disorders, or related degenerative and dementing illnesses.

"Substantial Assistance" means hands-on or stand-by assistance by another person without which you would not be able to safely and completely perform the **ADL**.

"Substantial Supervision" means the presence of another individual for the purpose of protecting you from harming yourself or others.

OPTIONAL BENEFITS AVAILABLE

Home Care Benefit- Home, Community-Based and Immediate Family Member Care
We will pay you the monthly **Home Care Benefit** amount if you choose to receive care anywhere other than a **Nursing Facility** or a **Residential Care Facility**.

"Home Care Services" means care, treatment or services provided under a **Plan of Care** at any type facility such as Adult Day Care Facility or in your home by immediate family members and includes Adult Day Care, Home Health Care, Homemaker Services, Hospice Services, Personal Care and Respite Care.

Inflation Protection Option - 5% Compound Inflation With No Cap
Your Monthly Benefit Amount will increase each year on January 1st by 5% of the Monthly Benefit in effect on that January 1st. Your remaining **Lifetime Maximum Amount** will also increase. Increases will be automatic and will occur regardless of your health and whether or not you are **Chronically Ill**. Your premium will not increase due to automatic increases in your monthly benefit amount.

The benefit paid is subject to the **Lifetime Maximum Amount**. Benefits are not paid during the **Elimination Period**.

Refer to the attached chart comparing a monthly benefit with and without Inflation Protection.

7. LIMITATIONS AND EXCLUSIONS
Unum will not make long term care payments to you for:

- a **Chronic Illness** which is caused by a war (whether declared or undeclared) or any act of war,
- a **Chronic Illness** caused by suicide, whether sane or insane, attempted suicide, or intentionally self-inflicted injury;
- a **Chronic Illness** caused by participation in a felony, riot, or insurrection;
- **Chronic Illness** or confinements during which you are outside the United States, its territories or possessions for longer than 30 days;
- treatment for alcoholism and drug addiction;
- a period in which you are confined in a hospital other than if you are confined in a **Nursing Facility** that is a distinctly separate part of a hospital (this exclusion does not apply to those periods covered under the Bed Reservation Benefit); or
- care, treatment, services or claims certification by a Physician who is you, or your Immediate Family Member who is your spouse, parent, daughter, son, sister or brother.

Pre-existing Condition
If you do not have to complete an Application for Long Term Care Insurance, a

Pre-existing Condition may apply to you.

A **Pre-existing Condition** is a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

Every Long Term Care insurance policy or certificate shall cover Preexisting Conditions that are disclosed on the application no later than six months following the effective date of the coverage of an insured, regardless of the date the loss or confinement begins.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

8. RELATIONSHIP OF COST OF CARE AND BENEFITS.
Because the costs of Long Term Care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted.

- **COST**
  The premium rate paid for your coverage over the duration of your initial coverage or for any increases is based on your insurance age.
- **ELECTION TO CHANGE COVERAGE**
  You can apply no less frequently than on each anniversary date after the Policy is issued to increase coverage by filling out a new Benefit Election Form and a Long Term Care Insurance Application.

  You can apply any time after the first year to lower your premium by reducing coverage or by discontinuing **Home Care** coverage.
- **INFLATION PROTECTION**
  If your plan includes an Inflation Protection option, your Monthly Benefit will increase each year on January 1st by 5%. Your remaining **Lifetime Maximum Amount** will also increase. Increases will be automatic and will occur regardless of your health and whether or not you are **Chronically Ill**. Your premium will not increase due to the automatic increases in your Monthly Benefit.

  The following chart is an example comparison of a monthly benefit with and without Inflation Protection.

Policy Year	Without Inflation Protection Monthly Benefit	With 5% Uncapped Compound Inflation Protection Monthly Benefit
1	$2000.	$2100.
2	$2000.	$2205.
3	$2000.	$2315.
4	$2000.	$2431.
5	$2000.	$2553.
6	$2000.	$2680.
7	$2000.	$2814.
8	$2000.	$2955.
9	$2000.	$3103.
10	$2000.	$3258.
11	$2000.	$3421.
12	$2000.	$3592.
13	$2000.	$3771.
14	$2000.	$3960.
15	$2000.	$4158.
16	$2000.	$4366.
17	$2000.	$4584.
18	$2000.	$4813.
19	$2000.	$5054.
20	$2000.	$5307.

9. TERMS UNDER WHICH THE GROUP COVERAGE THROUGH THE PLAN MAY BE CONTINUED IN FORCE OR DISCONTINUED.

- **RENEWABILITY**

  THE POLICY IS GUARANTEED RENEWABLE. The Policy takes effect on the Policy Effective Date shown on the face page of the Policy and continues until the end of the period for which the first premium has been paid. The Policyholder may renew the Policy on each Policy Anniversary by paying each premium before its Grace Period ends. Unum reserves the right to change the premiums for the Policy. We cannot change any of the terms of the Policy or decline to renew it on our own; except that we may, in accordance with the provisions of the Policy, and upon prior approval of the California Department of Insurance, change the premium rates for all insured with the same policy form number and in the same Class. A Class is a group of policies issued to individuals who share certain characteristics. The characteristics are based on the state where the policyholders live or the year of issue. Any change in premium will be effective on the Policy Anniversary Date. Written notification will be sent to the Policyholder at least 31 days in advance.

- **WHEN COVERAGE WILL END**

  Your coverage will end on the earliest of these dates:
  - The date the Policy ends,
  - The date you are no longer an **Active Employee** with the Policyholder,
  - The date you no longer work for the Policyholder,
  - The end of the period for which premiums were last paid to Unum for your coverage,
  - The date your total benefit payments equal your **Lifetime Maximum Amount**, or
  - The date you die.

  If you are absent from work at the Policyholder for any reason, you will continue to be covered for group coverage if the Policyholder continues to pay premiums to Unum.

- **CONTINUATION OF COVERAGE**

  If your group Long Term Care coverage ends for reasons other than your choice to have premium payments stopped for your coverage, you may elect continuation of coverage. This means that the same coverage you had under the plan can continue on a direct billed basis. If you are already direct billed, your coverage will automatically transfer to continuation of coverage.

  Election for continuation of coverage must be made within 31 days of the date the group coverage would otherwise end. Any premium that applies must be paid directly to Unum by you for any coverage to be continued.

- **PREMIUM WAIVER**

  When benefits become payable, there will be no more cost for your coverage as long as you continue to be eligible for a monthly benefit.

  If your plan includes a **Home Care Services** benefit and you do not receive these services for a period of 30 consecutive days, premium payments will again become due.

  Premiums are not waived while you are receiving a payment for **Respite Care**.

- **RIGHT TO CHANGE PREMIUMS**

  The rate will not increase because you grow older or because of your use of the benefits. However, the rate schedule may change in the future depending on the overall use of the benefits for all covered persons or changes in the benefit levels, plan design or other risk factors. Any such change will be made on a class basis according to Unum's underwriting risk studies under this type of insurance.

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

This policy provides coverage for **Severe Cognitive Impairment**. **Severe Cognitive Impairment** is not related to the inability to perform **ADLs**. Rather, **Severe Cognitive Impairment** means that you have lost the ability to reason and suffer a decrease in awareness, intuition and memory. Examples of conditions which may cause **Severe Cognitive Impairment** are: Alzheimer's disease, multi-infarct dementia, brain injury, brain tumors, or other such structural alterations of the brain.

11. PREMIUM

The initial premium charges will be figured at the premium rates as shown on the attached pages. Unum may change the premium rates when the terms of the policy are change.

12. ADDITIONAL FEATURES

- Medical underwriting may be required.
- Eligibility and Participation

  You are eligible for the plan if you are:

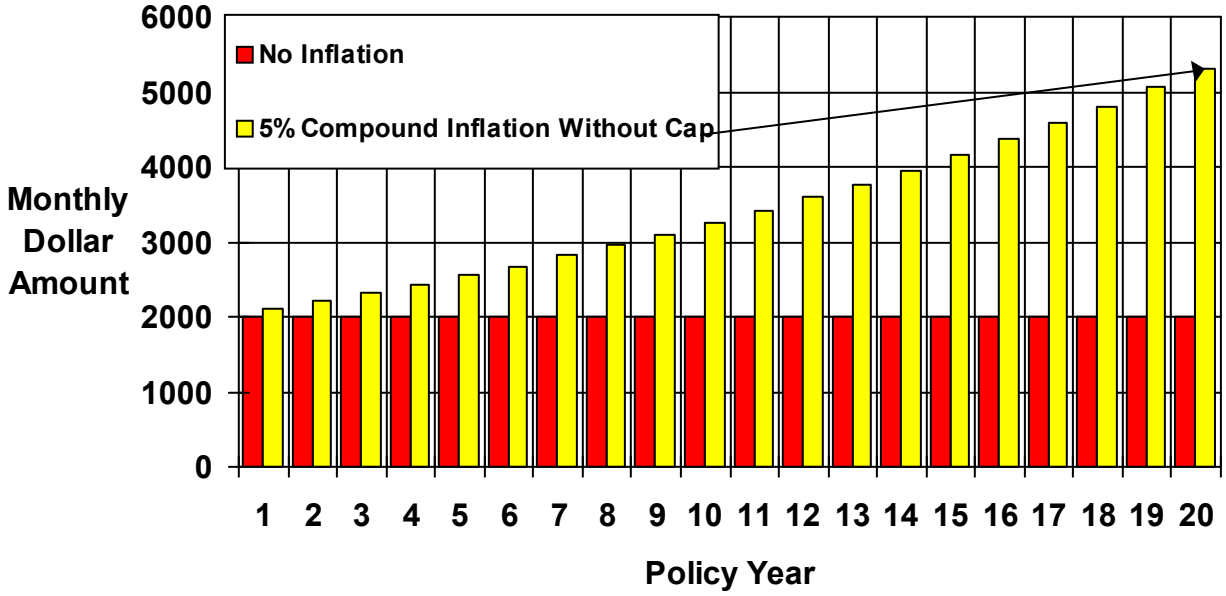
  - an **Active Employee** of the Policyholder and your **Family Members**

13. INFORMATION AND COUNSELING

The California Department of Insurance has prepared a Consumer Guide to Long Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP. Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging, provides Long Term Care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number 1-800-434-0222 for a referral to your local HICAP office.

Long Term Care

Comparison of Benefits for Compound Inflation Protection



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.

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RATE SHEET

MILPITAS CHRISTIAN SCHOOL

Base Plan		***Options***	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Home, Community-Based and Immediate Family Member Care**
Home Monthly Benefit	**$500**		
Facility Benefit Duration	**3 Years**		
Home Benefit	**50%**	Inflation Protection	**Compound Uncapped**
Lifetime Maximum	**$36,000**		
Elimination Period	**90 Days**		
Home Care Level	**Home and Community-Based Care**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Rate for Plan Chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Home, Comm-Based and Immediate Family Member Care Option	Plan 3 Base Plan With Compound Inflation Option	Plan 4 Base Plan With Home, Comm-Based and Immediate Family Member Care Compound Inflation Option
18-30	2.10	3.10	6.40	8.90
31	2.10	3.10	6.50	9.00
32	2.10	3.20	6.70	9.20
33	2.20	3.20	6.80	9.50
34	2.20	3.30	7.00	9.70
35	2.30	3.40	7.30	10.00
36	2.30	3.50	7.40	10.20
37	2.40	3.60	7.60	10.40
38	2.60	3.80	7.90	10.80
39	2.70	4.00	8.20	11.10
40	2.80	4.10	8.30	11.40
41	2.90	4.30	8.60	11.70
42	3.00	4.50	8.90	12.10
43	3.20	4.70	9.20	12.50
44	3.30	4.90	9.50	12.90
45	3.50	5.10	9.80	13.30
46	3.60	5.40	10.10	13.70
47	3.80	5.60	10.30	14.10
48	4.00	6.00	10.60	14.70
49	4.20	6.30	11.00	15.20
50	4.40	6.70	11.20	15.60
51	4.70	7.10	11.70	16.30
52	5.00	7.50	12.10	16.90
53	5.30	8.00	12.40	17.50
54	5.50	8.40	12.80	18.10
55	5.90	9.00	13.40	18.70
56	6.20	9.50	14.00	19.60
57	6.70	10.20	14.70	20.50
58	7.20	10.90	15.30	21.40
59	7.70	11.70	16.00	22.40

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RATE SHEET

MILPITAS CHRISTIAN SCHOOL

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Home, Community-Based and Immediate Family Member Care**
Home Monthly Benefit	**$500**		
Facility Benefit Duration	**3 Years**		
Home Benefit	**50%**	Inflation Protection	**Compound Uncapped**
Lifetime Maximum	**$36,000**		
Elimination Period	**90 Days**		
Home Care Level	**Home and Community-Based Care**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Rate for Plan Chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Home, Comm-Based and Immediate Family Member Care Option	Plan 3 Base Plan With Compound Inflation Option	Plan 4 Base Plan With Home, Comm-Based and Immediate Family Member Care Compound Inflation Option
60	8.30	12.50	16.80	23.50
61	9.00	13.50	18.00	25.00
62	9.90	14.80	19.40	26.90
63	10.80	16.00	20.70	28.40
64	11.90	17.40	22.30	30.40
65	13.50	19.40	24.70	33.30
66	15.00	21.10	26.70	35.60
67	16.70	23.10	29.10	38.40
68	18.40	25.10	31.40	40.90
69	20.40	27.40	34.10	43.90
70	22.60	29.90	36.70	46.80
71	25.10	32.80	40.10	50.70
72	27.80	35.90	43.60	54.50
73	30.80	39.40	47.30	58.70
74	34.10	43.00	51.20	63.10
75	41.10	51.30	60.60	74.00
76	45.10	55.80	65.70	79.50
77	49.40	60.60	70.70	84.90
78	54.20	65.90	76.50	91.10
79	59.50	71.70	82.20	97.30
80	65.30	78.00	89.00	104.60

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RATE SHEET

MILPITAS CHRISTIAN SCHOOL

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Home, Community-Based and Immediate Family Member Care**
Home Monthly Benefit	**$500**		
Facility Benefit Duration	**6 Years**		
Home Benefit	**50%**	Inflation Protection	**Compound Uncapped**
Lifetime Maximum	**$72,000**		
Elimination Period	**90 Days**		
Home Care Level	**Home and Community-Based Care**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Rate for Plan Chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Home, Comm-Based and Immediate Family Member Care Option	Plan 3 Base Plan With Compound Inflation Option	Plan 4 Base Plan With Home, Comm-Based and Immediate Family Member Care Compound Inflation Option
18-30	2.70	4.20	8.50	11.90
31	2.80	4.20	8.80	12.30
32	2.80	4.30	8.90	12.50
33	2.90	4.40	9.20	12.90
34	3.00	4.50	9.40	13.10
35	3.10	4.70	9.70	13.50
36	3.20	4.80	9.90	13.80
37	3.30	5.00	10.20	14.20
38	3.40	5.20	10.60	14.70
39	3.60	5.40	10.80	15.00
40	3.70	5.60	11.10	15.40
41	3.80	5.80	11.40	15.80
42	4.00	6.10	11.80	16.40
43	4.20	6.40	12.20	16.80
44	4.40	6.70	12.60	17.40
45	4.70	7.00	13.00	17.90
46	4.90	7.40	13.40	18.60
47	5.10	7.80	13.70	19.10
48	5.40	8.20	14.10	19.80
49	5.60	8.60	14.60	20.50
50	5.90	9.10	14.90	21.10
51	6.20	9.60	15.40	22.00
52	6.60	10.30	15.90	22.80
53	7.00	10.90	16.40	23.70
54	7.40	11.50	17.00	24.60
55	7.80	12.30	17.70	25.30
56	8.30	13.10	18.40	26.40
57	8.90	14.00	19.20	27.70
58	9.50	15.00	20.10	29.00
59	10.20	16.00	21.00	30.40

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RATE SHEET

MILPITAS CHRISTIAN SCHOOL

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Home, Community-Based and Immediate Family Member Care**
Home Monthly Benefit	**$500**		
Facility Benefit Duration	**6 Years**		
Home Benefit	**50%**	Inflation Protection	**Compound Uncapped**
Lifetime Maximum	**$72,000**		
Elimination Period	**90 Days**		
Home Care Level	**Home and Community-Based Care**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ Rate for Plan Chosen X _____ Facility Monthly Benefit Amount ÷ $1,000 = _____ Your Premium

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Home, Comm-Based and Immediate Family Member Care Option	Plan 3 Base Plan With Compound Inflation Option	Plan 4 Base Plan With Home, Comm-Based and Immediate Family Member Care Compound Inflation Option
60	10.90	17.10	21.90	31.80
61	11.90	18.60	23.50	34.10
62	13.00	20.30	25.30	36.50
63	14.20	22.00	26.90	38.70
64	15.50	24.00	28.90	41.40
65	17.60	26.70	32.00	45.40
66	19.50	29.20	34.60	48.60
67	21.60	31.90	37.60	52.50
68	23.80	34.80	40.50	55.90
69	26.30	37.90	43.70	60.00
70	29.10	41.50	47.10	64.10
71	32.30	45.50	51.40	69.50
72	35.70	49.80	55.90	74.80
73	39.50	54.50	60.30	80.50
74	43.60	59.70	65.40	86.60
75	52.40	71.20	77.10	101.50
76	57.60	77.40	83.60	109.20
77	63.10	84.30	89.90	116.70
78	69.20	91.60	97.10	125.10
79	75.80	99.70	104.30	133.90
80	83.10	108.40	112.80	144.00

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RATE SHEET

MILPITAS CHRISTIAN SCHOOL

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Home, Community-Based and Immediate Family Member Care**
Home Monthly Benefit	**$500**		
Facility Benefit Duration	**Unlimited**		
Home Benefit	**50%**	Inflation Protection	**Compound Uncapped**
Lifetime Maximum	**Unlimited**		
Elimination Period	**90 Days**		
Home Care Level	**Home and Community-Based Care**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Rate for Plan Chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Home, Comm-Based and Immediate Family Member Care Option	Plan 3 Base Plan With Compound Inflation Option	Plan 4 Base Plan With Home, Comm-Based and Immediate Family Member Care Compound Inflation Option
18-30	3.80	5.90	11.50	16.70
31	3.80	6.00	11.70	17.00
32	3.90	6.20	12.10	17.50
33	4.00	6.30	12.30	17.90
34	4.00	6.40	12.60	18.20
35	4.20	6.60	12.90	18.70
36	4.30	6.80	13.30	19.10
37	4.50	7.00	13.70	19.60
38	4.60	7.20	14.00	20.10
39	4.80	7.50	14.40	20.70
40	5.00	7.90	14.80	21.30
41	5.30	8.20	15.30	21.90
42	5.50	8.50	15.70	22.50
43	5.70	8.90	16.20	23.20
44	6.00	9.30	16.70	23.90
45	6.30	9.80	17.20	24.60
46	6.60	10.30	17.70	25.50
47	6.90	10.90	18.10	26.30
48	7.20	11.50	18.70	27.30
49	7.50	12.10	19.10	28.20
50	8.00	12.90	19.70	29.20
51	8.30	13.60	20.30	30.30
52	8.80	14.40	20.90	31.40
53	9.30	15.30	21.70	32.70
54	9.80	16.20	22.30	33.90
55	10.20	17.10	22.90	34.70
56	10.90	18.30	23.80	36.20
57	11.60	19.60	24.90	38.10
58	12.40	20.90	25.90	39.90
59	13.20	22.40	27.10	41.80

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RATE SHEET

MILPITAS CHRISTIAN SCHOOL

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Home, Community-Based and Immediate Family Member Care**
Home Monthly Benefit	**$500**		
Facility Benefit Duration	**Unlimited**		
Home Benefit	**50%**	Inflation Protection	**Compound Uncapped**
Lifetime Maximum	**Unlimited**		
Elimination Period	**90 Days**		
Home Care Level	**Home and Community-Based Care**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Rate for Plan Chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Home, Comm-Based and Immediate Family Member Care Option	Plan 3 Base Plan With Compound Inflation Option	Plan 4 Base Plan With Home, Comm-Based and Immediate Family Member Care Compound Inflation Option
60	14.20	24.00	28.20	43.70
61	15.40	26.10	30.20	46.80
62	16.80	28.40	32.20	50.10
63	18.30	30.90	34.20	53.20
64	19.90	33.50	36.50	56.80
65	22.40	37.40	40.40	62.40
66	24.90	40.90	43.70	66.90
67	27.50	44.60	47.40	72.00
68	30.30	48.70	51.00	76.80
69	33.50	53.00	55.10	82.50
70	36.90	57.90	59.40	88.30
71	40.90	63.40	64.60	95.40
72	45.20	69.20	70.10	102.60
73	49.70	75.50	75.50	110.10
74	54.70	82.30	81.60	118.00
75	65.70	97.90	96.10	138.00
76	72.10	106.50	104.10	148.50
77	79.00	115.70	111.90	158.60
78	86.30	125.70	120.60	169.80
79	94.40	136.50	129.50	181.60
80	103.30	148.10	139.70	194.80

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: _____

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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

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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.

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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.