



LONG TERM CARE

Underwritten by:
Unum Life Insurance Company of America
LTC Department - A204
2211 Congress Street, Portland, Maine 04122

LOUISIANA STATE UNIVERSITY SYSTEM
Long Term Care Insurance
Benefit Election Form
Policy #100057

Form with fields: Your Name, Social Security Number, Date of Birth, Street Address, Gender, Date of Hire, City, State, Zip Code, Home Telephone #, Work Telephone #

Complete the following only if applicant is not the employee

Form with fields: 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)

Form with checkboxes: Employee, Employee's Parent or Grandparent, Retiree, Employee's Spouse, Spouse's Parent or Grandparent, Retiree's Spouse

Plans section with checkboxes for Plan 1, Plan 2, Plan 3, Plan 4 and their respective benefits.

Facility Monthly Benefit Amount section with checkboxes for \$1,000, \$2,000, \$3,000, \$4,000

Facility Benefit Duration section with checkboxes for 3 Years, 6 Years

NOTE: All Active Employees, Newly Hired Employees & Spouses - who enroll after the Guarantee Issue enrollment period will be required to fill out a medical questionnaire. Retirees and all other applicants must complete a Benefit Election Form and Long Term Care Application (medical questionnaire) for any selection.

Calculate your Premium: Rate for plan chosen X Facility Monthly Benefit Amount ÷ \$1,000 = Your Premium

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

Family Members or Retirees, how would you like to be billed? Quarterly Semi-Annually Annually

Caution: If your answers on this Enrollment Form are incorrect or untrue, we may have the right to deny benefits or rescind your insurance.

By signing below, you signify that you have read and understand that loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after your effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to your coverage. This information is contained in your kit.

Signature and Date lines for Applicant and Employee

Employees and spouses, sign and submit this form to your employer. Other applicants, sign and mail to UnumProvident (address at top of page). You may want to make a copy for your records.

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

Voluntary