IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/sandiegocountyconsortium name or 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

SAN DIEGO COUNTY SCHOOLS FRINGE BENEFITS CONSORTIUM

EMPLOYEE Benefit Election Form

Long Term Care Insurance - Policy #105200

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:		

District Name: Palomar Community College District

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

Level of Care:	Nursing Facility
Monthly Benefit:	$1,000 Nursing Facility
Benefit Duration:	2 Years Nursing Facility

Your employer is funding Base Plan 1. You may purchase additional coverage. Please make your selections below:

(Check one)	☒ **Plan 1 (Funded Base Plan)**	☐ **Plan 2 ***	☐ **Plan 3 ***	☐ **Plan 4 ***
	• Nursing Facility	• Nursing Facility • Professional Home Care • Total Home Care	• Nursing Facility • Simple Inflation	• Nursing Facility • Professional Home Care • Total Home Care • Simple Inflation

Facility Monthly Benefit Amount

(Check one)	☒ $1,000 **(Funded Base Plan)**	☐ **$2,000 ***	☐ **$3,000 ***	☐ **$4,000 ***	☐ **$5,000 ***	☐ **$6,000 ***

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

(Check one)	☒ 2 Years **(Funded Base Plan)**	☐ **4 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.**

Facility Monthly Benefit Amount and Rate Calculation

For First $1,000 of benefit, check here and use Rate Table A for calculation below

☐ $1,000 Enter Rate for Plan Chosen from Table A _______ - $3.50 = **(A)** N/A
(The First $1,000 Facility Benefit is Funded by your Employer $3.50)

For additional benefit amount, check additional amount and use Rate Table B for calculation below

☐ $1,000 ☐ $2,000 ☐ $3,000 ☐ $4,000 ☐ $5,000
Enter Rate for Plan Chosen from Table B _________ X Monthly Benefit Amount _______ ÷ 1,000 = **(B)** N/A

Total Rate = (A + B) N/A

Form is Continued on Reverse Side

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.

_______________________________	__ __/__ __/__ __ __ __
Employee's Signature	*Date*

All applicants, sign and mail all required signature forms to your employer.
Retain a copy for your records. (M8)

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