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 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: _____

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)** _____
(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)** _____

Total Rate = (A + B) _____

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.

<u>Caution:</u> 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.

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

Please 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.