

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

MARSH & MCLENNAN AGENCY
Employee/Spouse Benefit Election Form
Long Term Care - Policy #902101

(one form to be completed by each applicant)

Your Name: (Last Name, First, Middle Initial)	Social Security Number - -	Date of Birth (MM/DD/YYYY) / /
Street Address	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Hire (MM/DD/YYYY) / /
City, State, Zip Code	Home Telephone # ()	Work Telephone # ()
Applicant's Email Address:		

Spouses complete the following:

Employee's Name	Employee Social Security No. - -	Employee Date of Birth / /	Employee Date of Hire / /
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Funded Plan (Employer Paid)

Level of Care:	Long Term Care Facility and 50% Professional Home & Community Care
Monthly Benefit:	\$2,000 Long Term Care Facility/ 50% Professional Home & Community Care
Benefit Duration:	3 Years Long Term Care Facility/ 50% Professional Home & Community Care

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

Spouse - You may choose any plan listed below. **

Plans – Check one (this Benefit Election Form must be completed for any selection).

<input type="checkbox"/> Plan 1 (Funded for Employees Only)	<input type="checkbox"/> Plan 2 *	<input type="checkbox"/> Plan 3 *
<ul style="list-style-type: none"> • Long Term Care Facility • Professional Home & Community Care 	<ul style="list-style-type: none"> • Long Term Care Facility • Professional Home & Community Care • CPI Inflation 	<ul style="list-style-type: none"> • Long Term Care Facility • Professional Home & Community Care • Compound Inflation

Facility Monthly Benefit Amount – Check one

<input type="checkbox"/> \$2,000 Funded for Employees Only	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$6,000	<input type="checkbox"/> \$7,000 *	<input type="checkbox"/> \$8,000 *	<input type="checkbox"/> \$9,000 *
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Facility Benefit Duration – Check one

Duration of benefits may vary depending on where benefits are received.

<input type="checkbox"/> 3 Years (Funded for Employees Only)	<input type="checkbox"/> 6 Years
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- *** Employees:** These options exceed the Guarantee Issue limits and their selection will require completion of the Long Term Care Insurance Application (medical questionnaire).
- **All active employees and newly hired employees** who enroll after the Guarantee Issue enrollment period or choose benefits over the Guarantee Issue limits must complete the Long Term Care Insurance Application (medical questionnaire).
- **** Spouses** must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire) for any selection.
- A signed Authorization to Request Medical Information (form #6720-03 in the kit) must accompany all medical questionnaires.

Form is Continued on Reverse Side

Calculate Your Premium:

Please refer to rate sheet in your kit to determine the rate for the plan chosen.

_____	X	_____	÷	\$1,000	=	_____	(A)
Rate for plan chosen		Monthly benefit amount				Your premium	
For Employees Only:							
_____	X	2			=	_____	(B)
Rate for funded Plan 1 (3 Year duration)		(Based on Funded Amount)				Employer Paid Amount	
A MINUS B						_____	
						EMPLOYEE'S COST	

Disclosures:

Note: We may have the right to deny benefits or rescind insurance if any of the information provided on this enrollment form is incorrect.

REQUEST FOR SIGNATURE: Please read this entire form carefully before signing below.

I acknowledge that I have received the **Potential Rate Increase Disclosure Form** and **Personal Worksheet**.

I certify that all statements are true to the best of my knowledge and belief. I have read and understand that, for coverage that does not require me to submit evidence of insurability, loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after my effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to my coverage.

Active Employees & Spouses: I authorize my employer to make the necessary payroll deduction to pay the premium when my insurance becomes effective.

Your premium: \$_____ (transfer from calculation above)

_____	____/____/____	_____	____/____/____
<i>Applicant's Signature</i>	<i>Date</i>	<i>Employee's Signature</i>	<i>Date</i>
		(Required for Spouse Coverage)	

**Please sign and mail all required signature forms to your employer.
Retain a copy for your records. (A1)**

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