



**1 Fountain Square
AW-400
Chattanooga, TN 37402**

**SAN DIEGO COUNTY SCHOOLS FRINGE BENEFITS
CONSORTIUM
Group Long Term Care**



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.

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 • Dressing
- Bathing • Toileting
- Continence • 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

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SAN DIEGO COUNTY SCHOOLS FRINGE BENEFITS CONSORTIUM #105237

PLAN HIGHLIGHTS / SCHEDULE OF BENEFITS

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, you 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) As an **Employee** you are eligible for benefit amounts on a Guarantee Issue basis of up to and including \$1,000 and a Facility Benefit Duration of 2 years. 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 any additional coverage. **Retirees** and all **Family Members** must complete the 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	2 Years	4 Years	Unlimited Duration
Facility Benefit Amount Per \$1,000 Increments	\$1,000 to \$6,000	\$1,000 to \$6,000	\$1000 to \$6,000
Assisted Living Facility Percent	60%	60%	60%
Total Home Care - Option (Includes Professional Home Care)	50%	50%	50%
Inflation Protection - Option	Simple Capped	Simple Capped	Simple Capped

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 & 2 Year Duration, your Lifetime Maximum is calculated as follows, \$3,000 per Month X 12 Months X 2 Years = \$72,000 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
SAN DIEGO COUNTY SCHOOLS FRINGE BENEFITS CONSORTIUM
(the Sponsoring Organization)

Group Master Summary of Benefits Form Number **105237**

NOTICE TO BUYER: This plan may not cover all costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all plan limitations.

Caution: If you must complete an Application for Long Term Care Insurance which includes evidence of insurability, the issuance of a long term care insurance certificate will be based on your responses 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 has 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. The Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction of **MAINE** and to the extent applicable by the Employee Retirement Income Security Act of 1974.

The Summary of Benefits is a part of the Select Group Insurance Trust situated in Maine.
Fleet Bank of Maine is the Trustee.

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 plans available to you. This is not an insurance contract, but only a summary of coverage.

Only the Summary of Benefits contains governing contractual provisions. This means that the Summary of Benefits 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 CERTIFICATE 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 such withdrawal must be sent to:
 - **if you are an active employee or a spouse of an active employee**, the Sponsoring Organization's Plan Administrator,
 - **if you are a retiree or a family member other than a spouse of an active employee**, UNUM, P. O. Box 9744, Portland, Maine 04104-9868.

Upon receipt, your insurance will be deemed void from its effective date and any premium contribution(s) 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**

Plans 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 plan provides coverage in the form of a fixed dollar indemnity monthly benefit if you suffer a covered loss of functional capacity or covered cognitive impairment.

The amount of the monthly benefit will be based on the plan of coverage you choose; any options you choose, if available, and the place of residence used for long term care.

6. **BENEFITS PROVIDED BY THE SUMMARY OF BENEFITS**

Monthly Benefit:

You are eligible for a monthly benefit if you are assessed as suffering a covered loss of functional capacity or cognitive impairment. You must be under the regular care of a doctor according to the condition.

NOTE: Any Activities of Daily Living that you cannot perform without standby assistance on the date you become insured under the plan will not be considered when determining the extent of your loss.

A monthly benefit will become payable on the day after you complete the Elimination Period.

The amount of your monthly benefit will be based on the coverage options you chose and the place of residence used for long term care. If your coverage includes Professional Home Care Services, the benefit payment will be based on the number of days you receive these services each month.

Activities of Daily Living are bathing, dressing, toileting, transferring, continence and eating.

Cognitive Impairment means a deterioration or loss in intellectual capacity resulting from Alzheimer's disease or similar forms of irreversible dementia.

Elimination Period means the number of consecutive days during which you must continue to qualify to receive a monthly benefit before a benefit will become payable.

Lifetime Maximum means the maximum UNUM will pay you for all long term care benefits. You have your own Lifetime Maximum.

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 qualify for a Home or another similar place Monthly 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 or another similar place Monthly Benefit for each day that you receive respite care.

OPTIONAL BENEFITS

Total Home Care (Includes Professional Home Care)

When benefits become payable, there will be no more cost to you for your coverage as long as you continue to have a loss of functional capacity or cognitive impairment.

Professional Home Care

When benefits become payable, there will be no more cost to you for your coverage as long as you continue to have a loss of functional capacity or cognitive impairment and receive Professional Home Care Services.

If you do not receive Professional Home Care for a period of 30 consecutive days, premium payments will again become due. To continue your coverage, premium payments **must** be resumed on the next premium due date following this 30-day period.

Inflation Protection Provision - 5% Simple Inflation With Cap

Your Monthly Benefit Amount will increase each year on January 1st by 5% of the original Monthly Benefit. Increases will be automatic and will occur regardless of your health and whether or not you are Disabled. Your premium will not increase due to automatic increases in your Monthly Benefit. In no event will the total Monthly Benefit Amount be more than 200% of your original Monthly Benefit Amount.

The benefit paid for the inflation protection provisions are subject to the Lifetime Maximum Benefit Amount. Benefits are not paid during the Elimination Period.

Refer to the graphic Comparison Chart of all types of Inflation, located in Section 8 of this Outline of Coverage

7. LIMITATIONS AND EXCLUSIONS

• EXCLUSIONS

UNUM will not make long term care payments to you for:

- losses caused by war (whether declared or not) or any act of war,
- losses caused by attempted suicide (while sane or insane) or self-destruction,
- losses caused by commission of a crime for which you have been convicted under state or federal law or attempting to commit a crime under state or federal law,
- losses or confinements during which you are outside the United States, its territories or possessions for longer than 30 days,
- any days over fifteen days in each calendar year during which you are confined in any facility for acute care (acute care is medical care obtained as a result of an injury or a sickness requiring immediate medical intervention),
- losses caused by alcoholism,
- losses caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you by a doctor. ("Controlled substance" is defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments) or
- losses caused by:
 - depression,
 - generalized anxiety disorders,
 - personality disorders,
 - schizophrenia, or
 - manic depressive disorders whether treated by drugs, counseling or other forms of therapy.

However, UNUM will make payments to you for conditions that are not psychological or psychiatric in nature, including Alzheimer's disease, multi-infarct dementia, or Parkinson's disease.

- **PRE-EXISTING CONDITION EXCLUSION**

UNUM will not make any payments for any loss of functional capacity or cognitive impairment that:

- is caused by, contributed to by, or results from a pre-existing condition, and
- begins during the first six months after your coverage begins.

A pre-existing condition is any condition that exists for which you:

- received medical treatment, consultation, care, or services, including diagnostic measures for the condition, or
- took drugs or medicines that were prescribed for the condition, during the six month period right before your coverage began.

UNUM calls this a pre-existing condition.

This pre-existing conditions exclusion will apply to all insurance that does not require evidence of insurability.

THIS PLAN 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:**

- **If you are an active employee**, you pay the cost of your coverage under UNUM's long term care insurance.
- **If you are a retired employee or a family member**, you pay the cost of coverage. The rate you pay over the duration of your initial coverage or for any increases is based on your insurance age.

- **ELECTION TO INCREASE COVERAGE:**

You can apply at any time to increase coverage by filling out a new Benefit Elections Form and an Application for Long Term Care Insurance.

INFLATION PROTECTION COMPARISON

The following chart is an example comparison of monthly benefits with and without the Simple Inflation Protection Option.

	Without Inflation Protection	With 5% Simple Inflation <u>Protection</u>
<u>Policy Year</u>	<u>Monthly Benefit</u>	<u>Monthly Benefit</u>
1	\$2000.	\$2100.
2	\$2000.	\$2200.
3	\$2000.	\$2300.
4	\$2000.	\$2400.
5	\$2000.	\$2500.
6	\$2000.	\$2600.
7	\$2000.	\$2700.
8	\$2000.	\$2800.
9	\$2000.	\$2900.
10	\$2000.	\$3000.
11	\$2000.	\$3100.
12	\$2000.	\$3200.
13	\$2000.	\$3300.
14	\$2000.	\$3400.
15	\$2000.	\$3500.
16	\$2000.	\$3600.
17	\$2000.	\$3700.
18	\$2000.	\$3800.
19	\$2000.	\$3900.
20	\$2000.	\$4000.

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

- **PREMIUM WAIVER**

- **Long Term Care Facility**

- When benefits become payable, there will be no more cost to you for your coverage as long as you continue to have a loss of functional capacity or cognitive impairment and reside in a Long Term Care Facility.

- **RIGHT TO CHANGE PREMIUMS**

- The premium rate will not increase because you grow older or because of your use of the benefits. However, the premium rate schedule may change in the future depending on the overall use of the benefits of 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.

- **PORTABLE COVERAGE**

- If the Employer or UNUM ends group long term care coverage, you or your authorized representative may elect portable coverage for you. This means that the same coverage you had under this plan can continue on a direct billing basis. Retired employees and any other persons who are direct billed will automatically transfer to portable coverage.

Any election for portable coverage must be made within 31 days of the date the group coverage would otherwise end. If so elected, you are a portable insured.

Any premium that applies must be paid directly to UNUM by you for any portable coverage to be continued.

Also, the premium rate schedule for portable coverage may change in the future, depending on the overall use of the benefits by all covered persons or changes in the benefit levels or other risk factors. Any such change will be made on a class basis according to UNUM's underwriting risk studies.

Once on portability, you can apply at any time to increase coverage by filling out a new Benefit Elections Form and Application for Long Term Care Insurance which includes evidence of insurability.

If you voluntarily end your group long term care coverage, you may not elect portable coverage. However, you may be eligible to continue a percentage of your Monthly Benefit Maximum(s) and Lifetime Maximum Amount if you elected the paid-up coverage option and have met the requirements under that option.

- **WHEN COVERAGE WILL END:**

Your coverage will end on the earliest of these dates:

- the date the Summary of Benefits under the policy ends,
- the date you no longer are in an eligible class,
- the date your class no longer is included for insurance,
- the end of the period for which premiums were last remitted to UNUM for your coverage.
- the date you no longer are an active employee with the Sponsoring Organization.

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

UNUM will not make long term care payments to you for losses caused by neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind whether treated by drugs, counseling or other forms of therapy.

However, UNUM will make payments to you for conditions that are not mental or nervous in nature, including Alzheimer's disease, multi-infarct dementia, brain injury, brain tumors, or other such structural alterations of the brain.

11. PREMIUMS

Premiums are based on the plan design selected and the Insurance Age of each enrolled person. UNUM may change the premium rates when the terms of the Summary of Benefits are changed.

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 Sponsoring Organization and your family members.
 - a retired employee of the Sponsoring Organization.
- Temporary or seasonal employees are excluded.

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.

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

**Benefit Election Form
Long Term Care - Policy #105237**

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:

Complete the following only if applicant is not the employee:

Employee's Name	Employee Social Security No. - - - - -	Employee Date of Birth / /	Employee Date of Hire / /
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District Name:

Applicant Is: (This Benefit Election Form must be completed for any selection)

<input type="checkbox"/> Employee	<input type="checkbox"/> Employee's Parent or Grandparent	<input type="checkbox"/> Retiree
<input type="checkbox"/> Employee's Spouse/ Registered Domestic Partner	<input type="checkbox"/> Spouse's/Registered Domestic Partner's Parent or Grandparent	<input type="checkbox"/> Retiree's Spouse

(Check one)	<input type="checkbox"/> Plan 1 • Nursing Home Facility	<input type="checkbox"/> Plan 2 * • Nursing Home Facility • Simple Inflation	<input type="checkbox"/> Plan 3 * • Nursing Home Facility • Professional Home Care • Total Home Care	<input type="checkbox"/> Plan 4 * • Nursing Home Facility • Simple Inflation • Professional Home Care • Total Home Care
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Facility Monthly Benefit Amount

(Check one)	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,000 *	<input type="checkbox"/> \$3,000 *	<input type="checkbox"/> \$4,000 *	<input type="checkbox"/> \$5,000 *	<input type="checkbox"/> \$6,000 *
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Facility Benefit Duration (Duration of benefits may vary depending on where benefits are received.)

(Check one)	<input type="checkbox"/> 2 Years	<input type="checkbox"/> 4 Years *	<input type="checkbox"/> Unlimited Duration *
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* **EMPLOYEES:** Selection of this option exceeds the Guarantee Issue limits and requires completion of the Long Term Care Insurance Application (medical questionnaire). **ALL OTHER APPLICANTS** must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire) for any selection. **ALL** Medical Questionnaires must accompany 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.

Active Employee or 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 or Retirees: 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
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Employees & Spouses/Registered Domestic Partners: Please sign and mail all required signature forms to your employer.

Family Members/Retirees: Please sign and mail all required signature forms to Unum (address at top of page).

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.

Voluntary



**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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • HICAP Notice (Item 13 in the Outline of Coverage) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • A Consumer's Guide to Long Term Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Things You Should Know Before You Buy Long Term Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Long Term Care Insurance Personal Worksheet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Notice to Applicant Regarding Replacement of Accident and Sickness, Nursing Home or Long Term Care Insurance | <input type="checkbox"/> Yes | <input type="checkbox"/> 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

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

Policyholder's (i.e. association, employer) Name	Policyholder's ID or Policy No.
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I. General Information

Your Name:

(First)	(Initial)	(Last)
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Complete Address:

(Street/PO Box)	(City)	(State)	(Zip Code)
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Social Security Number:	Date of Birth:	Month	Day	Year	Marital Status:	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Single	<input type="checkbox"/> Widowed
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Are you presently working? ☐ Yes ☐ No

If yes, list occupation:

Primary Physician's Name:

Primary Physician's Address:

Daytime Telephone Number:

()

Date of Last Physical Exam:

Month Day Year

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:

<input type="checkbox"/> Yes <input type="checkbox"/> No	Wheelchair	<input type="checkbox"/> Yes <input type="checkbox"/> No	Walker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Quad Cane
<input type="checkbox"/> Yes <input type="checkbox"/> No	Crutches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital Bed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dialysis Machine
<input type="checkbox"/> Yes <input type="checkbox"/> No	Oxygen	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stairlift	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hoyer Lift

II. Statement of Health - Part 2

Do you currently need or receive help in doing any of the following:

<input type="checkbox"/> Yes <input type="checkbox"/> No	Bathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dressing
<input type="checkbox"/> Yes <input type="checkbox"/> No	Toileting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transferring	<input type="checkbox"/> Yes <input type="checkbox"/> 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:					
<input type="checkbox"/> Yes <input type="checkbox"/> No been advised by a physician to limit, reduce, discontinue or seek counseling for the use of alcohol or drugs?					
Have you:					
<input type="checkbox"/> Yes <input type="checkbox"/> No been confined to any hospital or facility in the past 5 years?					
<input type="checkbox"/> Yes <input type="checkbox"/> 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
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ambulation Problems
<input type="checkbox"/>	<input type="checkbox"/>	Ataxia	<input type="checkbox"/>	<input type="checkbox"/>	Blindness
<input type="checkbox"/>	<input type="checkbox"/>	Catheter use	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy
<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis of the Liver	<input type="checkbox"/>	<input type="checkbox"/>	Confusion
<input type="checkbox"/>	<input type="checkbox"/>	Defibrillator use	<input type="checkbox"/>	<input type="checkbox"/>	Dementia
<input type="checkbox"/>	<input type="checkbox"/>	Hairy Cell Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Hodgkin's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence, bowel or bladder
<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Myeloma
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	Myasthenia Gravis
<input type="checkbox"/>	<input type="checkbox"/>	Organic Brain Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Ostomy
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Polycythemia Vera	<input type="checkbox"/>	<input type="checkbox"/>	Progressive Muscular Atrophy
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	Quadriplegia
<input type="checkbox"/>	<input type="checkbox"/>	Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>	Sjogren's Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Temporal Arteritis	<input type="checkbox"/>	<input type="checkbox"/>	Thrombocytopenia
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Cardiomyopathy
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Huntington's Chorea
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant (except cornea)
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Paraplegia
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Poliomyelitis (Polio)
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Post Polio Syndrome
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus Erythematosus
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	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	
<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmia/ Irregular Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/ Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Atrial Fibrillation
<input type="checkbox"/>	<input type="checkbox"/>	Back Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Barrett's Esophagus	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Carotid Artery Disease/ Stenosis	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	Colitis/Irritable Bowel Syndrome/Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure
<input type="checkbox"/>	<input type="checkbox"/>	Coronary Heart/Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Eye Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Fractures, including compression fractures of the spine
<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (Myocardial Infarction)
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Hip Fractures/ Disorders/ Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Hyperglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia
<input type="checkbox"/>	<input type="checkbox"/>	Joint Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease/ Renal Failure	<input type="checkbox"/>	<input type="checkbox"/>	Knee Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy
<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Paget's Disease of Bone
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Prostatic Hypertrophy, Benign (BPH)
<input type="checkbox"/>	<input type="checkbox"/>	Polymyalgia Rheumatica	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Sarcoidosis
<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Stenosis	<input type="checkbox"/>	<input type="checkbox"/>	Steroid Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/ Transient Ischemic Attack/ Cerebral Vascular Accident	<input type="checkbox"/>	<input type="checkbox"/>	Tic/ Tremor	<input type="checkbox"/>	<input type="checkbox"/>	Transient Global Amnesia
<input type="checkbox"/>	<input type="checkbox"/>	Thrombophlebitis/ Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	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. <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have another long term care insurance policy in force, including health care service contract, or health maintenance organization contract?
B. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you covered by Medicaid (not Medicare)?
D. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you receiving Disability, Worker's Compensation, or Social Security Disability Benefits?
E. <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you intend to replace any of your medical or health coverage with the coverage applied for?
F. <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____
Applicant's Signature

Date: _____
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 is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.



**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 MEDICAL 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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • HICAP Notice (Item 13 in the Outline of Coverage) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • A Consumer's Guide to Long Term Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Things You Should Know Before You Buy Long Term Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Long Term Care Insurance Personal Worksheet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Notice to Applicant Regarding Replacement of Accident and Sickness, Nursing Home or Long Term Care Insurance | <input type="checkbox"/> Yes | <input type="checkbox"/> 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

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

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)
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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:

<input type="checkbox"/> Yes <input type="checkbox"/> No	Wheelchair	<input type="checkbox"/> Yes <input type="checkbox"/> No	Walker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Quad Cane
<input type="checkbox"/> Yes <input type="checkbox"/> No	Crutches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital Bed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dialysis Machine
<input type="checkbox"/> Yes <input type="checkbox"/> No	Oxygen	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stairlift	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hoyer Lift

II. Statement of Health - Part 2

Do you currently need or receive help in doing any of the following:

<input type="checkbox"/> Yes <input type="checkbox"/> No	Bathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dressing
<input type="checkbox"/> Yes <input type="checkbox"/> No	Toileting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transferring	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had a weight gain of 10 or more pounds in the last 12 months?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had a weight loss of 10 or more pounds in the last 12 months?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Was the weight change due to a medical condition?
In the next 6 months, do you plan to:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	be hospitalized?
<input type="checkbox"/> Yes <input type="checkbox"/> No	have surgery?
<input type="checkbox"/> Yes <input type="checkbox"/> No	have any diagnostic tests (e.g. EKG, MRI, x-ray)?
In the last 12 months, have you:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	experienced episodes of falling, fainting, dizziness or imbalance?
<input type="checkbox"/> Yes <input type="checkbox"/> No	used tobacco products (smoked, chewed, or used a nicotine delivery system), including pipes and cigars?

In the last 36 months, have you:					
<input type="checkbox"/> Yes <input type="checkbox"/> No been advised by a physician to limit, reduce, discontinue or seek counseling for the use of alcohol or drugs?					
Have you:					
<input type="checkbox"/> Yes <input type="checkbox"/> No been confined to any hospital or facility in the past 5 years?					
<input type="checkbox"/> Yes <input type="checkbox"/> 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
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ambulation Problems
<input type="checkbox"/>	<input type="checkbox"/>	Ataxia	<input type="checkbox"/>	<input type="checkbox"/>	Blindness
<input type="checkbox"/>	<input type="checkbox"/>	Catheter use	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy
<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis of the Liver	<input type="checkbox"/>	<input type="checkbox"/>	Confusion
<input type="checkbox"/>	<input type="checkbox"/>	Defibrillator use	<input type="checkbox"/>	<input type="checkbox"/>	Dementia
<input type="checkbox"/>	<input type="checkbox"/>	Hairy Cell Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Hodgkin's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence, bowel or bladder
<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Myeloma
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	Myasthenia Gravis
<input type="checkbox"/>	<input type="checkbox"/>	Organic Brain Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Ostomy
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Polycythemia Vera	<input type="checkbox"/>	<input type="checkbox"/>	Progressive Muscular Atrophy
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	Quadriplegia
<input type="checkbox"/>	<input type="checkbox"/>	Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>	Sjogren's Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Temporal Arteritis	<input type="checkbox"/>	<input type="checkbox"/>	Thrombocytopenia
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Cardiomyopathy
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Huntington's Chorea
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant (except cornea)
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Paraplegia
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Poliomyelitis (Polio)
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Post Polio Syndrome
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus Erythematosus
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	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	
<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmia/ Irregular Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/ Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Atrial Fibrillation
<input type="checkbox"/>	<input type="checkbox"/>	Back Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Barrett's Esophagus	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Carotid Artery Disease/ Stenosis	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	Colitis/Irritable Bowel Syndrome/Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure
<input type="checkbox"/>	<input type="checkbox"/>	Coronary Heart/Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Eye Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Fractures, including compression fractures of the spine
<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (Myocardial Infarction)
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Hip Fractures/ Disorders/ Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Hyperglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia
<input type="checkbox"/>	<input type="checkbox"/>	Joint Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease/ Renal Failure	<input type="checkbox"/>	<input type="checkbox"/>	Knee Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy
<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Paget's Disease of Bone
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Prostatic Hypertrophy, Benign (BPH)
<input type="checkbox"/>	<input type="checkbox"/>	Polymyalgia Rheumatica	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Sarcoidosis
<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Stenosis	<input type="checkbox"/>	<input type="checkbox"/>	Steroid Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/ Transient Ischemic Attack/ Cerebral Vascular Accident	<input type="checkbox"/>	<input type="checkbox"/>	Tic/ Tremor	<input type="checkbox"/>	<input type="checkbox"/>	Transient Global Amnesia
<input type="checkbox"/>	<input type="checkbox"/>	Thrombophlebitis/ Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	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. <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have another long term care insurance policy in force, including health care service contract, or health maintenance organization contract?
B. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you covered by Medicaid (not Medicare)?
D. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you receiving Disability, Worker's Compensation, or Social Security Disability Benefits?
E. <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you intend to replace any of your medical or health coverage with the coverage applied for?
F. <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____
Applicant's Signature

Date: _____
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.

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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.

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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

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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

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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

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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 than \$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: _____



Unum Life Insurance Company of America
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)
Complete if applying through Employer offer

(Group Policy Number, if available)

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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.

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NOTICE CONCERNING COVERAGE UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Insurance companies and health maintenance organizations (HMOs) licensed in this state to write life insurance, annuities or health insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to provide a safety net of coverage, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverage, exclusions and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, HMO contract, or an annuity, or if they are insured under a group insurance contract issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

- 1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state);
- 2) the insurer was not authorized to do business in this state;
- 3) their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

- 1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- 2) any policy of reinsurance (unless an assumption certificate was issued);
- 3) interest rate yields that exceed an average rate;

- 4) dividends;
- 5) credits given in connection with the administration of a policy by a group contractholder;
- 6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- 7) unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- \$300,000 for policies and contracts of all types, except as described in the next point
- \$500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010.

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - \$300,000
- life insurance cash surrender value - \$100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - \$100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 - \$250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - \$100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
 - \$100,000 for limited benefits and supplemental health coverages
 - \$300,000 for disability and long term care insurance
 - \$500,000 for basic hospital, medical and surgical insurance or major medical insurance

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.



Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

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.

Unum is a registered trademark and marketing brand of the Unum Group and its insuring subsidiaries.

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.

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7640-04

CA (01/08)



Connecticut Resident Identification Form
Group Long Term Care

If you were a Connecticut resident at the time your initial Unum Group Long Term Care coverage was issued, please complete this form.

By completing and submitting this form to Unum, you certify that you were a resident of Connecticut when you were initially insured under this long term care policy, and subject to applicable Connecticut regulatory requirements.

Please provide current information (please print)

Group Policy Number: _____

Group Policy Name: _____

Certificateholder Name: _____

Social Security Number: _____ - _____ - _____

Certificateholder Address: _____

Certificateholder Phone Number: (____ __) ____ __ - ____ __

Certificateholder Email Address: _____

Please provide Connecticut residence information at the time you were initially issued coverage (please print)

Connecticut Address: _____

Dates of Connecticut residency: _____

You signify that the statements made on this form are true and complete to the best of your knowledge and you understand that we may request additional information to verify your residence. Any person who knowingly presents false, incomplete or misleading information to an insurance company with intent to injure, defraud or deceive the insurer, may be subject to a fine or imprisonment or both.

Certificateholder Signature: _____ Date _____

Send completed forms through one of the following options:

Fax: (207) 541-7606

Mail: Unum Life Insurance Company of America
ATTN: Group Long Term Care
2211 Congress Street
Portland, Maine 04122-8831

