

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

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

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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EMPLOYEES LOCATION: (Check one)

- | | |
|---|---|
| <input type="checkbox"/> Div. 001 LSU System – Baton Rouge, LSU-A, LSU-E, Ag Center, Pennington, Law Center | <input type="checkbox"/> Div. 005 LSU Shreveport - HSC |
| <input type="checkbox"/> Div. 003 LSU Medical Center New Orleans | <input type="checkbox"/> Div. 006 LSU Baton Rouge – 9 th Month Employees |
| <input type="checkbox"/> Div. 004 LSU in Shreveport | <input type="checkbox"/> Div. 017 LSU – HCSD Headquarters |
| | <input type="checkbox"/> Div. 018 LSU – Lallie Kemp Reg Med Ctr |

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	<input type="checkbox"/> Spouse's Parent or Grandparent	<input type="checkbox"/> Retiree's Spouse

(Check one)	Plans			
	<input type="checkbox"/> Plan 1 • Long Term Care Facility • Professional Home Care	<input type="checkbox"/> Plan 2 • Long Term Care Facility • Professional Home Care • Total Home Care	<input type="checkbox"/> Plan 3 • Long Term Care Facility • Professional Home Care • Simple Inflation	<input type="checkbox"/> Plan 4 • Long Term Care Facility • Professional Home Care • Total Home Care • Simple Inflation
(Check one)	Facility Monthly Benefit Amount			
	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$4,000
(Check one)	Facility Benefit Duration (Duration of benefits may vary depending on where benefits are received.)			
	<input type="checkbox"/> 3 Years		<input type="checkbox"/> 6 Years	

NOTE TO EMPLOYEES: All Active Employees, Newly Hired Employees & Spouses – who enroll after the Guarantee Issue enrollment period will be required to fill out a medical questionnaire and a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit. **RETIREEES AND ALL OTHER APPLICANTS** must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire), and a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit.

Form is continued on reverse side.

Calculate your Premium:

$$\frac{\text{Rate for plan chosen}}{\text{Facility Monthly Benefit Amount}} \times \$1,000 = \text{Your Premium}$$

Active Employee or Spouse: 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. You also acknowledge that you have received the **Potential Rate Increase Disclosure Form** and **Personal Worksheet**. All information is contained in your kit.

_____/_____/_____
Applicant's Signature Date

_____/_____/_____
Employee's Signature
(Required for Spouse Coverage) Date

Employees & Spouses: 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. (L4)

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