IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/hsta 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 Co of America
LTC Department
2211 Congress Street
Portland, Maine 04122

HSTA VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION TRUST
MEMBER Benefit Election Form
Long Term Care - Policy #536134-002

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

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

Level of Care:	Long Term Care Facility and 50% Professional Home Care
Monthly Benefit:	$1,000 Long Term Care Facility/ 50% Professional Home Care
Benefit Duration:	3 Years Long Term Care Facility/ 50% Professional Home Care

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

(Check one)	☐ **Plan 1 (Funded)**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 4**
	• Long Term Care Facility • Professional Home Care	• Long Term Care Facility • Professional Home Care • Total Home Care	• Long Term Care Facility • Professional Home Care • Simple Inflation	• Long Term Care Facility • Professional Home Care • Non Forfeiture Benefit
	☐ **Plan 5**	☐ **Plan 6**	☐ **Plan 7**	☐ **Plan 8**
	• Long Term Care Facility • Professional Home Care • Total Home Care • Simple Inflation	• Long Term Care Facility • Professional Home Care • Total Home Care • Non Forfeiture Benefit	• Long Term Care Facility • Professional Home Care • Simple Inflation • Non Forfeiture Benefit	• Long Term Care Facility • Professional Home Care • Total Home Care • Simple Inflation • Non Forfeiture Benefit

Facility Monthly Benefit Amount

(Check one)							
☐ $1,000 **(Funded)**	☐ $1,500	☐ $2,500	☐ $3,500	☐$4,500	☐$5,500	☐$6,500	☐$7,500
	☐$2,000	☐$3,000	☐$4,000	☐$5,000	☐$6,000	☐$7,000	☐$8,000

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

(Check one)		
☐ 3 Years **(Funded)**	☐ 4 Years	☐ 6 Years

***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 the Long Term Care Insurance Application (medical questionnaire) and a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit.**

Calculate your Premium:

_____ (Your Rate for plan chosen) **X** _____ (Facility Monthly Benefit Amount) ÷ $500 = _____ **(A)** (Your Premium)

FOR EMPLOYEES ONLY: _____ (Rate for Funded Plan 1 (3 Year Duration)) = _____ **(B)** (Employer Paid Amount)

A MINUS B = _____
EMPLOYEE'S COST

Form is continued on reverse side

Your premium for the buy-up options will be paid through payroll deduction from your paycheck. You must sign below to authorize your employer to make the payroll deduction.

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.

Your Premium: $_____ ***(Transfer the premium amount from the calculation on the rate sheet.)***

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

Please sign and submit this form to HSTA Voluntary Employees Beneficiary Trust.
Retain a copy for your records. (K6)

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