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
Benefit Election Form
Long Term Care – Policy: 536134-004

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

Complete the following only if applicant is not the Retiree

Retiree's Name	Retiree Social Security No. __ __ __ - __ __ - __ __ __ __	Retiree Date of Birth __ __/__ __/__ __ __ __	Date of Hire - N/A __ __/__ __/__ __ __ __

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

☐ Retiree	☐ Retiree's Spouse	☐ Retiree's Parent or Grandparent	
☐ Retiree's Spouse's Parent or Grandparent		☐ Sibling *(minimum age 18)*	☐ Child *(minimum age 18)*

You may choose any of the plans listed below. The Long Term Care Application (medical questionnaire), the Benefit Election form and a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit, must be completed and you must be approved for coverage in order to enroll in the Long Term Care plan.

(Check one)

☐ **Plan 1**	☐ **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
☐ **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	• Long Term Care Facility • Professional Home Care • Simple Inflation • Non Forfeiture	• Long Term Care Facility • Professional Home Care • Total Home Care • Simple Inflation • Non Forfeiture

Facility Monthly Benefit Amount

(Check one)

☐ $1,000	☐ $2,000	☐ $3,000	☐ $4,000	☐ $5,000	☐ $6,000	☐ $7,000	☐ $8,000
☐ $1,500	☐ $2,500	☐ $3,500	☐ $4,500	☐ $5,500	☐ $6,500	☐ $7,500	

(Check one)

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

☐ 2 Years	☐ 3 Years	☐ 5 Years

Calculate your Premium:

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

If you are an **HSTA VEBA Trust Participant or Spouse** your premium will be deducted from Participant's payroll or retirement check. Trust Participant must sign below to authorize deduction.

If you are not an HSTA VEBA Trust Participant or Spouse, 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.** This information is contained in your kit.

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

Please sign and submit this form to HSTA-VEBA Trust. Other applicants, sign and mail all required signature forms to Unum (address at top of page). Retain a copy for your records. (K6)

If you have questions about Long Term Care coverage, please call HSTA-VEBA Trust at (808)-440-6940.