***Underwritten by:***
First Unum Life Insurance Company
666 Third Avenue
New York, NY 10017

**NEW PALTZ UNITED TEACHERS**
**BENEFIT TRUST FUND**
**Long Term Care – Policy #299907-001**
**Benefit Election Form**
***Employee/Spouse***

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

**Spouse complete the following:**

| Employee's Name | Social Security Number<br>__ __ __ - __ __ - __ __ __ __ | Date of Birth (MM/DD/YYYY)<br>__ __ / __ __ / __ __ __ __ | Date of Hire (MM/DD/YYYY)<br>__ __ / __ __ / __ __ __ __ |
|---|---|---|---|

**ONE FORM TO BE COMPLETED BY EACH APPLICANT**

**EMPLOYEES – Your employer is funding the following Plan.**

☐ **Plan 1 – Employer Funded**

| | |
|---|---|
| Level of Care: | Long Term Care Facility and 100% Professional Home & Community Care |
| Monthly Benefit: | $3,500 Long Term Care Facility / 100% Professional Home & Community Care |
| Benefit Duration: | 2 Years (Duration of benefits may vary depending on where benefits are received) |

**You may also purchase additional coverage at your expense by selecting one of the plans below. Options * exceed the Guarantee Issue Limits.** Selecting any of these options will require completion of the Long Term Care Insurance Application (medical questionnaire). **All active employees and newly hired employees** who enroll after the Guarantee Issue (GI) enrollment period or choose benefits over the GI limits must complete the Long Term Care Insurance Application (medical questionnaire). A signed Authorization to Request Medical Information (form #6720-03-NY in the kit) must accompany all medical questionnaires. If you select a Plan that required completion of the Long Term Care Insurance application and you are **NOT** approved for coverage, you will be eligible to receive the Employer Funded Plan listed above.

**Level of Care – Check Only One**

| ☐ **Plan 2** | ☐ **Plan 3** | ☐ **Plan 4** |
|---|---|---|
| • Long Term Care Facility<br>• 100% Professional Home & Community Care<br>• 3 Year SBP | • Long Term Care Facility<br>• 100 % Professional Home & Community Care<br>• Simple Inflation | • Long Term Care Facility<br>• 100 % Professional Home & Community Care<br>• Simple Inflation<br>• 3 Year SBP |

**Facility Monthly Benefit Amount – Check Only One**

| | | | | | |
|---|---|---|---|---|---|
| ☐ $4,000 | ☐ $5,000 | ☐ $6,000 | ☐ **$7,000*** | ☐ **$8,000*** | ☐ **$9,000*** |

**Facility Benefit Duration – Check one** (Duration of benefits may vary depending on where benefits are received)

| | |
|---|---|
| ☐ 6 Years | ☐ **Lifetime*** |

**SPOUSE -** You may choose any of the plans listed below. You must also complete the Long Term Care Insurance Application (medical questionnaire) for any selections you make. A signed Authorization to Request Medical Information (form #6720-03-NY in the kit) must accompany all medical questionnaires. **Check Only One -**

| ☐ **Plan 1** | ☐ **Plan 2** | ☐ **Plan 3** | ☐ **Plan 4** |
|---|---|---|---|
| • Long Term Care Facility<br>• 100% Professional Home & Community Care | • Long Term Care Facility<br>• 100% Professional Home & Community Care<br>• 3 Year SBP | • Long Term Care Facility<br>• 100% Professional Home & Community Care<br>• Simple Inflation | • Long Term Care Facility<br>• 100% Professional Home & Community Care<br>• Simple Inflation<br>• 3 Year SBP |

**Facility Monthly Benefit Amount – Check Only One**

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ $3,500 | ☐ $4,000 | ☐ $5,000 | ☐ $6,000 | ☐ $7,000 | ☐ $8,000 | ☐ $9,000 |

**Facility Benefit Duration – Check Only One** (Duration of benefits may vary depending on where benefits are received)

| | | |
|---|---|---|
| ☐ 2 Years | ☐ 6 Years | ☐ Lifetime |

**FORM IS CONTINUED ON REVERSE SIDE**

**Calculate Your Premium -** Please refer to rate sheet in your kit to determine the rate for the plan chosen.

| | | | | | | |
|---|---|---|---|---|---|---|
| _____ | **X** | _____ | **÷ $1,000** | **=** | _____ | **(A)** |
| (Rate for Plan chosen) | | (Monthly Benefit Amount) | | | (Your Premium) | |

**For Employees Only:**

| | | | | | | |
|---|---|---|---|---|---|---|
| _____ | **X** | **3.5** | | **=** | _____ | **(B)** |
| (Rate for Funded Plan 1) | | (Based on Funded Amount) | | | (Employer Paid Amount) | |

**A – B = _____**

**EMPLOYEE'S COST**

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**Disclosures:**

**Massachusetts Residents:** You signify that you have received and read the MassHealth eligibility notice entitled "For Massachusetts Residents Only" – form #7650-04-NY. The notice is contained in your kit.

**REQUEST FOR SIGNATURE:** Please read the following carefully before signing below.

**Active Employees and Spouses:** Your signature below authorizes your employer to deduct the required premium from your paycheck. Final cost of coverage will be based on your Insurance Age. If you enroll for coverage on or before the group policy effective date, Insurance Age is your age on the group policy effective date. If you enroll for coverage after the group policy effective date, Insurance Age is your age on the date you sign this enrollment form.

Your premium: $_____ (transfer from calculation above)

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

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

**Caution: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

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

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**Please sign and mail all required signature forms to your employer.**
**Retain a copy for your records. (M7)**

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