



Underwritten by:  
 Unum Life Insurance Company of America  
 LTC Department  
 2211 Congress Street,  
 Portland, Maine 04122

**SARASOTA COUNTY GOVERNMENT**  
**Employee/Spouse Benefit Election Form (FL)**  
**Long Term Care - Policy #123354-005**

**(one form to be completed by each applicant)**

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 # ( )	
<b>Spouses complete the following:</b>			
Employee's Name	Employee Social Security No. - - -	Employee Date of Birth / /	Employee Date of Hire / /

**Funded Plan (Employer Paid)**

Level of Care:	Long Term Care Facility and 50% Professional Home & Community Care
Monthly Benefit:	\$1,000 Long Term Care Facility/ 50% Professional Home & Community Care
Benefit Duration:	3 Years Long Term Care Facility/ 50% Professional Home & Community Care
<input type="checkbox"/> <b>Employee</b> - Your employer is funding <u>Plan 1</u> . You may purchase additional coverage. Please make your selections below.	
<input type="checkbox"/> <b>Spouse</b> - You may choose any plan listed below. **	

**Plans – Check one (this Benefit Election Form must be completed for any selection).**

<input type="checkbox"/> <b>Plan 1</b> (Funded for Employees Only)	<input type="checkbox"/> <b>Plan 2</b>	<input type="checkbox"/> <b>Plan 3</b>	<input type="checkbox"/> <b>Plan 4</b>
<ul style="list-style-type: none"> <li>• Long Term Care Facility</li> <li>• Professional Home &amp; Community Care</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care Facility</li> <li>• Total Choice Home Care</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care Facility</li> <li>• Professional Home &amp; Community Care</li> <li>• Simple Inflation</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care Facility</li> <li>• Total Choice Home Care</li> <li>• Simple Inflation</li> </ul>

**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 – Check one** Duration of benefits may vary depending on where benefits are received.

<input type="checkbox"/> 3 Years (Funded for Employees Only)	<input type="checkbox"/> 6 Years	<input type="checkbox"/> 10 Years*
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- **\* Employees:** This option exceeds the **Guarantee Issue limits** and their selection 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 enrollment period or choose benefits over the Guarantee Issue limits must complete the Long Term Care Insurance Application (medical questionnaire).
- **\*\* Spouses** must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire) for any selection.
- A signed Authorization to Request Medical Information (form #6720-03 in the kit) must accompany all medical questionnaires.

**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.

	<b>X</b>		<b>÷ \$1,000</b>	<b>=</b>		<b>(A)</b>
Rate for plan chosen		Monthly benefit amount			Your premium	
<b>For Employees Only:</b>						<b>(B)</b>
		Rate for funded Plan 1 (3 Year duration)			Employer Paid Amount	
			<b>A MINUS B</b>			
					<b>EMPLOYEE'S COST</b>	

**Disclosures:**

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

**Note:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**REQUEST FOR SIGNATURE:** Please read this entire form carefully before signing below.

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.

**Active Employees & Spouses:** I authorize my employer to make the necessary payroll deduction to pay the premium when my insurance becomes effective. **Your premium:** \$\_\_\_\_\_ (transfer from calculation above)

\_\_\_\_\_  
*Applicant's Signature*

\_\_\_/\_\_\_/\_\_\_  
*Date*

\_\_\_\_\_  
*Employee's Signature*  
(Required for Spouse Coverage)

\_\_\_/\_\_\_/\_\_\_  
*Date*

**Please sign and mail all required signature forms to your employer.  
Retain a copy for your records. (J1)**

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