Better benefits at work.

Long term care insurance

Everything you need to apply for coverage
for yourself and your family members

What you need to know

This booklet provides all the information you need to understand the long term care (LTC) insurance coverage your employer is offering through Unum.

Please follow the tabs to make sure you complete each section.

How it works

This includes information about why this coverage is important, detailed plan information, and what is not covered. Be sure to review this information before enrolling.

How to enroll in the plan

This section includes rates for the plan(s) being offered, Benefit Election Forms, Long Term Care Insurance Applications (medical questionnaire), replacement forms, and other forms that require a signature.

Please refer to the grid below to determine which forms to complete.

	Benefit Election Form	Long Term Care Application (medical questionnaire)	Protection Against Unintentional Lapse	Authorization and Agreement for Automatic Payments	Personal Worksheet
Employee*	✓	✓*			
Spouse¥	✓	✓			
Other family members	✓	✓	✓	✓†	✓
Retired employee and spouse	✓	✓	✓	✓†	✓

* Employees: Complete the Long Term Care Application (medical questionnaire) only if you are choosing coverage over the guarantee issue limit or if you are enrolling after your initial guarantee issue enrollment period.

¥ For definition of spouse, please refer to the Benefit Election Form.

† This form is only required if you choose for your payment to be automatically deducted from your checking account.

• Call 1-800-227-4165 if you have any question about the forms.

State forms to review

These are forms for your review only. There is nothing to fill out. The state where your employer is located requires that this information be included for all consumers.

Underwritten by:
First Unum Life Insurance Company

Long term care insurance

The purpose of this communication is the solicitation of insurance. Contact will be made by an insurance agent or insurance company.

How it works

Who controls your future?

Be prepared with long term care insurance from Unum.

Your life, your choice

There are plenty of decisions to make for retirement...

- Fishing or golf?
- Motor home or long-awaited cruise?
- A house at the beach — or close to the grandchildren?

Long term care insurance may help you avoid a far more difficult decision: whether to exhaust your savings or liquidate your assets to pay for a period of long term care. This policy may help you be prepared for the financial realities and help you maintain control of some important decisions, such as:

- Who would take care of me?
- Where can I choose to receive care?
- Would I be a burden on my children if my savings couldn't cover my care?

What is long term care?

Whether it's due to a motorcycle accident or a serious illness, it is the type of care you may need if you couldn't independently perform the basic activities of daily living: bathing, dressing, using the toilet, transferring from one location to another, continence and eating, or if you suffered severe cognitive impairment from a condition such as Alzheimer's disease.

Who's at risk?

Long term care insurance is not just for the elderly.

- 40% of people currently receiving long term care are working-age adults 18 to 64 years old.[1]
- About 70% of individuals over age 65 will require some type of long term care services during their lifetime.[2]
- By 2020, 12 million people are projected to need long term care.[3]

How does this coverage help?

Here are some examples of how you may use a long term care benefit of $3,000 per month, based on the national averages for care:[4]

Home health:	
Home health aide: $18.50/hr	**$24,050/year*** – $36,000 annual benefit = **$11,950** left for out-of-pocket medical/prescription costs
Assisted living:	
Assisted living cost: $2,825.25/month	**$33,903/year** – $36,000 annual benefit = **$2,097** left for out-of-pocket
Private nursing home:	
Private nursing home cost: $203.31/day	**$74,208.15/year** – $36,000 annual benefit = **$38,208.15** of cost of care is paid out of pocket

*Based on receiving care five hours a day/five days a week at $18.50/hour. For illustrative purposes only.

How to apply

Your benefit enrollment is coming soon. To learn more, watch for information from your employer.

EN-1168-NY (5-10)

Get the coverage you need.

Won't my other insurance pay for long term care?
Unfortunately, no.

- Medical insurance and Medicare are designed to pay for specific care for acute conditions — not for long term help with daily living.
- Medicaid only helps with long term care expenses after you have depleted virtually all of your assets. The exact amount varies by state but usually leaves just a few thousand dollars in total assets.

  Only long term care insurance may cover those costs and allow you to maintain as much of your assets as possible.

Do I need to be in a nursing home to use my LTC insurance?
All Unum plans include a home health option. This allows you to use your benefit to pay for an aide to come to your home, so you can remain in your residence as long as possible. For an extra premium, some plans allow you to pay a family member or friend to take care of you.

Why buy now?
People often buy long term care insurance at an early age, because the younger you are, the more affordable the rates.

In fact, 63% of the people who buy group LTC insurance are under age 55.[5]

Why buy coverage at work?
1. You may get more affordable rates when you buy this coverage through your employer and you may extend your coverage to your parents and spouse.

2. Depending on your plan, you may be able to pay your premiums through convenient payroll deduction.

3. Your employer has selected coverage from Unum, the leading provider of group LTC insurance for employees in the U.S.[6]

Additional help for caregivers
Even if you don't need long term care in the immediate future, you may be a caregiver for someone you love. Your plan includes LTC Connect® service, which gives you access to counselors who can help you find long term care providers in your area, a support group, or other assistance you may need. This service also provides discounts for medical equipment such as walkers, hearing aids, wheelchairs, and other related needs.

1,2,3 U.S. Department of Health and Human Services, "National Clearinghouse for Long-Term Care Information," updated October 2008. Available at: http://www.longtermcare.gov/LTC/Main_Site/Understanding_Long_Term_Care/Basics/Basics.aspx, cited November 17, 2009.
4 Genworth Financial, "2009 Cost of Care Study," April 2009.
5 American Association for Long Term Care Insurance, "2008 LTCI Sourcebook," February 2008.
6 LIMRA, 2008 Group LTC Report, 2009. Based on inforce cases. Excluding federal and California-specific Group LTC plans, Unum also ranks first in number of employees enrolled.

Nursing home care based on 24 hour care for one year. Assisted living based on 12 months care. Home care based on five hours of care per day, five days per week for Non-Medicaid Certified home health aide services.

For employee information

EN-1168-NY (5-10)

Underwritten by: First Unum Life Insurance Company, New York, New York
unum.com

Southern Westchester BOCES Teachers Association Benefit Trust
SCHEDULE OF BENEFITS / PLAN HIGHLIGHTS

Your Long Term Care (LTC) insurance plan is listed below.

Elimination Period: Your plan's elimination period of 90 days is the amount of time you must wait before benefits become payable. This time period can be accumulated over a period of 730 days and needs to be satisfied only once during the life of your plan.

Newly Hired Employees: Once eligible for the plan, will have 31 days to sign up for Guarantee Issue coverage. Please check with your employer for your effective date.

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 a medical questionnaire.

Medical Underwriting Effective Date: The effective date for those applicants requiring medical underwriting is the later of the Plan Effective Date or the Medical Underwriting Approval Date.
Medical Underwriting means that you must answer all questions on a medical questionnaire. In some cases, an interview may also be necessary.

Delayed Effective Date: If you are absent from work because you are injured, sick, temporarily laid off or on a leave of absence, your coverage will not begin on your otherwise expected effective date.

Medical Underwriting for Employees and Family: Completion of the Benefit Election Form is required for enrollment. **Employees:** Your employer funded basic plan, as well as additional benefit amounts of up to and including $6,000 and a Facility Benefit Duration of 3 or 6 years, is being offered on a Guarantee Issue basis. This does not require completion of the Long Term Care Insurance Application (medical questionnaire) if you apply during your initial eligibility period. The Long Term Care Insurance Application (medical questionnaire) is required if enrolling after your initial eligibility period or if you choose to buy $7,000, $8,000, $9,000 or the Lifetime Duration coverage. **Spouses** and all **Family Members** must complete the Benefit Election Form, the Long Term Care Insurance Application (medical questionnaire) and must be approved for coverage in order to enroll in the Long Term Care plan. **All** Medical Questionnaires must accompany a signed Authorization to Request Medical Information Form #6720-03-NY located in the enrollment kit.

Benefit Duration	3 Years	6 Years	Lifetime
Facility Benefit Amount **In Increments of $1,000**	$4,000 to $9,000	$4,000 to $9,000	$4,000 to $9,000
Assisted Living Facility Percent	100%	100%	100%
Professional Home & Community Care	100%	100%	100%
Total Choice Home Care - **Option**	100%	100%	100%
Inflation Protection * - **Option**	Compound	Compound	Compound

***** *If you selected an inflation option, and you terminate that inflation option at a future date, you can purchase the inflated coverage amount at your original age.*

Lifetime Maximum: The Lifetime Maximum is the maximum benefit dollar amount Unum will pay over the life of your coverage. This dollar amount is based on the Facility Benefit Amount and Benefit Duration.
For Example: If you choose $4,000 Facility Monthly Benefit Amount & 3 Year Duration, your Lifetime Maximum is calculated as follows, $4,000 per Month X 12 Months X 3 Years = $144,000 Lifetime Maximum.

Insurance Age: 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 the enrollment form.

Questions: Please call 1-800-227-4165 with questions regarding your Long Term Care Insurance.

First Unum Life Insurance Company
666 Third Avenue
New York, New York 10017
(212) 953-1130

LONG TERM CARE INSURANCE
REQUIRED DISCLOSURE STATE
FOR THE EMPLOYEES OF
Southern Westchester BOCES Teachers Association Benefit Trust
Policy: 135005
Group Master Policy/Certificate Form Number GLTC04/CLTC04

FEDERAL TAX CONSEQUENCES. The policy is intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

Caution: If you must complete an Application for Long Term Care Insurance which includes evidence of insurability, the issuance of a long term care insurance certificate will be based on your responses to the questions on your application. You retained a copy of your Application for Long Term Care Insurance when you applied. If your answers are incorrect or untrue, the company may have the right to deny benefits or rescind your coverage. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact First Unum at this address: First Unum Life Insurance Company, 2211 Congress Street, Portland, Maine 04122.

1. The policy is a group policy which is issued in the state of **New York**.

2. **PURPOSE OF DISCLOSURE STATEMENT**. This disclosure statement provides a very brief description of the important features of the policy. You should compare this disclosure statement to outlines of coverage for other policies available to you. **This is not an insurance contract, but only a summary of coverage. Only the group policy contains governing contractual provisions. This means that the group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR CERTIFICATE CAREFULLY!**

3. **TERMS UNDER WHICH THE CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED**.
   a. You may cancel your coverage for any reason within 30 days after it is delivered to you or your representative. Simply return your certificate, within 30 days of its receipt, to us. If this is done, your certificate will be canceled from the beginning and all premiums paid for your coverage will be refunded.
   b. If you die while insured under the policy, we will refund any pro rata portion of any premium paid covering the period after your death. We will make the refund within 30 days after we receive written notice of your death. Payment will be made to your estate.

4. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE**. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the insurance company. Neither First Unum nor its agents represent Medicare, the federal government or any state government.

5. **LONG TERM CARE INSURANCE**. Policies of this category are designed to provide coverage for not less than twenty-four (24) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis and provides coverage of all levels of care in a nursing home and home care benefit.

The policy provides coverage in the form of a fixed dollar indemnity benefit if you are Chronically Ill and you are receiving care while confined in a Long Term Care Facility. If your coverage includes a Professional Home and Community Care Benefit or a Total Choice Home and Community Care Benefit, we will pay you a benefit if you choose to receive care at home or in the community. Coverage is subject to the policy limitations, benefit maximums and elimination period requirements.

6. **BENEFITS PROVIDED BY THE POLICY**. Refer to the attached **SUMMARY OF BENEFITS** for the benefits available under the Policyholder's plan.

Eligibility for the Payment of Benefits
You will be eligible for a benefit if, on or after the effective date of your coverage and while your coverage is in effect, you become Chronically Ill.

Conditions for Payment of Benefits
To receive benefits under the policy, the following conditions must be met:
- you must satisfy the Elimination Period, if applicable;
- you must be receiving Qualified Long Term Care Services;
- the treatment for your Chronic Illness must be provided pursuant to a written Plan of Care; and
- we must approve your claim.

You must also provide us with a Licensed Health Care Practitioner's Certification that you are unable to perform (without Substantial Assistance from another individual) two or more Activities of Daily Living for a period of at least 90 days, or that you require Substantial Supervision by another individual to protect you from threats to your health or safety due to Severe Cognitive Impairment. You will be required to submit a Licensed Health Care Practitioner's Certification every 12 months.

Limitations on Payment of Benefits
We will not pay benefits in excess of any coverage amounts you choose or for coverages that you have not elected. Benefits paid will reduce your Lifetime Maximum Benefit and will no longer be available once your Lifetime Maximum has been reached. We will not pay benefits for Qualified Long Term Care Services you receive during the Elimination Period, except as described in the Respite Care Benefit and the Additional Care Benefit provisions. The policy only pays benefits if you are receiving Qualified Long Term Care services.

LTC Facility Benefit Payment
You must give us proof that you are receiving Qualified Long Term Care Services in a LTC Facility before a LTC Facility Monthly Benefit is paid. The benefit payment will be calculated by dividing the LTC Facility Monthly Benefit by the number of days in the calendar month and multiplying by the number of days that you received Qualified Long Term Care Services in the LTC Facility.

Additional Care Benefit:
Once you are eligible for a benefit payment, you will have access to Additional Care designed to assist you in living at home or in other residential housing. You do not need to complete your Elimination Period for an Additional Care Benefit payment to begin. The Additional Care must be:
- appropriate for your Chronic Illness and conform with generally accepted medical standards;
- provided pursuant to a written Plan of Care;
- recommended by a Licensed Health Care Practitioner; and
- approved by us prior to receipt of Additional Care.

Bed Reservation Benefit
If you are receiving a LTC Facility Monthly Benefit and your stay in the facility is interrupted due to a stay in an acute care facility, or due to a temporary absence and a charge is made to reserve your LTC Facility accommodations, you will be eligible for a Bed Reservation Benefit. We will pay you 1/30th of the LTC Facility Monthly Benefit for each day you are absent from the LTC Facility:

- up to 90 days per calendar year if your absence is due to a stay in an acute care facility; or
- up to 30 days per calendar year for a temporary absence not related to a stay in an acute care facility.

In no event will the maximum number of Bed Reservation days exceed 90 days per calendar year. Bed Reservation Benefit payments will reduce your Lifetime Maximum Benefit and will no longer be available once your Lifetime Maximum Benefit has been reached. If your stay in a LTC Facility is interrupted while you are satisfying your Elimination Period, such days will be used to help satisfy your Elimination Period.

Respite Care Benefit
If you are Chronically Ill and receiving Respite Care but you are not receiving a LTC Facility Monthly Benefit (or a Home Care Monthly Benefit if your coverage includes a home care benefit) you will be eligible to receive a Respite Care Benefit. The Respite Care Benefit payment will be calculated by dividing the LTC Facility Monthly Benefit by the number of days in the calendar month and multiplying by the number of days you have Respite Care up to 21 days each calendar year. You do not need to complete your Elimination Period for Respite Care payments to begin and the days you are receiving Respite Care will count toward satisfying your Elimination Period.

Words That Have A Special Meaning
Activities of Daily Living (ADLs) are bathing, dressing, toileting, transferring, continence and eating.

Additional Care means special services; equipment or caregiver training designed to assist you in living at home or in other residential housing. Additional Care may include:

- assistance in locating long term care providers and caregivers in your area (this service is also available even if you are not eligible for benefits);
- a visit from a Licensed Health Care Practitioner who will develop your Plan of Care;
- a visit from a home safety expert who will assess your residence and offer suggestions for increased personal safety;
- purchase or rental of a medical alert service;
- purchase or rental of durable medical equipment;
- home modifications for your support; or
- caregiver training.

Chronic Illness and Chronically Ill means you are unable to perform, without Substantial Assistance from another individual, two or more Activities of Daily Living; or you require Substantial Supervision by another individual to protect you from threats to your health and safety due to Severe Cognitive Impairment.

Elimination Period means the number of days during which you are Chronically Ill and you are receiving services appropriate for your Chronic Illness, but no benefit is payable.

Lifetime Maximum Benefit means the total dollar amount of benefits that will be paid under the policy, excluding any Additional Care Benefit.

Long Term Care (LTC) Facility means a facility (such as a nursing facility, an assisted living facility, a hospice facility, a rehabilitation facility, an Alzheimer's facility or a residential care facility) that is licensed by the appropriate federal or state agency to engage primarily in providing care and services sufficient to support your needs resulting from Chronic Illness.

Plan of Care means a written plan prescribed by a Licensed Health Care Practitioner, based upon an assessment that evaluates your level of functional capacity.

Qualified Long Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services and maintenance or personal care services that are required by you.

Respite Care means short-term or periodic Qualified Long Term Care Services which are required to maintain your health or safety and to give temporary relief to your primary caregiver from his or her caregiving duties.

Severe Cognitive Impairment means a severe deterioration or loss in your short or long term memory; your orientation as to person, place, or time; or your deductive or abstract reasoning as reliably measured by clinical evidence and standardized tests. Such loss can result from a sickness, injury, advanced age, Alzheimer's disease or similar form of dementia.

Substantial Assistance means stand-by or hands-on assistance without which you would not be able to safely and completely perform the ADL. Stand-by assistance means the presence of another person within arm's reach of you while you are performing the ADL. Hands-on assistance means physical assistance (minimal, moderate or maximal) without which you would not be able to perform the ADL.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures or other demonstrations) by another individual for the purpose of protecting you from threats to your health or safety.

OPTIONAL BENEFITS PROVIDED BY THE POLICY -- EACH OF THE FOLLOWING OPTIONAL BENEFITS IS AVAILABLE UNDER THE POLICYHOLDER'S PLAN. OPTIONAL BENEFITS MAY BE AVAILABLE AT AN ADDITIONAL COST TO YOU. YOU MAY ALSO REFER TO THE ATTACHED SUMMARY OF BENEFITS TO DETERMINE AVAILABLE OPTIONAL BENEFITS.

Home Care Options:

Total Choice Home Care Benefit:

If your coverage includes the Total Choice Home Care Benefit, we will pay you the Total Choice Home Care benefit for each day in the calendar month that you received Total Choice Home Care Services. The benefit payment will be calculated by dividing the Total Choice Home Care Monthly Benefit by the number of days in the calendar month and multiplying by the number of days that you received Total Choice Home Care Services. Total Choice Home Care Services may be provided anywhere other than a LTC Facility, an acute care facility or other location excluded by the policy.

Total Choice Home Care Services means Qualified Long Term Care Services provided to you by anyone, including a Family Member, by or through a Licensed Home Health Care Agency; by a Licensed Home Health Care Professional; in an Adult Day Care Facility; or by an informal caregiver. Total Choice Home Care Services include nursing care; physical, respiratory, and occupational or speech therapy; homemaker services; hospice care; or other services pursuant to your Plan of Care.

Included in the Total Choice Home Care Benefit is an International Benefit. You may be eligible to receive International Benefits if you become Chronically Ill and are receiving Qualified Long Term Care Services while traveling outside of the United States, its territories or possessions, or Canada. International Benefits will be paid on an indemnity basis.

Inflation Protection and Benefit Increase Options:

5% Compound Inflation Protection:

If your coverage includes this option, your LTC Facility Monthly Benefit will increase each year on the Coverage Effective Date by 5% of your LTC Facility Monthly Benefit in effect on that date. Increases will be automatic and will occur regardless of your health and whether or not you are eligible for or are receiving benefit payments. Your premium will not increase due to automatic increases in your LTC Facility Monthly Benefit.

7. **LIMITATIONS AND EXCLUSIONS**

We will not provide benefits for:

- a Chronic Illness caused by war or any act of war, whether declared or undeclared, that occurs while your coverage is in force.
- a Chronic Illness caused by intentionally self-inflicted injuries or attempted suicide, while sane.
- a Chronic Illness caused by the participation in a felony, riot or insurrection caused by your participation in a felony, riot or insurrection.
- treatment of alcoholism or drug addiction.
- any period of time while you are Chronically Ill and you are confined in a hospital, other than if you are confined to a LTC Facility that is a distinctly separate part of a hospital. This exclusion does not apply to those periods covered under the Bed Reservation Benefit.

THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

8. **RELATIONSHIP OF COST OF CARE AND BENEFITS.** Because the cost of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted.

    - If the plan provides an Inflation Protection or Benefit Increase Option and you have chosen the option, your LTC Facility Monthly Benefit will increase each year on the Coverage Effective Date. Increases will be automatic and will occur regardless of your health and whether or not you are Chronically Ill. Your premium will not increase due to the automatic increases in your LTC Facility Monthly Benefit.
    - After your coverage is in force, you will be allowed to increase your coverage based on the benefits available under the Policyholder's plan. To do so, you must complete a new benefit election form and a Long Term Care Insurance Application. No increased or additional coverage will become effective unless we approve your Long Term Care Insurance Application for such change. Premiums for your coverage may be adjusted due to changes or increase in your coverage based on your age on the date you apply to change or increase your coverage.

9. **TERMS UNDER WHICH THE CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED**

    - **RENEWABILITY - THE CERTIFICATE IS GUARANTEED RENEWABLE**. This means you have the right, subject to the terms of the policy to continue your coverage as long as premium for your coverage is paid on time. First Unum cannot change any of the terms of the policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

- **CONTINUATION OF COVERAGE**. If your group long term care coverage ends for reasons other than non-payment of premium or your choice to have premium payments stopped for your coverage, you may elect continuation of coverage. This means that the same coverage you had under this plan can continue on a direct billed basis. If you are already direct billed, your coverage will automatically transfer to continued coverage. Election for continued coverage must be made within 60 days of the date your group coverage would otherwise end. Any premium that applies must be paid directly to First Unum by you for any coverage to be continued.
- **WAIVER OF PREMIUM**. We will waive payment of premium for your coverage during any period of time that you are receiving benefits under the policy. However, premium payments will not be waived if you are only receiving Respite Care or Additional Care Benefits.

10. **PREMIUM**

The initial premium charges will be figured at the premium rates as shown on the attached pages. First Unum may change the premium rates when the terms of the policy are changed.

We reserve the right to change any and all premiums. Any change in premium must apply to all similar policies issued on this policy form and in the state in which the policy is sitused. Premiums cannot be increased because of any change in the age or health of the persons covered under the policy. We cannot discontinue the policy except where required by law or as a result of non-payment of premium.

If you die while insured under the policy, we will refund any pro rata portion of your premium paid covering the period after your death. We will make the refund within 30 days after we received written notice of your death. Payment will be made to your estate.

In the event your coverage under the policy is cancelled by you, we will, within 30 days of the effective date of such cancellation, refund the premium paid for any period beyond the end of the month following the date of cancellation of coverage.

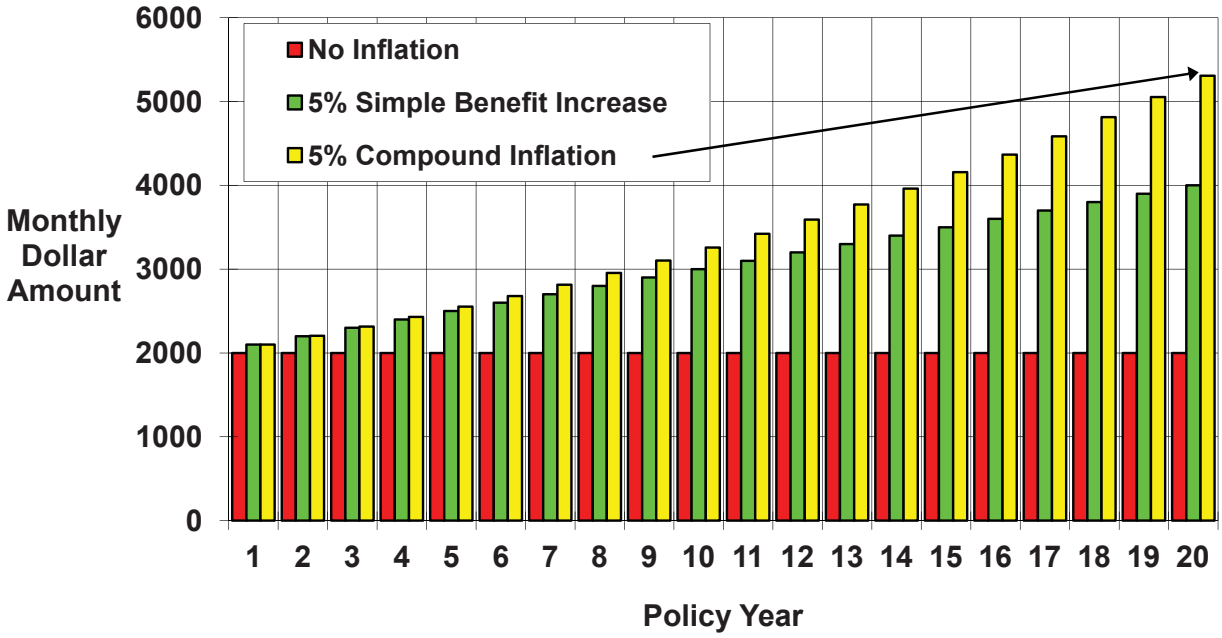
11. **ADDITIONAL FEATURES**

- If the policy and your coverage includes the Non-forfeiture Benefit Option - Shortened Benefit Period and premium payments for your coverage are stopped after your Shortened Benefit Non-Forfeiture has been in force for at least three (3) full years from your Coverage Effective Date, you will be eligible for a Non-Forfeiture Benefit. This means that your coverage will continue automatically with the same level of benefits, except for a reduction in your Lifetime Maximum Benefit Amount. Your Lifetime Maximum Benefit Amount under this Non-Forfeiture Benefit will be equal to the total premium paid up to the date premium payment stopped minus the total amount of benefits already paid to you.
- The policy provides for coverage of Severe Cognitive Impairment. Severe Cognitive Impairment is not related to the inability to perform ADLs. Rather, Severe Cognitive Impairment means that you have lost the ability to reason and suffer a decrease in awareness, intuition and memory. Examples of Severe Cognitive Impairment are: Alzheimer's disease, multi-infarct dementia, brain injury, brain tumors or other such structural alterations of the brain.
- The benefit ratio for the policy is expected to be at least 70%. This ratio is the portion of future premiums, which the company expects to return as benefits, when averaged over all people with the policy.
- Medical underwriting may be required.
- Eligibility and Participation

  You are eligible for the plan if you are: an Active Employee of the Policyholder and your Family Members.

Long Term Care

Comparison of Benefits for Simple and Compound Inflation Protection



Monthly Premium Based On the Following:

- Issue Age 65
- LTC Facility with Professional Home and Community Care (50%)
- 90 Day Elimination Period
- Lifetime Maximum Benefit Period

Monthly Premium Without Inflation Protection:	$253.12
Monthly Premium With 5% Simple Benefit Increase:	$379.67
Monthly Premium With 5% Compound Inflation Protection:	$440.42

Premium will remain level; it will not increase due to automatic increases in benefit amounts.

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

Southern Westchester BOCES Teachers
Association Benefit Trust
Long Term Care – Policy #135005**
Employee /Spouse Benefit Election Form

**** Amounts below $3500 are called Nursing Home and Home Care**

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:		

Spouse complete the following:

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

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:	$4,000 Long Term Care Facility / 100% Professional Home & Community Care
Benefit Duration:	3 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 • 100% Professional Home & Community Care • Compound Inflation	• Long Term Care Facility • 100% Total Choice Home Care	• Long Term Care Facility • 100% Total Choice Home Care • Compound Inflation

Facility Monthly Benefit Amount – Check Only One

☐ $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 • 100% Professional Home & Community Care	• Long Term Care Facility • 100% Professional Home & Community Care • Compound Inflation	• Long Term Care Facility • 100% Total Choice Home Care	• Long Term Care Facility • 100% Total Choice Home Care • Compound Inflation

Facility Monthly Benefit Amount – Check Only One

☐ $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)

☐ 3 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**	**4**		**=**	_____	**(B)**
(Rate for Funded Plan 1)		(Based on Funded Amount)			(Employer Paid Amount)	

A – B **=** _____
EMPLOYEE'S COST

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

---

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.

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

Southern Westchester BOCES
Teachers Association Benefit Trust
Long Term Care** – Policy #135005
Family - Benefit Election Form

**** Amounts below $3500 are called Nursing Home and Home Care**

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:		

Employee's Name	Social Security Number __ __ __ - __ __ - __ __ __ __	Date of Birth (MM/DD/YYYY) __ __ / __ __ / __ __ __ __	Date of Hire (MM/DD/YYYY) __ __ / __ __ / __ __ __ __
Relationship to Employee:			
☐ Parent or Grandparent ☐ Parent or Grandparent of Employee's Spouse			

ONE FORM TO BE COMPLETED BY EACH APPLICANT

You may choose coverage options from the Plans listed below. In addition to this Benefit Election form, 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 your application.

Plans – Check Only One

☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 4**
• Long Term Care Facility • 100% Professional Home & Community Care	• Long Term Care Facility • 100% Professional Home & Community Care • Compound Inflation	• Long Term Care Facility • 100% Total Choice Home Care	• Long Term Care Facility • 100% Total Choice Home Care • Compound Inflation

Facility Monthly Benefit Amount – Check One

☐ $4,000	☐ $5,000	☐ $6,000	☐ $7,000	☐ $8,000	☐ $9,000

Facility Benefit Duration – Check one

☐ 3 Years	☐ 6 Years	☐ Lifetime

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

_____ **X** _____ **÷ $1,000** = _____
(Rate for Plan Chosen) (Monthly Benefit Amount) Your Premium

FORM IS CONTINUED ON REVERSE SIDE

REQUEST FOR SIGNATURE
Please read the following carefully before signing below

Select payment method:

Automatic Payments (deducted from your checking account – complete Authorization/Agreement for Automatic Payments):

☐ Monthly; **OR**

Billed directly (paper) by the insurance company:

☐ Quarterly ☐ Semi-Annually ☐ Annually

Your premium: $_____ (transfer from calculation [on previous page])

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.

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.

We may have the right to deny benefits or rescind insurance if any of the information provided 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 Date

<u>Family Members:</u> Please sign and mail all required signature forms to Unum (address at top of page). 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.**

Southern Westchester BOCES Teachers Association Benefit Trust

Rates Shown are for $1,000 Facility Monthly Benefit

(You may choose from $4,000 - $9,000 in Facility Monthly Benefit)

Monthly Rates	**Plan 1** Long Term Care Facility Prof Home-Comm Care 100%			**Plan 2** Long Term Care Facility Prof Home-Comm Care 100% Compound Inflation			**Plan 3** Long Term Care Facility Total Home Care 100%			**Plan 4** Long Term Care Facility Total Home Care 100% Compound Inflation		
Benefit Duration	3 YR	6 YR	Lifetime	3 YR	6 YR	Lifetime	3 YR	6 YR	Lifetime	3 YR	6 YR	Lifetime
AGE												
18 - 30	2.50	3.30	5.00	13.90	19.00	25.10	4.00	5.30	7.90	19.20	26.30	34.80
31	2.60	3.40	5.10	14.30	19.60	25.90	4.10	5.40	8.10	19.80	27.10	35.80
32	2.70	3.50	5.30	14.80	20.20	26.70	4.20	5.60	8.40	20.40	28.00	37.00
33	2.70	3.70	5.40	15.20	20.80	27.50	4.40	5.80	8.60	21.10	28.90	38.10
34	2.80	3.80	5.60	15.70	21.50	28.40	4.50	6.10	8.90	21.80	29.80	39.30
35	2.90	4.00	5.80	16.20	22.20	29.30	4.70	6.30	9.20	22.50	30.70	40.50
36	3.00	4.10	6.00	16.80	22.90	30.20	4.80	6.60	9.60	23.20	31.70	41.80
37	3.10	4.30	6.20	17.30	23.70	31.20	5.00	6.80	9.90	24.00	32.70	43.10
38	3.30	4.50	6.50	17.90	24.40	32.20	5.20	7.10	10.30	24.70	33.80	44.50
39	3.40	4.70	6.70	18.50	25.20	33.20	5.40	7.50	10.70	25.60	34.90	46.00
40	3.50	4.90	7.00	19.10	26.10	34.30	5.60	7.80	11.20	26.40	36.10	47.40
41	3.90	5.50	7.80	20.80	28.40	37.40	6.30	8.70	12.40	28.90	39.40	51.80
42	4.10	5.70	8.20	21.30	29.10	38.20	6.60	9.10	13.00	29.50	40.30	52.90
43	4.30	6.00	8.50	21.90	29.80	39.10	6.90	9.50	13.60	30.30	41.30	54.20
44	4.50	6.30	8.90	22.50	30.60	40.20	7.20	10.00	14.20	31.10	42.40	55.60
45	4.80	6.60	9.40	23.10	31.50	41.20	7.60	10.50	14.90	32.00	43.60	57.10
46	5.00	7.00	9.80	23.70	32.30	42.20	8.00	11.10	15.70	32.80	44.70	58.50
47	5.20	7.30	10.30	24.20	32.90	43.00	8.30	11.60	16.40	33.50	45.50	59.50
48	5.60	7.80	11.00	25.40	34.50	45.00	8.90	12.40	17.50	35.20	47.70	62.30
49	6.00	8.40	11.80	26.70	36.30	47.30	9.60	13.30	18.70	37.00	50.20	65.50
50	6.50	9.00	12.60	28.20	38.10	49.60	10.30	14.30	20.10	39.00	52.80	68.70
51	7.40	10.20	14.30	31.80	43.00	55.90	11.80	16.30	22.70	44.00	59.60	77.40
52	7.90	10.90	15.20	33.70	45.60	59.20	12.60	17.40	24.20	46.70	63.20	82.00
53	8.40	11.50	15.90	35.00	47.40	61.40	13.40	18.30	25.30	48.50	65.60	85.10
54	8.90	12.10	16.70	36.40	49.20	63.80	14.10	19.20	26.50	50.40	68.10	88.30
55	9.50	12.80	17.70	37.90	51.20	66.40	15.10	20.40	28.10	52.40	70.90	91.90
56	10.10	13.60	18.60	39.40	53.30	69.00	16.00	21.60	29.60	54.60	73.70	95.60
57	10.70	14.30	19.60	40.90	55.30	71.60	17.00	22.80	31.20	56.60	76.50	99.20
58	11.50	15.30	20.90	43.10	58.20	75.30	18.30	24.30	33.30	59.60	80.50	104.20
59	12.40	16.40	22.40	45.60	61.60	79.60	19.70	26.10	35.60	63.20	85.30	110.20
60	13.40	17.70	24.00	48.50	65.40	84.40	21.30	28.20	38.20	67.10	90.50	116.90
61	15.50	20.40	27.70	54.80	74.10	95.60	24.70	32.50	44.10	75.90	102.50	132.30
62	16.90	22.20	30.10	58.40	79.10	102.10	26.90	35.40	47.90	80.80	109.50	141.30
63	18.30	24.00	32.50	61.20	83.10	107.40	29.20	38.20	51.70	84.70	115.10	148.70
64	19.70	25.80	34.90	64.10	87.30	112.80	31.40	41.00	55.50	88.70	120.80	156.20
65	23.20	30.30	41.20	70.20	96.00	125.70	36.90	48.20	65.50	97.20	132.90	174.10
66	24.90	32.40	44.00	73.70	100.90	132.10	39.60	51.50	70.00	102.00	139.70	182.90
67	27.70	35.90	48.70	80.20	110.00	144.00	44.10	57.10	77.40	111.00	152.40	199.40
68	30.10	38.80	52.60	85.20	117.20	153.30	47.90	61.80	83.60	118.00	162.30	212.20
69	32.60	41.90	56.60	90.30	124.50	162.60	51.80	66.70	90.10	125.00	172.30	225.10
70	35.40	45.50	61.20	96.30	133.00	173.50	56.40	72.30	97.40	133.40	184.20	240.20
71	38.80	49.80	66.80	102.50	141.40	183.90	61.80	79.20	106.30	141.90	195.80	254.60
72	43.00	55.10	73.70	110.20	152.00	197.00	68.40	87.60	117.20	152.60	210.40	272.80
73	47.50	60.70	80.90	118.10	162.60	210.20	75.50	96.60	128.70	163.50	225.20	291.00
74	52.50	67.00	88.90	126.70	174.40	224.50	83.40	106.50	141.50	175.50	241.40	310.80
75	59.60	76.10	101.80	133.40	183.60	239.00	94.70	121.10	161.90	184.70	254.30	330.90
76	66.50	84.90	113.10	144.90	199.30	258.60	105.70	135.00	179.90	200.60	275.90	358.00
77	74.70	95.20	126.40	158.50	217.80	281.50	118.80	151.40	201.00	219.50	301.50	389.70
78	82.40	104.80	138.60	170.40	233.60	300.70	131.10	166.70	220.40	235.90	323.50	416.40
79	91.00	115.60	152.20	183.20	250.80	321.60	144.80	183.90	242.00	253.60	347.30	445.30
80	100.00	126.70	166.00	195.80	267.80	341.70	159.00	201.50	264.00	271.20	370.80	473.10

First Unum Life Insurance Company
666 Third Avenue, Suite 301
New York, New York 10017

FOR HOME OFFICE USE ONLY
FN _____ MI ___ LN _____
PN _____ SN _____

Group Long Term Care Insurance Application
Evidence of Insurability

Please complete all sections, answer all questions and sign and date where indicated. Processing will be delayed if this form is incomplete.

Send fully completed form to your plan administrator or First Unum Life Insurance Company, Attn: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122-2295

Alterations to the pre-printed text will void this application. To ensure timely handling of this application, the applicant's name and social security number must be added at the top of each page.

As the applicant, or person applying for this coverage, you are required to answer all of the following questions.

Policyholder Name (e.g. Employer Name)

Group Policy No. or ID

Applicant First Name:

M.I.

Last Name

Number and Street Address / P.O. Box Number

City

State

Zip Code

Applicant Social Security Number

Applicant Gender
❑ Male ❑ Female

Group Division Number

Applicant Marital Status
❑ Married ❑ Divorced
❑ Single ❑ Widowed

Applicant Date of Birth
Month/Day/Year

Applicant
Daytime Telephone Number

Is the Applicant an employee of this group? ❑ Yes ❑ No If Yes, please indicate ❑ Active ❑ Retired

If you are the employee, you may skip this section and turn to the top of the next page. Otherwise, please complete the following:

Employee First Name:

M.I.

Employee Last Name

Employee Social Security Number

Employee Date of Birth
Month/Day/Year

Employee Date of Hire
Month/Day/Year

What is your relationship to this employee (please select from the options below):
❑ Spouse ❑ Domestic Partner ❑ Parent/Parent In-law ❑ Grandparent/Grandparent In-law
❑ Sibling/Sibling In-law ❑ Spouse of Sibling In-law ❑ Adult Child/Spouse of Adult Child

RETAIN A COMPLETED COPY FOR YOUR RECORDS

How to enroll

Applicant Name:	Applicant Social Security Number

Are you (applicant) presently working? ❑ Yes ❑ No If yes, list occupation:			
Applicant Height:	Applicant Weight:	Have you (applicant)used tobacco products in the last 12 months (chew or smoke - circle applicable activity)? ❑ Yes ❑ No	
Have you (applicant) had any change in weight in the last 12 months? ❑ Yes ❑ No	❑ Gain _____lbs. ❑ Loss _____lbs.	Reason for Weight Change:	
Primary Physician's Name:			Date Last Consulted Month __ __ / Year__ __ __ __
Primary Physician's Address: Street:			Date of Last Physical Exam Month __ __ / Year__ __ __ __
Primary Physician's Address: City, State, Zip Code:		Primary Physician's Telephone Number: ( )	

I. Insurability Profile

As the Applicant, or person applying for this coverage, you are required to answer the following questions:

A. ❑ Yes ❑ No	Do you use mechanical devices, such as: a wheelchair, walker, quad cane, crutches, hospital bed, dialysis machine, oxygen, or stairlift?
B. ❑ Yes ❑ No	Do you currently need or receive help in doing any of the following: bathing; eating; dressing; toileting; transferring; maintaining continence?
C. ❑ Yes ❑ No	Do you currently have, or have you ever had a diagnosis for or symptoms of: Alzheimer's disease, dementia, loss of memory, or organic brain syndrome?
D. ❑ Yes ❑ No	Do you currently have, or have you ever had a diagnosis for or symptoms of: Multiple Sclerosis, Muscular Dystrophy, ALS (Lou Gehrig's Disease) or Parkinson's Disease?
E. ❑ Yes ❑ No	Have you been diagnosed as having and/or treated by a member of the medical profession for AIDS or ARC (Aids Related Complex)?

STOP HERE! If you answered "Yes" to any part of questions A through E above, DO NOT SUBMIT THIS APPLICATION. Otherwise, please continue.

II. Medical Profile

A. Do you have symptoms of, or within the last five (5) years have you received medical advice, been diagnosed, treated or consulted with a member of the medical profession or other health care professional for any of the following conditions? **Please circle condition(s) for all "YES" answers.**

❑ Yes ❑ No	1. High blood pressure, irregular heart beat, atrial fibrillation, coronary artery disease, or other diseases or disorders of the heart or circulatory system, blood or blood vessels.
❑ Yes ❑ No	2. Polyp, benign tumor, leukemia, lymphoma, cancer, melanoma, or a disorder of the immune system (excluding HIV tests).
❑ Yes ❑ No	3. Diabetes, thyroid problems, or any glandular disease or disorder.
❑ Yes ❑ No	4. Intestines, liver or disease or disorder of the stomach or digestive system.
❑ Yes ❑ No	5. Bowel, rectum, kidney, bladder, prostate, urinary tract, or reproductive system.

RETAIN A COMPLETED COPY FOR YOUR RECORDS

Applicant Name:	Applicant Social Security Number

❑ Yes ❑ No	6. Mental disorder, depression, bulimia, anorexia or other eating disorder, alcohol abuse, drug addiction or any psychological or emotional condition or disorder; or been advised to limit, reduce or discontinue the use of alcohol; been arrested in connection with use of alcohol or drugs; or been advised to seek or receive counseling for alcoholism or drug abuse.
❑ Yes ❑ No	7. Arthritis, osteoporosis, any chronic pain condition, or chronic fatigue or any other disease or disorder of the back, spine, joints, muscles or neck.
❑ Yes ❑ No	8. Lung disorder, shortness of breath, or any disease or disorder of the respiratory system.
❑ Yes ❑ No	9. Falls, dizziness, imbalance, or any disease or disorder of the eyes or ears.
❑ Yes ❑ No	10. Seizures, tremors, stroke, transient ischemic attack (TIA), paralysis or any other disease or disorder of the brain or nervous system.
❑ Yes ❑ No	11. Any other conditions or diseases not mentioned above? Please describe in this area _____ _____ _____

If you answered "Yes" to any of the questions in section IIA, please indicate question number from IIA and provide full details on the condition, treatment dates and the name, address and telephone number of your medical advisor.

Ques No.	Date of Last Visit (mm/dd/yyyy)	Reason/ Name of Condition	Treatment Given	Medical Advisor's Full Name, Address & Telephone Number

B. ❑ Yes ❑ No	Have you taken any prescription/non-prescription medications in the past 24 months, including all prescription/non-prescription medications you are currently taking? Please list the medication and details.

Date Last Taken (mm/dd/yyyy)	Name of Medication	Dosage/ Frequency	Reason/Name of Condition	Prescribing Physician

RETAIN A COMPLETED COPY FOR YOUR RECORDS

Applicant Name:	Applicant Social Security Number

C. ❑ Yes ❑ No — Have you been hospitalized, been advised to have, or had surgery, medical care, EKG, x-ray, diagnostic test or been confined to any facility in the last five (5) years? If yes, provide details.

Test(s) Performed	Date Mth/ Day/ Year	Reason	Results	Name, Address & Telephone Number of Medical Advisor Requesting Test(s)

D. ❑ Yes ❑ No — Do you live alone? If no, who lives with you?
_____

E. ❑ Yes ❑ No — Do you drive? If no, why?
_____

F. Please describe your daily routine, i.e. work, exercise, travel, socializing, physical/recreational activities, etc.:
_____

III. Insurance History

A. ❑ Yes ❑ No — Are you covered by Medicaid? (If yes, details.)
_____
_____

B. ❑ Yes ❑ No — Are you receiving any disability benefits? (If yes, provide details including health condition(s))
_____
_____

C. ❑ Yes ❑ No — Have you had another long-term care insurance policy or certificate, nursing home only insurance policy or certificate, nursing home and home care insurance policy or certificate, or home care only insurance policy or certificate in force during the last 12 months?
If yes — Name of Company: _____
If it lapsed, when did it lapse? (mm/dd/yyyy) _____

D. ❑ Yes ❑ No — Do you have another accident and health insurance policy or certificate including a long-term care insurance policy or certificate, nursing home only insurance policy or certificate, nursing home and home care insurance policy or certificate, or home care only insurance policy or certificate currently in force? Please list)

Company	Do you intend to replace?
_____	❑ Yes ❑ No
_____	❑ Yes ❑ No
_____	❑ Yes ❑ No

E. ❑ Yes ❑ No — Do you intend to replace any of your long term care, medical or health coverage with the coverage applied for? If yes —
Name of Company: _____ Policy Number: _____ Type and Amount of Benefits: _____

F. ❑ Yes ❑ No — Have you been denied coverage for medical insurance, disability insurance, long-term care insurance, nursing home insurance, life insurance or received substandard coverage? If yes –
Name of Company:_____ Coverage:_____
Date Denied: (mm/dd/yyyy) _____ Reason for Denial? _____

G. ❑ Yes ❑ No — Have you signed and activated a Power of Attorney authorizing another individual to manage your personal affairs? If yes, please provide the date _____ and reason _____
_____
_____

RETAIN A COMPLETED COPY FOR YOUR RECORDS

Applicant Name:	Applicant Social Security Number

IV. Applicant's Signature

I agree that payment of premium is my responsibility. If any other person or entity collects, pays or forwards any part of the premium for this coverage, the person or entity acts as my agent and not an agent of First Unum Life Insurance Company.

Payroll Deduction: If applicable, I authorize my employer to deduct the premiums for this insurance from my earnings.

I have read this application and I understand that: First Unum Life Insurance Company will rely on the information provided in this application and any medical exams or tests and other questionnaires including a face to face assessment, if required, to determine whether to provide the coverage I have requested. All these documents shall form a part of my certificate of insurance and any coverage based on such information is contestable in accordance with the provisions of the Policy.

The statements I have made on this application are true to the best of my knowledge and belief.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION FAIL TO INCLUDE ALL MATERIAL MEDICAL INFORMATION REQUESTED, FIRST UNUM LIFE INSURANCE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR INSURANCE.

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.

X_____ Date: _____
Applicant's Signature (mm/dd/yyyy)

_____
Signed at (City/State)

RETAIN A COMPLETED COPY FOR YOUR RECORDS

First Unum Life Insurance Company

Printed Name of Applicant: _____
(First Name) (MI) (Last Name)

Social Security Number: _____

Policy Number: _____

NOTE: The Health Insurance Portability and Accountability Act (HIPAA) requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or process your application. Please sign and return this authorization to: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory or other medically related facility or service; insurance company; insurance service provider; third party administrator; producer; and employer that has information about my health; employment; or other insurance coverage, claims and benefits to disclose any and all of this information to persons who evaluate and process applications for Unum, First Unum Life Insurance Company, and duly authorized representatives ("Unum"). Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information Unum obtains pursuant to this authorization will be used for evaluating and processing my application for coverage. I further understand that the information is subject to redisclosure and might not be protected by HIPAA.

This authorization is valid for two (2) years from the date below. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Unum has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Unum may not be able to evaluate or process my application and this may be the basis for denying my application. I may revoke this authorization by sending written notice to: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or process my application and this may be the basis for denying my application.

_____ _____
(Applicant Signature) (Date Signed (mm/dd/yyyy)

I, _____, signed on behalf of the applicant as the applicant's Personal Representative. Please circle the type of Personal Representative: Power of Attorney Designee, Guardian, Conservator; and attach a copy of the document granting authority.

First Unum Life Insurance Company
666 Third Avenue, Suite 301, New York, NY 10017

First Unum Life Insurance Company
666 Third Avenue, Suite 301
New York, New York 10017

FOR HOME OFFICE USE ONLY
FN _____ MI ___ LN _____
PN _____ SN _____

Group Long Term Care Insurance Application
Evidence of Insurability

Please complete all sections, answer all questions and sign and date where indicated. Processing will be delayed if this form is incomplete.

Send fully completed form to your plan administrator or First Unum Life Insurance Company, Attn: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122-2295

Alterations to the pre-printed text will void this application. To ensure timely handling of this application, the applicant's name and social security number must be added at the top of each page.

As the applicant, or person applying for this coverage, you are required to answer all of the following questions.

Policyholder Name (e.g. Employer Name)

Group Policy No. or ID

Applicant First Name:

M.I.

Last Name

Number and Street Address / P.O. Box Number

City

State

Zip Code

Applicant Social Security Number

Applicant Gender
❑ Male ❑ Female

Group Division Number

Applicant Marital Status
❑ Married ❑ Divorced
❑ Single ❑ Widowed

Applicant Date of Birth
Month/Day/Year

Applicant
Daytime Telephone Number

Is the Applicant an employee of this group? ❑ Yes ❑ No If Yes, please indicate ❑ Active ❑ Retired

If you are the employee, you may skip this section and turn to the top of the next page. Otherwise, please complete the following:

Employee First Name:

M.I.

Employee Last Name

Employee Social Security Number

Employee Date of Birth
Month/Day/Year

Employee Date of Hire
Month/Day/Year

What is your relationship to this employee (please select from the options below):
❑ Spouse ❑ Domestic Partner ❑ Parent/Parent In-law ❑ Grandparent/Grandparent In-law
❑ Sibling/Sibling In-law ❑ Spouse of Sibling In-law ❑ Adult Child/Spouse of Adult Child

RETAIN A COMPLETED COPY FOR YOUR RECORDS

How to enroll

Applicant Name:	Applicant Social Security Number

Are you (applicant) presently working? ❑ Yes ❑ No If yes, list occupation:			
Applicant Height:	Applicant Weight:	Have you (applicant)used tobacco products in the last 12 months (chew or smoke - circle applicable activity)? ❑ Yes ❑ No	
Have you (applicant) had any change in weight in the last 12 months? ❑ Yes ❑ No	❑ Gain _____lbs. ❑ Loss _____lbs.	Reason for Weight Change:	
Primary Physician's Name:			Date Last Consulted Month __ __ / Year__ __ __ __
Primary Physician's Address: Street:			Date of Last Physical Exam Month __ __ / Year__ __ __ __
Primary Physician's Address: City, State, Zip Code:		Primary Physician's Telephone Number: ( )	

I. Insurability Profile

As the Applicant, or person applying for this coverage, you are required to answer the following questions:

A. ❑ Yes ❑ No	Do you use mechanical devices, such as: a wheelchair, walker, quad cane, crutches, hospital bed, dialysis machine, oxygen, or stairlift?
B. ❑ Yes ❑ No	Do you currently need or receive help in doing any of the following: bathing; eating; dressing; toileting; transferring; maintaining continence?
C. ❑ Yes ❑ No	Do you currently have, or have you ever had a diagnosis for or symptoms of: Alzheimer's disease, dementia, loss of memory, or organic brain syndrome?
D. ❑ Yes ❑ No	Do you currently have, or have you ever had a diagnosis for or symptoms of: Multiple Sclerosis, Muscular Dystrophy, ALS (Lou Gehrig's Disease) or Parkinson's Disease?
E. ❑ Yes ❑ No	Have you been diagnosed as having and/or treated by a member of the medical profession for AIDS or ARC (Aids Related Complex)?

STOP HERE! If you answered "Yes" to any part of questions A through E above, DO NOT SUBMIT THIS APPLICATION. Otherwise, please continue.

II. Medical Profile

A. Do you have symptoms of, or within the last five (5) years have you received medical advice, been diagnosed, treated or consulted with a member of the medical profession or other health care professional for any of the following conditions? **Please circle condition(s) for all "YES" answers.**

❑ Yes ❑ No	1. High blood pressure, irregular heart beat, atrial fibrillation, coronary artery disease, or other diseases or disorders of the heart or circulatory system, blood or blood vessels.
❑ Yes ❑ No	2. Polyp, benign tumor, leukemia, lymphoma, cancer, melanoma, or a disorder of the immune system (excluding HIV tests).
❑ Yes ❑ No	3. Diabetes, thyroid problems, or any glandular disease or disorder.
❑ Yes ❑ No	4. Intestines, liver or disease or disorder of the stomach or digestive system.
❑ Yes ❑ No	5. Bowel, rectum, kidney, bladder, prostate, urinary tract, or reproductive system.

RETAIN A COMPLETED COPY FOR YOUR RECORDS

Applicant Name:	Applicant Social Security Number

❑ Yes ❑ No	6. Mental disorder, depression, bulimia, anorexia or other eating disorder, alcohol abuse, drug addiction or any psychological or emotional condition or disorder; or been advised to limit, reduce or discontinue the use of alcohol; been arrested in connection with use of alcohol or drugs; or been advised to seek or receive counseling for alcoholism or drug abuse.
❑ Yes ❑ No	7. Arthritis, osteoporosis, any chronic pain condition, or chronic fatigue or any other disease or disorder of the back, spine, joints, muscles or neck.
❑ Yes ❑ No	8. Lung disorder, shortness of breath, or any disease or disorder of the respiratory system.
❑ Yes ❑ No	9. Falls, dizziness, imbalance, or any disease or disorder of the eyes or ears.
❑ Yes ❑ No	10. Seizures, tremors, stroke, transient ischemic attack (TIA), paralysis or any other disease or disorder of the brain or nervous system.
❑ Yes ❑ No	11. Any other conditions or diseases not mentioned above? Please describe in this area _____ _____ _____

If you answered "Yes" to any of the questions in section IIA, please indicate question number from IIA and provide full details on the condition, treatment dates and the name, address and telephone number of your medical advisor.

Ques No.	Date of Last Visit (mm/dd/yyyy)	Reason/ Name of Condition	Treatment Given	Medical Advisor's Full Name, Address & Telephone Number

B. ❑ Yes ❑ No	Have you taken any prescription/non-prescription medications in the past 24 months, including all prescription/non-prescription medications you are currently taking? Please list the medication and details.

Date Last Taken (mm/dd/yyyy)	Name of Medication	Dosage/ Frequency	Reason/Name of Condition	Prescribing Physician

RETAIN A COMPLETED COPY FOR YOUR RECORDS

Applicant Name:	Applicant Social Security Number

C. ❑ Yes ❑ No — Have you been hospitalized, been advised to have, or had surgery, medical care, EKG, x-ray, diagnostic test or been confined to any facility in the last five (5) years? If yes, provide details.

Test(s) Performed	Date Mth/ Day/ Year	Reason	Results	Name, Address & Telephone Number of Medical Advisor Requesting Test(s)

D. ❑ Yes ❑ No — Do you live alone? If no, who lives with you?
_____

E. ❑ Yes ❑ No — Do you drive? If no, why?
_____

F. Please describe your daily routine, i.e. work, exercise, travel, socializing, physical/recreational activities, etc.:
_____

III. Insurance History

A. ❑ Yes ❑ No — Are you covered by Medicaid? (If yes, details.)
_____
_____

B. ❑ Yes ❑ No — Are you receiving any disability benefits? (If yes, provide details including health condition(s))
_____
_____

C. ❑ Yes ❑ No — Have you had another long-term care insurance policy or certificate, nursing home only insurance policy or certificate, nursing home and home care insurance policy or certificate, or home care only insurance policy or certificate in force during the last 12 months?
If yes — Name of Company: _____
If it lapsed, when did it lapse? (mm/dd/yyyy) _____

D. ❑ Yes ❑ No — Do you have another accident and health insurance policy or certificate including a long-term care insurance policy or certificate, nursing home only insurance policy or certificate, nursing home and home care insurance policy or certificate, or home care only insurance policy or certificate currently in force? Please list)

Company	Do you intend to replace?
_____	❑ Yes ❑ No
_____	❑ Yes ❑ No
_____	❑ Yes ❑ No

E. ❑ Yes ❑ No — Do you intend to replace any of your long term care, medical or health coverage with the coverage applied for? If yes —
Name of Company: _____ Policy Number: _____ Type and Amount of Benefits: _____

F. ❑ Yes ❑ No — Have you been denied coverage for medical insurance, disability insurance, long-term care insurance, nursing home insurance, life insurance or received substandard coverage? If yes –
Name of Company:_____ Coverage:_____
Date Denied: (mm/dd/yyyy) _____ Reason for Denial? _____

G. ❑ Yes ❑ No — Have you signed and activated a Power of Attorney authorizing another individual to manage your personal affairs? If yes, please provide the date _____ and reason _____
_____
_____

RETAIN A COMPLETED COPY FOR YOUR RECORDS

Applicant Name:	Applicant Social Security Number

IV. Applicant's Signature

I agree that payment of premium is my responsibility. If any other person or entity collects, pays or forwards any part of the premium for this coverage, the person or entity acts as my agent and not an agent of First Unum Life Insurance Company.

Payroll Deduction: If applicable, I authorize my employer to deduct the premiums for this insurance from my earnings.

I have read this application and I understand that: First Unum Life Insurance Company will rely on the information provided in this application and any medical exams or tests and other questionnaires including a face to face assessment, if required, to determine whether to provide the coverage I have requested. All these documents shall form a part of my certificate of insurance and any coverage based on such information is contestable in accordance with the provisions of the Policy.

The statements I have made on this application are true to the best of my knowledge and belief.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION FAIL TO INCLUDE ALL MATERIAL MEDICAL INFORMATION REQUESTED, FIRST UNUM LIFE INSURANCE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR INSURANCE.

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.

X_____ Date: _____
Applicant's Signature (mm/dd/yyyy)

_____
Signed at (City/State)

RETAIN A COMPLETED COPY FOR YOUR RECORDS

First Unum Life Insurance Company

Printed Name of Applicant: _____
(First Name) (MI) (Last Name)

Social Security Number: _____

Policy Number: _____

NOTE: The Health Insurance Portability and Accountability Act (HIPAA) requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or process your application. Please sign and return this authorization to: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory or other medically related facility or service; insurance company; insurance service provider; third party administrator; producer; and employer that has information about my health; employment; or other insurance coverage, claims and benefits to disclose any and all of this information to persons who evaluate and process applications for Unum, First Unum Life Insurance Company, and duly authorized representatives ("Unum"). Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information Unum obtains pursuant to this authorization will be used for evaluating and processing my application for coverage. I further understand that the information is subject to redisclosure and might not be protected by HIPAA.

This authorization is valid for two (2) years from the date below. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Unum has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Unum may not be able to evaluate or process my application and this may be the basis for denying my application. I may revoke this authorization by sending written notice to: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or process my application and this may be the basis for denying my application.

_____ _____
(Applicant Signature) (Date Signed (mm/dd/yyyy)

I, _____, signed on behalf of the applicant as the applicant's Personal Representative. Please circle the type of Personal Representative: Power of Attorney Designee, Guardian, Conservator; and attach a copy of the document granting authority.

First Unum Life Insurance Company
666 Third Avenue, Suite 301, New York, NY 10017

First Unum Life Insurance Company

First Unum Life Insurance Company
666 Third Avenue, Suite 301
New York, New York 10017

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE AND THE PURCHASE OF MULTIPLE ACCIDENT AND HEALTH COVERAGES

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

Do you intend to lapse or otherwise terminate existing accident and health insurance and replace it with group long term care insurance to be issued by First Unum Life Insurance Company? If so, you should review this new coverage carefully, comparing it with all accident and sickness, or long term care insurance coverage you now have, and terminate your present insurance only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

Your new certificate provides thirty (30) days within which you may decide, without cost, whether you desire to keep the insurance. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new certificate.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new insurance. This could result in denial or delay in payment of benefits under the new insurance, whereas a similar claim might have been payable under your present insurance.

2. You should be aware that the premium rate for the replacement coverage may be higher than what you are paying for the existing coverage that you plan to replace. If the premium for your existing coverage is based on your age when it was issued, you have built up equity in that coverage which may be lost if you terminate it.

3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present insurance. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

Authorization and Agreement for Automatic Payments

Drawn By and Payable To: Unum Life Insurance Company of America
(hereinafter referred to as "the Company")

Please Print

Policy Number	Insured Name	Social Security Number

1. Check all that apply:

☐ New authorized payment request ☐ Change in bank ☐ Change in account number

2. Tape voided check on space provided below. Deposit tickets do not contain all necessary information.

Tape
Voided Check
Here

How to enroll

I (each of the premium payors whose signature appears on the next page) have **carefully read** the terms of this authorization, and I **understand** and **agree** that:

1) This Authorization applies to coverage provided under the policy listed above and to any coverage subsequently added.
2) My signature on the next page reflects my intent that my account be debited by the Company in the amount necessary to pay premium.
3) No notice of premium due will be furnished while the Authorization is in effect, except, if any check or other debit entry made pursuant to this Authorization is not paid, the Company will send notice of premium past due.
4) It is my responsibility to fund my account in an amount sufficient to pay premium when due and failure to do so may result in lapse of coverage.
5) This Authorization does not waive, alter or amend any provision of coverage under the above policy.
6) No premium shall be deemed paid until the Company receives payment at its Home Office.
7) The Company shall incur no liability as a result of the dishonor of any debit entry or any check, draft or other instrument drawn pursuant to this Authorization Agreement.
8) This Authorization shall remain in effect unless and until the bank, the insured person or premium payor presents written notice of termination to Unum.
   Exception: The Company may terminate this Agreement, by providing written notice thereof, in the event that, within any period of twelve consecutive months, two or more premium debits are not paid upon presentation, or if any time the Company is required to refund to the bank any amount paid pursuant to this Authorization.

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL
Please retain a copy of this form for your records

9) Upon termination of this Agreement, premiums will be payable at the rate (amount) and mode (frequency) required under the Company's usual rate and mode for coverages not enrolled in the Automatic Payment Plan.
10) Funds must be paid in U.S. dollars and withdrawn from a U.S. bank.

3. Please sign. I authorize the bank indicated below to pay and charge to my account monthly debit entries, including checks, drafts and other orders by electronic or paper means, made by and payable to the Company.

Signature(s) of Premium Payor(s)	Signature Date(s)	Bank Information
_____	_____	_____ Name
_____	_____	_____ Street
		_____ City State Zip

4. Mail to: Unum Life Insurance Company of America
2211 Congress Street
Portland Maine 04122

First Unum Life Insurance Company

unum

First Unum Life Insurance Company
666 Third Avenue, Suite 301
New York, New York 10017

PROTECTION AGAINST UNINTENTIONAL LAPSE
ADDITIONAL DESIGNATION
GROUP LONG TERM CARE INSURANCE

Your Name:_____

Your Social Security Number:_____

Policyholder's Name:_____

Policy Number:_____

You, the insured, will receive notice if any coverage for which you are required to pay the cost is about to terminate because you have not paid the required premiums.

You are required to provide your insurer with a written designation of at least one person, in addition to you, who is to receive the notice of cancellation of your coverage for nonpayment of premium OR sign a waiver electing not to designate a person. You have the right to change these designations. Designation does not constitute acceptance of any liability on the part of the designated person or persons for services provided to you. The designated person or persons will not receive the notice until 30 days after the premium is due and unpaid.

My designations are as follows:

Name:_____

Address: Street/PO Box_____ City, State, Zip Code:_____

Name:_____

Address: Street/PO Box_____ City, State, Zip Code:_____

Insured's Signature:_____ Date:_____

WAIVER ELECTING NOT TO NAME AN ADDITIONAL DESIGNATION FOR PROTECTION AGAINST UNINTENTIONAL LAPSE

I understand that I have the right to designate at least one person, other than myself, to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. **I elect NOT to designate any person to receive such notice.**

Insured's Signature:_____ Date:_____

Please return this form to:
Group Long Term Care
First Unum Life Insurance Company
2211 Congress Street, Portland, Maine 04122

New Jersey and New York Residents – Age 62 and older: Per New Jersey insurance code C.17:29C-1.2 and §3111 of the New York Insurance Laws, this form shall be delivered to First Unum by certified mail, return receipt requested along with the completed Designee Acceptance form (on the back page of this form). Your Designee(s) must accept in writing that they are willing to receive copies of notices of cancellation, non-renewal and conditional renewal from us.

First Unum Life Insurance Company

First Unum Life Insurance Company
666 Third Avenue, Suite 301
New York, New York 10017

DESIGNEE ACCEPTANCE
LONG TERM CARE INSURANCE

This form needs to be completed by the Designee, if the named Insured is age 62 or over and a resident of New Jersey or New York.

Insurance Applicant: Please complete this section prior to sending this form to your Designee for signature.

Insured's Name:_____

Policy Number: _____

Prior to issuing a long term care policy, the Insured is required to provide the insurer with a written designation of at least one person, who is to receive the notice of cancellation of this policy for nonpayment of premium, in addition to the insured OR sign a waiver electing not to designate a person. You have been listed as one of the designees. Designation does not constitute acceptance of any liability on the part of the designated person or persons for services provided to the insured.

You must accept in writing that you are willing to receive copies of notices of cancellation, non-renewal and conditional renewal from the insurer. Should you desire to terminate the status as a third party designee, you shall provide written notice to both the insurer and the insured.

Designee's Signature: _____

Print Name: _____

Date: _____

First Unum Life Insurance Company

First Unum Life Insurance Company
666 Third Avenue, Suite 301
New York, New York 10017

MEDICARE NOTICE

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

(For long term care policies providing both nursing home and non-institutional coverage)

Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.

This is long term care insurance that provides benefits for covered nursing home and home care services.

In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.

This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplemental insurance provides benefits for most nursing home and home care expenses.

Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about long term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available at http://w3.unum.com/enroll/booklets. To have a printed copy mailed to you, call 1-877-678-6040.

For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available at http://w3.unum.com/enroll/booklets. To have a printed copy mailed to you, call 1-877-678-6040.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

State forms to review