IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/LSUS or in a paper enrollment kit. You can request a paper enrollment kit by calling 1-800-227-4165. DO NOT submit this form if you have not reviewed those materials.

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

LOUISIANA STATE UNIVERSITY SYSTEM

Benefit Election Form

Long Term Care - Policy #100057

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:		

Complete the following only if applicant is not the employee:

Employee's Name	Employee Social Security No. __ __ __ - __ __ - __ __ __ __	Employee Date of Birth __ __/__ __/__ __ __ __	Employee Date of Hire __ __/__ __/__ __ __ __

EMPLOYEES LOCATION: (Check one)

☐ **Div. 001 LSU System – Baton Rouge, LSU-A, LSU-E, Ag Center, Pennington, Law Center**
☒ **Div. 003 LSU Medical Center New Orleans**
☐ **Div. 004 LSU in Shreveport**
☐ **Div. 005 LSU Shreveport - HSC**
☐ **Div. 006 LSU Baton Rouge – 9th Month Employees**
☐ **Div. 017 LSU – HCSD Headquarters**
☐ **Div. 018 LSU – Lallie Kemp Reg Med Ctr**

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

☐ Employee	☐ Employee's Parent or Grandparent	☐ Retiree
☐ Employee's Spouse	☐ Spouse's Parent or Grandparent	☐ Retiree's Spouse

	Plans			
(Check one)	☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 4**
	• Long Term Care Facility • Professional Home Care	• Long Term Care Facility • Professional Home Care • Total Home Care	• Long Term Care Facility • Professional Home Care • Simple Inflation	• Long Term Care Facility • Professional Home Care • Total Home Care • Simple Inflation
	Facility Monthly Benefit Amount			
(Check one)	☐ $1,000	☐ $2,000	☐ $3,000	☐ $4,000
	Facility Benefit Duration *(Duration of benefits may vary depending on where benefits are received.)*			
(Check one)	☐ 3 Years		☐ 6 Years	

***NOTE TO EMPLOYEES*: All Active Employees, Newly Hired Employees & Spouses – who enroll after the Guarantee Issue enrollment period will be required to fill out a medical questionnaire and a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit. RETIREES AND ALL OTHER APPLICANTS must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire), and a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit.**

Form is continued on reverse side.

Calculate your Premium:

_____	X	_____	÷	$1,000	=	_____
Rate for plan chosen		Facility Monthly Benefit Amount				**Your Premium**

Active Employee or Spouse: Your premium will be paid through the Employee's payroll deduction. Employee must sign below to authorize the Employer to make the payroll deduction.

All other eligible Family Members or Retirees: Please select payment method: ☐ Monthly Automatic Payments (deducted from your checking account – complete Authorization/Agreement for Automatic Payments), **OR** Billed directly (paper) by the insurance company: ☐ Quarterly ☐ Semi-Annually ☐ Annually

Caution: If your answers on this Enrollment Form are incorrect or untrue, we may have the right to deny benefits or rescind your insurance.

By signing below, you signify that you have read and understand that loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after your effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to your coverage. You also acknowledge that you have received the **Potential Rate Increase Disclosure Form** and **Personal Worksheet.** All information is contained in your kit.

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

Employees & Spouses: Please sign and mail all required signature forms to your employer.
Family Members/Retirees: Please sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (L4)

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

Reset Form