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

LOS ANGELES FIREMEN'S RELIEF ASSOCIATION

Family Surviving Spouses

Benefit Election Form

Long Term Care - Policy #951328-003

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 # ( )

Surviving Spouse Name	Surviving Spouse Social Security No. __ __ __ - __ __ - __ __ __ __	Surviving Spouse Date of Birth __ __/__ __/__ __ __ __	Surviving Spouse Date of Hire __ __/__ __/__ __ __ __
Email Address:			

Is this a change to existing coverage? □ Yes □ No
If yes, new elections made below will replace existing coverage upon underwriting approval, if applicable.

Applicant is: (please circle)		The Minimum age for a sibling or child is 18.
Parent or Grandparent;	Sibling;	Child;

Plans – Check one

□ **Plan 1**	□ **Plan 2**	□ **Plan 3**
• 100% Facility • 100% Home and Community Based Care	• 100% Facility • 100% Home and Community Based Care • 5% Simple Inflation	• 100% Facility • 100% Home and Community Based Care • 5% Compound Inflation

Facility Monthly Benefit Amount – Check one

□ $1,500	□ $2,500	□ $3,500	□ $4,500	□ $5,500	□ $6,500	□ $7,500	□ $8,500

Facility Benefit Duration – Check one. **Note: Duration of benefits may vary depending on where benefits are received.**

□ 2 Years	□ 5 Years	□ Lifetime

- **All applicants** 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-CA in the kit) must accompany all medical questionnaires.

Form is continued on reverse side.

Calculate Your Premium:
To calculate your premium using the formula below: 1. Refer to the rate sheet available at www.lafraltcenroll.com or 2. Contact Unum at 1-800-227-4165 to request an enrollment kit, which includes the rate sheet. You can also use the online calculator available at www.lafraltcenroll.com to calculate your premium.

_____	**X**	_____	**÷ $1,000 =**	_____
Rate for plan chosen		Monthly benefit amount		Your premium

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

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.

All eligible Family Surviving Spouse s: 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

Your premium: $_____ (transfer from calculation above)

_____	__ __/__ __/__ __ __ __	_____	__ __/__ __/__ __ __ __
Applicant's Signature	*Date*	*Surviving Spouse 's Signature*	*Date*

Please sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (M8)

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