

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

SHURTAPE TECHNOLOGIES, LLC Benefit Election Form (NC) Long Term Care - Policy #096363-002

You	ur Name: (Last Name	nitial)	Social Security Number				Date of Birth (MM/DD/YYYY)					
Str	eet Address			Gender Male Female				Date of Hire (MM/DD/YYYY)				
City	y, State, Zip Code		Home Telephone #				Work Telephone #					
Email Address:												
Complete the following only if applicant is not the employee												
Employee Name E		Employee	Employee Social Security No.		Employee Date of		Birth	Employee Date of Hire				
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.												
Employee; Spouse; Parent or Grandparent; Sibling; Child												
Plans – Check one												
□ Plan 1			□ Plan	□ Plan 2			□ Plan 3					
• Lo	ong Term Care Facilit	• Long	Long Term Care Facility				Long Term Care Facility					
• 100% Professional Home and Community Care			Commu	100% Professional Home and Community Care 5% Simple Inflation				100% Professional Home and Community Care5% Compound Inflation				
• 5% Simple Inflation • 5% Compound Inflation												
Fa	cility Monthly Ben	efit Amount -	- Check o	ne						1		
□ \$2,000 □ \$3,000				□ \$4,000			□ \$5,000			□ \$6,000		
Facility Benefit Duration - Check one. Note: Duration of benefits may vary depending on where benefits are received.												
□ 3 Years			□ 6 Yea	□ 6 Years			□ Lifetime *					
>	*These options exceed the Guarantee Issue limits and their selection will require completion of the Long Term Care Insurance Application (medical questionnaire).											
>	All active employees and newly hired employees who enroll after the Guarantee Issue enrollment period must complete the Long Term Care Insurance Application (medical questionnaire).											
>	All other 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 in the kit) must accompany all medical questionnaires.											

Form is continued on reverse side.

7721-04 GLTC04-EF001-VOL

	x	÷ \$1,000 =								
Rate for plan chosen	Monthly benefit amour		Your premit	um						
Disclosures:										
Massachusetts Residen Massachusetts Residen	ents: You also signify thats Only"- Form #7650-04	at you have rec . The notice is	eived and read contained in yo	the MassHealth eligibilit our kit.	y notice entitled "For					
Note: We may have the enrollment form is inc	e right to deny benefits orrect.	or rescind in	surance if any	of the information pro	vided on this					
REQUEST FOR SIGNATURE: Please read this entire form carefully before signing below.										
☐ I am declining addit	ional coverage at this ti	me.								
does not require me to somust occur after my effective to the service of the serv	nts are true to the best of submit evidence of insural ective date of coverage upons apply to my coverage. pouses: Your signature to coverage will be based on the earlier by Agreement for the submit of the coverage will be select pay the coverage will be select pay the coverage of the submit of the coverage will be select pay the coverage of the submit of the coverage of the cov	ability, loss of Ander this Long below authorized by your Insuran group policy effected attention to the second second by the se	ctivities of Daily Term Care plan es your employe ce Age. If you fective date. If his enrollment f	r Living (ADL) or Severe in order to be covered, er to deduct the required enroll for coverage on or you enroll for coverage a form.	Cognitive Impairment and that certain I premium from your refore the group policy after the group policy					
	horization/Agreement for the insurance company:		□ Quarterly	☐ Semi-Annually	☐ Annually					
Your premium: \$	(transfer fro	om calculation a	above)							
Applicant's Signatur	Applicant's Signature —				// Date					
	ployee & Spouse: Please embers: Please sign and r Re	nail all required		s to Unum (address at top						

Calculate Your Premium:

Please refer to rate sheet in your kit to determine the rate for the plan chosen.

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

7721-04 GLTC04-EF001-VOL