



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

**AQUINAS COLLEGE**  
**Benefit Election Form**  
**Long Term Care - Policy #150983**

Your Name: (Last Name, First, Middle Initial)	Social Security Number ____ - ____ - ____	Date of Birth (MM/DD/YYYY) ____ / ____ / ____
Street Address	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Hire (MM/DD/YYYY) ____ / ____ / ____
City, State, Zip Code	Home Telephone # (    )	Work Telephone # (    )

**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 ____ / ____ / ____
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**All applicants must complete this form. Applicant is:**

<input type="checkbox"/> Employee	<input type="checkbox"/> Employee's Parent or Grandparent	<input type="checkbox"/> Sibling ( <i>minimum age 18</i> )
<input type="checkbox"/> Employee's Spouse	<input type="checkbox"/> Spouse's Parent or Grandparent	<input type="checkbox"/> Child ( <i>minimum age 18</i> )

**Plans – Check one**

<input type="checkbox"/> <b>Plan 1</b>	<input type="checkbox"/> <b>Plan 2</b>	<input type="checkbox"/> <b>Plan 3</b>	<input type="checkbox"/> <b>Plan 4</b>
<ul style="list-style-type: none"> <li>• Long Term Care Facility</li> <li>• 75% Professional Home &amp; Community Care</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care Facility</li> <li>• 50% Total Choice Home Care</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care Facility</li> <li>• 75% Professional Home &amp; Community Care</li> <li>• Simple Inflation</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care Facility</li> <li>• 50% Total Choice Home Care</li> <li>• Simple Inflation</li> </ul>

**Facility Monthly Benefit Amount – Check one**

<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$6,000
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**Facility Benefit Duration – Check one. Note: Duration of benefits may vary depending on where benefits are received.**

<input type="checkbox"/> 3 Years	<input type="checkbox"/> 6 Years
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- **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.**

