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:
Unum Life Insurance Company of America

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:	
Long term care annual benefit	**$36,000**
Home health aide ($18.50/hour)	– $24,050/year*
Left over for out-of-pocket expenses	= **$11,950**

Assisted living:	
Long term care annual benefit	**$36,000**
Assisted living ($2,825.25/month)	– $33,903/year
Left over for out-of-pocket expenses	= **$2,097**

Private nursing home:	
Long term care annual benefit	**$36,000**
Private nursing home ($203.31/day)	– $74,208.15/year
The cost of care that you will pay out of pocket	= **–$38,208.15**

*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.

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.

Underwritten by: Unum Life Insurance Company of America, Portland, Maine

unum.com

COUNTY OF DANE A MUNICIPAL CORPORATION
PLAN HIGHLIGHTS / SCHEDULE OF BENEFITS

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

Elimination Period: Your plan's Elimination Period of 90 consecutive days is the amount of time you must wait before benefits become payable. This time period must be satisfied only once during the life of your plan.

Newly Hired Employees – once eligible for the plan, you will have 30 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 passing medical underwriting between the 1st and 15th of the month is the first of the month following their date of approval. For those approved between the 16th and the end of the month, their effective date is the first of the second month following their date of approval.
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) As an **Employee** you are eligible for benefit amounts on a Guarantee Issue basis of up to and including $6,000 and a Facility Benefit Duration of 3 or 6 years. 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 the Unlimited Duration coverage. **Retirees, Spouses/Domestic Partners** and all **Family Members** must complete 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 located in the enrollment kit.

Benefit Duration	3 Years	6 Years	Unlimited Duration
Facility Benefit Amount **Per $1,000 Increments**	$2,000 to $6,000	$2,000 to $6,000	$2,000 to $6,000
Assisted Living Facility Percent	100%	100%	100%
Professional Home Care	100%	100%	100%
Non Forfeiture - **Option**	Shortened Benefit Period	Shortened Benefit Period	Shortened Benefit Period
Inflation Protection* - **Option**	Compound Uncapped	Compound Uncapped	Compound Uncapped

***** *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 $3,000 Facility Monthly Benefit Amount & 3 Year Duration, your Lifetime Maximum is calculated as follows, $3,000 per Month X 12 Months X 3 Years = $108,000 Lifetime Maximum.

Insurance Age: Insurance Age is used to determine the cost of your coverage. Insurance Age is your age on the plan effective date if you enroll for coverage prior to the plan effective date. If you enroll for coverage on or after the plan 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.

UNUM Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
(207) 575-2211

LONG TERM CARE INSURANCE POLICY
OUTLINE OF COVERAGE
FOR THE EMPLOYEES OF
COUNTY OF DANE A MUNICIPAL CORPORATION
(the Policyholder)
Policy Number **574655**

The Wisconsin Insurance Commissioner has established minimum standards for Long Term Care Insurance. The Policy meets those standards.

The Policy covers certain types of nursing home and home health care services. There may be limitations on the services covered. This Outline of Coverage provides a brief description of benefits. Read your Certificate carefully.

For more information on Long Term Care see the "Guide to Long-Term Care" given to you when you applied for coverage under the Policy.

The Policy's benefits are <u>not</u> related to Medicare.

1641-95

The Policy is intended to be a qualified Long Term Care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

In order to meet the requirements of a tax-qualified policy, the inability to perform two or more Activities of Daily Living due to functional incapacity must be expected to last for at least 90 days.

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 response to the questions in your application. A copy of your Application for Long Term Care Insurance was retained by you when you applied. If your answers are incorrect or untrue, UNUM 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 UNUM at this address: UNUM Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122.

NOTICE TO BUYER: This plan may not cover all of the costs associated with long term care which you may incur during the period of coverage. You are advised to review carefully all coverage limitations.

1. The policy is a group policy of insurance which was issued in **Wisconsin.**

2. **PURPOSE OF OUTLINE OF COVERAGE**
   This outline of coverage provides a very brief description of the important features of the plan. You should compare this outline of coverage to outlines of coverage for other plans available to you.

This is not an insurance contract, but only a summary of coverage. Only the Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both you and UNUM. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR CERTIFICATE CAREFULLY!**

3. TERMS UNDER WHICH THE GROUP COVERAGE THROUGH THE PLAN MAY BE CONTINUED IN FORCE OR DISCONTINUED

- **RENEWABILITY**
  THE POLICY IS GUARANTEED RENEWABLE. This means that you have the right, subject to the terms of the policy, to continue this coverage as long as you pay your premiums on time. 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.

- **WHEN COVERAGE WILL END**
  Your coverage will end on the earliest of these dates;
  - the date the Policy ends,
  - the date you are no longer an Active employee with the Policyholder,
  - the date you no longer work for the Policyholder,
  - the end of the period for which premiums were last paid to UNUM for your coverage,
  - the date your total benefit payments equal your Lifetime Maximum Amount, or
  - the date you die.

  If you are absent from work at the Policyholder for any reason, you will continue to be covered for group coverage if the Policyholder continues to pay premiums to UNUM.

- **CONTINUATION OF COVERAGE**
  If your group long term care coverage ends, for reasons other than your choice to have premium payments stopped for your coverage, you may elect continuation of coverage. This means 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 31 days of the date the group coverage would otherwise end. Any premium that applies must be paid directly to UNUM by you for any coverage to be continued.

- **WAIVER OF PREMIUM**
  When benefits become payable, there will be no more cost for your coverage as long as you continue to be eligible for a monthly benefit.

  If your plan includes Professional Home Care Services and you do not receive these services for a period of 30 consecutive days, premium payments will again become due.

  Premiums are <u>not waived</u> while you are receiving a payment for Respite Care.

- **RIGHT TO CHANGE PREMIUMS**
  The rate will not increase because you grow older or because of your use of the benefits. However, the rate schedule may change in the future depending on the overall use of the benefits of all covered persons or changes in the benefit levels, plan design or other risk factors. Any such change will be made on a class basis according to UNUM's underwriting risk studies under this type of insurance. Any premium rate increase after the initial 3 year period is guaranteed for at least 2 years after its effective date.

4. TERMS UNDER WHICH THE CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED

- You have a 30-day right to examine the certificate. If, after examining the certificate, you are not satisfied for any reason, you may withdraw your enrollment in the plan by returning your certificate within 30 days of its delivery to you. The certificate, together with a written request for withdrawal must be sent to the Plan Administrator. Upon receipt, your insurance will be deemed void from its effective date and any premium contribution(s) paid will be returned.
- Premiums for additional, increased or terminated insurance may cause a pro-rata adjustment on the next premium due.

5. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from UNUM. You may obtain a copy of the Guide by calling 1-800-227-4165. UNUM Life Insurance Company of America is not representing Medicare, the federal government or any state government

6. LONG TERM CARE COVERAGE

Plans of this category are designed to provide coverage for one or more diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital, such as a nursing home, in the community, or in the home.

This plan provides coverage in the form of a fixed dollar indemnity monthly benefit if you become Disabled, and are receiving care while confined in a Long Term Care Facility or Assisted Living Facility. We will pay a Home Care benefit if you elect to receive care other than in a Long Term Care Facility or Assisted Living Facility.

Coverage is subject to policy limitations, benefit maximums and elimination periods.

7. BENEFITS PROVIDED BY THE POLICY

REFER TO THE ATTACHED SUMMARY OF BENEFITS FOR THE BENEFITS AVAILABLE UNDER THE POLICYHOLDER'S PLAN.

You are eligible for a monthly benefit if, after the effective date of your coverage and while your coverage is in effect,:

- you suffer the loss of 2 or more ADLs; or
- you suffer Severe Cognitive Impairment; and;
- you are receiving services in a Long Term Care Facility or Assisted Living Facility; or Professional Home Care Services if your plan includes a Professional Home Care Services benefit; or Total Home Care if your plan includes a Total Home Care benefit;
- you have satisfied your Elimination Period; and
- a Physician has certified that you are unable to perform (without Substantial Assistance from another individual) two or more ADLs for a period of at least 90 days, or that you require Substantial Supervision by another individual to protect you and others from threats to health or safety due to Severe Cognitive Impairment. You will be required to submit a Physician certification every 12 months.

A monthly benefit will become payable once all of these requirements are met.

The treatment and services you receive for your Disability must be provided pursuant to a plan of care developed by a Licensed Health Care Practitioner.

After you satisfy the Elimination Period, we will pay you:

- the Long Term Care Facility Benefit Amount if you receive care while confined in a Long Term Care Facility. Your confinement must be because you are receiving care and need either: (1) Substantial Assistance from another person to perform 2 or more Activities of Daily Living (ADLs); or (2) Substantial Supervision because you suffer from Severe Cognitive Impairment, or
- the Assisted Living Facility Benefit Amount if you are Disabled and are receiving services in an Assisted Living Facility.

The Assisted Living Facility Benefit Amount will be the greater of:
(1) 60% of the Long Term Care Facility Benefit Amount; or
(2) the Total Home Care or Professional Home Care Services Benefit Amount shown on the SUMMARY OF BENEFITS.

Professional Home Care Services Benefit: We will pay you 1/30th of the Monthly Professional Home Care Services Benefit Amount for each day you receive Professional Home Care Services if:
a. you are Disabled and under the regular care of a licensed or certified professional; and
b. you choose to receive care anywhere other than in a Long Term Care Facility, or Assisted Living Facility.

This care can be provided at any type of facility, such as an adult day care facility, or your home by/through a licensed Home Health Care Provider.

OPTIONAL BENEFITS AVAILABLE

Nonforfeiture Benefit (Shortened Benefit Period)
If your coverage lapses due to nonpayment of premium after your coverage has been inforce for three years, you will be eligible for a Nonforfeiture Benefit. This means your coverage will continue inforce with the same level of benefits, except for a reduction in your Lifetime Maximum Amount.

Inflation Protection Provision - 5% Compound Inflation With No Cap
Your Monthly Benefit will increase each year on January 1st by 5% of the Monthly Benefit in effect on January 1st. Your remaining Lifetime Maximum Benefit Amount will also increase. Increases will be automatic and will occur regardless of your health and whether or not you are Disabled. Your premium will not increase due to automatic increases in your Monthly Benefit.

The benefit paid is subject to the Lifetime Maximum Benefit Amount. Benefits are not paid during the Elimination Period.

Refer to the graphic Comparison Chart of Inflation, located in Section 9 of this Outline of Coverage

IMPORTANT TERMS YOU SHOULD KNOW

"Activities of Daily Living" (ADLs) are:
- BATHING - washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower with or without equipment or adaptive devices.
- DRESSING - putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- TOILETING - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- TRANSFERRING - moving into or out of a bed, chair or wheelchair with or without equipment such as canes, quad canes, walkers, crutches or grab bars, or other supportive devices including mechanical or motorized devices.
- CONTINENCE - the ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- EATING - feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

“Adult Day Care” means a community-based program offering health, social and related support services to impaired adults. Adult Day Care can be provided by:
- a Home Health Care Provider; or
- an Adult Day Care Facility.

“Adult Day Care Facility” means a facility that operates under applicable state licensing laws and any other laws that apply, or meets the following tests:

- operates a minimum of 5 days a week;
- remains open for at least 6 hours a day;
- is not an overnight facility;
- maintains a written record of care on each patient;
- includes a plan of care and record of services provided;
- has a staff that includes a full-time director and at least one registered nurse who are there during operating hours for at least 4 hours a day;
- has established procedures for obtaining appropriate aid in the event of a medical emergency; and
- provides a range of physical and social support services to adults.

“Custodial Care” means the type of care that can be provided by persons without medical skills or extensive training to assist you in performing the Activities of Daily Living.

"Disability" and "Disabled" mean:

- you are unable to perform, without Substantial Assistance from another individual, at least two Activities of Daily Living; or
- you require Substantial Supervision by another individual to protect you from threats to health and safety due to Severe Cognitive Impairment.

“Elimination Period” is the number of **consecutive** days during which you must continue to be eligible for a monthly benefit before a benefit becomes payable. The Elimination Period must be satisfied **in full** before benefits become payable. Once the Elimination Period is satisfied **in full**, you will never have to satisfy it again in your lifetime.

“Intermediate Nursing Care” means basic care including physical, emotional, social and other restorative services under periodic medical supervision. This nursing care requires the skill of the registered nurse in administration, including observation and recording of reactions and symptoms, and supervision of nursing care.

“Lifetime Maximum Amount” is the maximum that UNUM will pay you for all long term care benefits. You have your own Lifetime Maximum.

"Professional Home Care Services" means:

- visits to your residence by a Home Health Care Provider to provide skilled nursing care; physical, respiratory, occupational, dietary or speech therapy; and homemaker services. Each one hour or more per day of a Home Health Care Provider's services will be considered one visit;
- Adult Day Care; or
- Hospice Care

The treatment and services you receive must be provided pursuant to a written plan of care developed by a Licensed Health Care Practitioner.

Professional Home Care Services do not include services performed by your spouse, daughter, son, parent, sister, brother, grandparent or grandchild through a Home Health Care Provider or an Adult Day Care Facility.

“Respite care” means care provided to you for a short period of time to allow your informal caregiver a break from their caregiving responsibilities. If you are eligible for a home care monthly benefit but benefits have not yet become payable, payments will be made to you for each day you receive Respite care for up to 15 days each calendar year. The amount of your payment will equal 1/30th of your home care monthly benefit for each day that you receive Respite care.

"Severe Cognitive Impairment" means a severe deterioration or loss in intellectual capacity, as reliably measured by clinical evidence and standardized tests in:

- short or long term memory;
- orientation to people, places or time; and
- deductive or abstract reasoning; or

"Skilled Nursing Care" means care furnished on a Physician's orders which requires the skills of professional personnel such as a registered or licensed practical nurse and is provided either directly by or under the supervision of these personnel.

"Substantial Assistance" means stand-by assistance by another person without which you would not be able to safely and completely perform the ADL.

"Substantial Supervision" means the presence of another individual for the purpose of protecting you from harming yourself or others.

8. LIMITATIONS AND EXCLUSIONS

UNUM will not make long term care payments to you for:

- a Disability caused by war (whether declared or not) or any act of war,
- a Disability caused by attempted suicide (while sane or insane) or self-destruction,
- a Disability caused by a commission of a crime for which you have been convicted under state or federal law or attempting to commit a crime under state or federal law,
- Disabilities or confinements during which you are outside of the United States, its territories or possessions for longer than 30 days,
- a Disability caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you by a Physician. ("Controlled substance" is defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments), or
- a period in which you are confined in a hospital other than if you are confined in a nursing facility that is a distinctly separate part of a hospital (this exclusion does not apply to those periods covered under the Bed Reservation benefit), or
- a Disability caused by psychological or psychiatric or mental conditions, regardless of cause, which include:
  - depression,
  - generalized anxiety disorders,
  - personality disorders,
  - schizophrenia,
  - manic depressive disorders, or
  - adjustment disorders and other conditions that are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or similar methods of treatment.

  However, UNUM will make payments to you for conditions that are not psychological, psychiatric or mental in nature, including Alzheimer's disease or similar forms of irreversible dementia.

Pre-Existing Conditions Exclusion

If you do not have to complete an Application for Long Term Care Insurance, which includes evidence of insurability, a pre-existing conditions exclusion may apply to you.

"Pre-Existing Condition" means any condition that exists for which medical advice was given or treatment was recommended by or received from a Physician within six months before the effective date of coverage.

UNUM will not make any payments to you for a Disability that is caused by, contributed to by, or results from a pre-existing condition, and begins during the first six months after your coverage begins.

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

9. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted.

- **COST**
  The premium rate paid for your coverage over the duration of your initial coverage or for any increases is based on your insurance age. To determine insurance age, subtract your date of birth from the date you are applying for initial coverage or for any increase in coverage.
- **ELECTION TO INCREASE COVERAGE**
  You can apply at any time to increase coverage by filling out a new Benefit Election Form and Application for Long Term Care Insurance which includes evidence of insurability.

INFLATION PROTECTION COMPARISON

The following chart is an example comparison of monthly benefits with and without the Compound Inflation Protection Option.

Policy Year	Without Inflation Protection Monthly Benefit	With 5% Uncapped Compound Inflation Protection Monthly Benefit
1	$2000.	$2100.
2	$2000.	$2205.
3	$2000.	$2315.
4	$2000.	$2431.
5	$2000.	$2553.
6	$2000.	$2680.
7	$2000.	$2814.
8	$2000.	$2955.
9	$2000.	$3103.
10	$2000.	$3258.
11	$2000.	$3421.
12	$2000.	$3592.
13	$2000.	$3771.
14	$2000.	$3960.
15	$2000.	$4158.
16	$2000.	$4366.
17	$2000.	$4584.
18	$2000.	$4813.
19	$2000.	$5054.
20	$2000.	$5307.

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

The policy provides coverage for 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 conditions which may cause Severe Cognitive Impairment are: Alzheimer's disease, multi-infarct dementia, brain injury, brain tumors, and other such structural alterations of the brain.

11. PREMIUM

The initial premium charges will be figured at the premium rates as shown on the attached pages. These charges will not be increased during the initial 3 years in which the policy is in force, unless the terms of the policy or certificateholder's plan of insurance are changed. UNUM may change the premium rates when the terms of the policy are changed.

12. RIGHT OF APPEAL

UNUM will notify you, in writing, if a claim or any part of a claim is denied. The denial letter will state:

- the specific reason(s) for the denial with reference to the applicable policy provision(s);
- a description of any additional material or information, if any, necessary to complete the claim; and
- an explanation of why the additional material is necessary.

If you are not satisfied with the reason for the denial, you or your representative may ask to have the claim reviewed by UNUM's Quality Review Section. The request must be in writing and may include any supporting material or information that may help UNUM to review the claim.

With proper authorization, you may request copies of the pertinent documents used for the claim review. In some cases, UNUM may request that you provide additional information to assist in the review.

Within 30 days after receipt of the request or after the date all the needed information has been received from you, UNUM will notify you or your representative of UNUM's determination, in writing. An explanation of the determination will also be provided.

13. ADDITIONAL FEATURES

- Medical underwriting may be required
- Eligibility and Participation
  You are eligible for the plan if you are:
  - an Active or Retired Employee of the Policyholder, Spouses/Domestic Partners and your Family Members.

IMPORTANT INSTRUCTIONS: Prior to submitting this form, all applicants must review the important disclosures and information found on www.unuminfo.com/countyofdane 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

COUNTY OF DANE
A MUNICIPAL CORPORATION
Benefit Election Form
Long Term Care - Policy #574655

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 __ __/__ __/__ __ __ __

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

☐ Employee	☐ Employee's Parent or Grandparent	☐ Sibling *(minimum age 18)*	☐ Retiree
☐ Employee's Spouse	☐ Spouse's / Domestic Partner's Parent or Grandparent	☐ Child *(minimum age 18)*	☐ Retiree's Spouse
☐ Employee's Domestic Partner			

Plans

(Check one)	☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 4**
	• Long Term Care Facility • 100% Professional Home Care	• Long Term Care Facility • 100% Professional Home Care • Non Forfeiture	• Long Term Care Facility • 100% Professional Home Care • Compound Inflation	• Long Term Care Facility • 100% Professional Home Care • Non Forfeiture • Compound Inflation

Facility Monthly Benefit Amount

(Check one)	☐ $2,000	☐ $3,000	☐ $4,000	☐ $5,000	☐ $6,000

Facility Benefit Duration ***(Duration of benefits may vary depending on where benefits are received)***

(Check one)	☐ 3 Years	☐ 6 Years	☐ **Unlimited Duration ***

*** EMPLOYEES: Selection of this option exceeds the Guarantee Issue limits and requires completion of 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. ALL Medical Questionnaires must accompany a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit.**
NOTE TO EMPLOYEES: **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 and sign Form #6720-03.**

Form is continued on reverse side.

REQUEST FOR SIGNATURE: Must check either accept or reject. Please read this entire form carefully before signing below.

NOTE: I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this insurance with and without the Uncapped Compound Growth Inflation Protection Option and I accept ☐ / reject ☐ this option.

Active Employee or Spouse/Domestic Partner: 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 acknowledge that you have received **the Potential Rate Increase Disclosure Form** and **Personal Worksheet. MA Residents ONLY: You also signify that you have received and read the MassHealth eligibility notice entitled "For Massachusetts Residents Only" -Form #7650-04.** This information is contained in your kit.

Your Premium: $_____ ***(Transfer the premium amount from the calculation on the rate sheet)***

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

Employees & Spouses/ Domestic Partners: Please sign and mail all required signature forms to your employer.
Domestic Partners must also complete and submit Form #1434-97 located in kit.
Family Members/Retirees: Please sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (M3)

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

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

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 Unum Life Insurance Company of America, 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: 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 : Multiple Sclerosis, Muscular Dystrophy, ALS (Lou Gehrig's Disease) or Parkinson's Disease?
E. ❑ Yes ❑ No	Have you been diagnosed and/or treated by a member of the medical profession for HIV+?
F. ❑ Yes ❑ No	Have you been diagnosed and/or treated by a member of the medical profession for AIDS?

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

II. Medical Profile

A. 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.
❑ 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 or are you scheduled to be 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 (mm/dd/yyyy)	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 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 long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract?) If yes —
Name of Company: _____ Policy Number: _____ Type and Amount of Benefits: _____

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. Acknowledgement

I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this insurance with and without the Inflation Protection option and I Accept ❑ / Reject ❑ this option.

I have received the Potential Rate Increase Disclosure Form and Personal Worksheet.

V. 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 Unum Life Insurance Company of America.

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: Unum Life Insurance Company of America 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 ARE INCORRECT OR UNTRUE, UNUM LIFE INSURANCE COMPANY OF AMERICA MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR INSURANCE.

Notice: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be prosecuted for insurance fraud.

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

_____
Signed at (City/State)

RETAIN A COMPLETED COPY FOR YOUR RECORDS

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, Unum Life Insurance Company of America, 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.

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

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

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 Unum Life Insurance Company of America, 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: 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 : Multiple Sclerosis, Muscular Dystrophy, ALS (Lou Gehrig's Disease) or Parkinson's Disease?
E. ❑ Yes ❑ No	Have you been diagnosed and/or treated by a member of the medical profession for HIV+?
F. ❑ Yes ❑ No	Have you been diagnosed and/or treated by a member of the medical profession for AIDS?

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

II. Medical Profile

A. 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.
❑ 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 or are you scheduled to be 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 (mm/dd/yyyy)	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 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 long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract?) If yes —
Name of Company: _____ Policy Number: _____ Type and Amount of Benefits: _____

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. Acknowledgement

I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this insurance with and without the Inflation Protection option and I Accept ❑ / Reject ❑ this option.

I have received the Potential Rate Increase Disclosure Form and Personal Worksheet.

V. 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 Unum Life Insurance Company of America.

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: Unum Life Insurance Company of America 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 ARE INCORRECT OR UNTRUE, UNUM LIFE INSURANCE COMPANY OF AMERICA MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR INSURANCE.

Notice: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be prosecuted for insurance fraud.

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

_____
Signed at (City/State)

RETAIN A COMPLETED COPY FOR YOUR RECORDS

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, Unum Life Insurance Company of America, 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.

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

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

DOMESTIC PARTNER STATEMENT

We, _____ and _____, for the purpose of establishing Domestic Partner status under Long Term Care Policy No. _____ issued by Unum Life Insurance Company of America ("Unum") to _____ (Policyholder Name), attest and agree as follows:

1. We each attest that we are Domestic Partners, with a close and personal relationship with one another, as evidenced by the following facts:

A. We are responsible for our joint financial and common welfare and intend to remain so indefinitely;

B. We have resided together continuously for at least twelve (12) months before the date of this statement, are living together now and intend to do so indefinitely;

C. We are each at least eighteen (18) years of age and competent to contract;

D. Neither of us are married to anyone else; and

E. Neither of us has signed a Domestic Partner Statement as partner of anyone else during the twelve (12) months prior to the date of this statement;

F. Not be related to one another by blood, closer than would bar marriage.

2. We understand that:

A. Documentation or other proof of our Domestic Partner status may be required by Unum;

B. The final determination of Domestic Partner status is made by Unum, which is relying on this certification and any other submitted documentation or proof;

3. In the event of a change in Domestic Partner status as attested herein (for example, a change in joint residence or if we are no longer each other's sole domestic partner);

A. We each agree to notify Unum and _____ (Policyholder Name) in writing of the change in our status within thirty-one (31) days of such change;

B. We each agree to mail a copy of this written notice to the other party; and

How to enroll

C. We understand that for a period of twelve (12) months following termination of our Domestic Partner Status:

I. Neither of us can file another Domestic Partner Statement with _____ (Policyholder Name) or Unum;

ii. No other person will be eligible under the Policy as a Domestic Partner of the Employee;

WE HAVE PROVIDED THE INFORMATION IN THE DOMESTIC PARTNER STATEMENT TO _____ (POLICYHOLDER NAME) AND Unum Life Insurance Company of America FOR THE SOLE PURPOSE OF ESTABLISHING ELIGIBILITY UNDER THE POLICY AS DOMESTIC PARTNERS.

WE HEREBY AFFIRM THAT THE ASSERTIONS IN THIS STATEMENT ARE TRUE TO THE BEST OF OUR KNOWLEDGE.

_____ _____

Date Employee Signature

_____ - ____ - _____

Social Security Number

Street Address:_____

City:_____

State:_____ Zip Code:_____

_____ _____

Date Named Domestic Partner Signature

_____ - ____ - _____

Social Security Number

Street Address:_____

City:_____

State:_____ Zip Code:_____

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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS NURSING HOME OR LONG-TERM CARE INSURANCE

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

Do you intend to lapse or otherwise terminate existing accident and sickness, nursing home or long term care insurance and replace it with group long term care insurance to be issued by Unum Life Insurance Company of America? If so, you should review this new coverage carefully, comparing it with all accident and sickness, nursing home 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. State law provides that your replacement coverage may not contain new pre-existing conditions or waiting periods. Your insurer will waive any time periods applicable to pre-existing conditions or waiting periods in the new coverage for similar benefits to the extent such time was spent (depleted) under the original coverage.

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

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
(207) 575-2211

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
Unum Life Insurance Company of America
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 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.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
(207) 575-2211

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: _____

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

LONG TERM CARE INSURANCE PERSONAL WORKSHEET

Applicant Name: _____
Social Security Number: _____
Group Policy Number: _____

People buy long term care insurance for many reasons. Some don't want to use their own assets to pay for long term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. However, long term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this long term care insurance coverage.

Premium Information

The premium for the coverage you are considering will be $ _____ per month, or $ _____ per year.

Type of Policy - guaranteed renewable.

The Company's Right to Increase Premiums: The company has the right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History: [Unum Life Insurance Company of America has sold long term care insurance since 1988; the B.LTC policy series has been sold since 1990, the GLTC95 policy series has been sold since 1997 and the GLTC04 policy has been sold since 2005. The company has not raised its rates on these or similar policy forms in the last ten years.]

Questions Related to Your Income

How will you pay each year's premium? (check one)
❒ From My Income ❒ From My Savings/Investments ❒ My Family Will Pay

Have you considered whether you could afford to keep this coverage if the premiums went up, for example, by 20%?

What is your annual income? (check one) ❒ Under $20,000 ❒ $20-29,999 ❒ $30-50,000 ❒ Over $50,000

How do you expect your income to change over the next 10 years? ❒ No change ❒ Increase ❒ Decrease

If you will be paying premiums with money received only from your income, a rule of thumb is that you may not be able to afford this coverage if the premiums will be more than 7% of your income.

Will you buy inflation protection? * ❒ Yes ❒ No
* Please refer to your enrollment form to determine if inflation protection is available.

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? ❒ My Income ❒ My Savings/Investments ❒ My Family Will Pay

The national average annual cost of care in a nursing home in [2006] was close to [$74,460] [1]*, but this figure varies across the country. In ten years the national average cost would be about [$115,512] if cost increase 5% annually.*

Please consider your elimination period. The elimination period is selected by the policyholder. Refer to your enrollment form to determine what the elimination period is.
Number of days: _____ Approximate cost $_____ for that period of care.

[1 "Using Medicaid to Pay for Nursing Home Care: County Differences Emerge." Agency for Health Care Research and Quality News Release, April, 2009]

Long Term Care Personal Worksheet - Continued
Questions Related to Your Savings and Investments

How are you planning to pay for your care during the elimination period?
❒ From My Income ❒ From My Savings/Investments ❒ My Family Will Pay

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one) ❒ Under $20,000 ❒ $20-29,999 ❒ $30-50,000 ❒ Over $50,000

How do you expect your assets to change over the next ten years? (check one)
❒ No change ❒ Increase ❒ Decrease

If you are buying this coverage to protect your assets and your assets are less then $30,000, you may wish to consider other options for financing your long term care.

In order for us to process your application, if applicable, and enrollment form, please sign and return this form to Unum Life Insurance Company of America. We may contact you to verify your answers. Employees and their spouses need not sign and return this form to us.

Disclosure Statement

Please check one

❒ The answers to the questions above describe my financial situation.
OR
❒ I choose not to complete this information. I have reviewed and signed the **Verification of Non-Disclosure of Financial Information** below.

This box must be checked

❒ I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history, and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**

Signature of Applicant: _____ Date: _____

Applicant's Printed Name: _____ Social Security No. _____

Group Policy Number (if available): _____

Name of Employer (complete if applying through Employer offer): _____
_____

Verification of Non-Disclosure of Financial Information

Complete if applicable

❒ Yes. I choose not to provide any financial information. I wish to purchase this coverage. Please resume review of my application.

❒ No. I have decided not to buy long term care insurance coverage at this time.

Signature of Applicant: _____ Date: _____

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

Long Term Care Insurance
Potential Rate Increase Disclosure Form

This form provides information to the applicant regarding premium rates, rate adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Premium Rates

The premium rate that is applicable to you and that will be in effect until we make and file a request for an increase is on the application. The premium rate for this policy is also shown on the schedule page of your policy.

Premium Adjustments

Any change in premium will be effective on your Policy Anniversary Date. We will send you written notice at least 60 days in advance.

Potential Rate Revisions

This policy is Guaranteed Renewable. This means that the rates for this policy may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours. If you receive a premium rate increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your non-forfeiture option if purchased. (This option is available for purchase for an additional premium.
- Exercise your contingent non-forfeiture rights.* (This option may be available if you do not purchase a separate non-forfeiture option).

*Contingent Non-Forfeiture

If the premium rate for your policy goes up in the future and you didn't buy a non-forfeiture option, you may be eligible for contingent non-forfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

(a) Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
(b) You lapse (not pay more premiums) within 120 days of the increase;

The amount of coverage (i.e. new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you have paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you have paid, the amount of coverage will be that remaining amount. Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter. Should you choose this Contingent Non-Forfeiture option your policy with this reduced maximum benefit amount will be considered paid up with no further premiums due.

Example: You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium. In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums). Your paid-up policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy).

State forms to review

Contingent Non-Forfeiture

Cumulative Premium Increase over Initial Premium that qualifies for Contingent Non-Forfeiture.
Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

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

Things You Should Know Before You Buy Long Term Care Insurance

Long Term Care Insurance	• A long term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it. • You should not buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future. • The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
Medicare	• Medicare does not pay for most of long term care.
Medicaid	• Medicaid will generally pay for long term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid. • Many people become eligible for Medicaid after they have used up their own financial resources by paying for long term care services. • When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance and some of your joint assets. • Your choice of long term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local and state Medicaid agency.
Shopper's Guide	• Make sure the insurance company or agent gives you a copy of a booklet called the "Guide to Long Term Care." Read it carefully. If you have decided to apply for long term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
Counseling	• Free counseling and additional information about long term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.
Facilities	• Some long term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long term care policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

State forms to review

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

FOR MASSACHUSETTS RESIDENTS ONLY

Re: Long-Term Care Insurance Policies Issued in Massachusetts that are Intended to Qualify Insureds for Certain MassHealth Exemptions

The purpose of this notice is to describe the minimum coverage requirements needed to potentially qualify for exemptions from some MassHealth eligibility and recovery rules. Information about these coverage requirements is also available in the publication *Your Options for the Financing of Long-Term Care: A Massachusetts Guide.* The Commissioner of Insurance has instructed all long-term care insurance carriers to provide this notice to clarify the coverage requirements associated with MassHealth exemptions.

Buying long-term care insurance in Massachusetts that meets certain standards may qualify the insured for exemptions from some of the eligibility and recovery rules under the Massachusetts MassHealth (Medicaid) Program. **It is important to note that MassHealth minimum coverage requirements are based upon benefits available as of the day the individual enters a nursing home, not what is available on the day the person buys a policy**.

One of the existing requirements to qualify for MassHealth exemptions is that an individual's long-term care insurance must have benefits available to pay at least $125 per day for at least 730 days (2 years) of nursing home care as of the day the individual enters a nursing home.

Although a long-term care insurance policy may satisfy the MassHealth minimum coverage requirements at the time it is purchased, if the insured uses the policy to pay for non-nursing home benefits (e.g., home health care, personal care or assisted living benefits), the amount of benefits available to pay for nursing home care may be reduced. Depending upon the original maximum benefit and other benefits that may have been used, the policy may not meet the MassHealth minimum coverage requirements as of the day the individual enters a nursing home.

For example: a person purchased a policy with 730 days of nursing home and home health care coverage and, prior to entering the nursing home, used 100 days of coverage to pay for home health care services. On the day the individual enters the nursing home, the person would have 630 days of coverage left to pay for nursing home care. This is less than the minimum 730 days of nursing home coverage required for certain MassHealth exemptions.

It should also be noted that a long-term care policy with an inflation protection benefit may ultimately satisfy the MassHealth minimum coverage requirements, even if the policy failed to meet the MassHealth minimum coverage requirements on the day it was purchased. For example, a policy that initially had a $100 per day benefit with an annual inflation adjustment could potentially increase over time to meet the MassHealth minimum coverage requirements as of the day the person enters a nursing home.

Qualifying for insurance benefits is independent from qualifying for an exemption under MassHealth. For more information, contact your agent or read *Your Options for Financing Long-Term Care: A Massachusetts Guide*.

Please be aware that laws may change and the exemptions and the MassHealth minimum coverage requirements that exist today may not necessarily be the same in the future (or might not exist at all).

State forms to review

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 Supplement insurance provides benefits for most long term 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

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

(For long term care policies providing nursing home only coverage)

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

- This insurance provides benefits primarily for covered nursing home services.
- In some situations Medicare pays for short periods of skilled nursing home care 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 Supplement insurance provides benefits for most nursing home 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, 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.