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

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
Benefit Election Form
Long Term Care - Policy #510487

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 # ( )

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 __ __/__ __/__ __ __ __

Division (check one): ☐ **State Central Payroll** ☐ **All Others**

Applicant Is:

☐ Employee	☐ Retiree
☐ Employee's Spouse	☐ Retiree's Spouse

You may choose any of the plans listed below. The Long Term Care Application (medical questionnaire), the Benefit Election form and a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit, must be completed and you must be approved for coverage in order to enroll in the Long Term Care plan.

Plans *(Check one)*

☐ **Plan 1A**
- Nursing Home Facility / $3,000 Monthly Benefit
- Professional Home Care

☐ **Plan 2A**
- Nursing Home Facility / $3,000 Monthly Benefit
- Professional Home Care
- Total Home Care

☐ **Plan 3A**
- Nursing Home Facility / $3,000 Monthly Benefit
- Professional Home Care
- Simple Inflation

☐ **Plan 4A**
- Nursing Home Facility / $3,000 Monthly Benefit
- Professional Home Care
- Total Home Care
- Simple Inflation

☐ **Plan 1B**
- Nursing Home Facility / $3,000 Monthly Benefit
- Paid Up Benefit
- Professional Home Care

☐ **Plan 2B**
- Nursing Home Facility / $3,000 Monthly Benefit
- Paid Up Benefit
- Professional Home Care
- Total Home Care

☐ **Plan 3B**
- Nursing Home Facility / $3,000 Monthly Benefit
- Paid Up Benefit
- Professional Home Care
- Simple Inflation

☐ **Plan 4B**
- Nursing Home Facility / $3,000 Monthly Benefit
- Paid Up Benefit
- Professional Home Care
- Total Home Care
- Simple Inflation

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

(Check one)	☐ 3 Years	☐ 5 Years

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

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. **MA Residents ONLY: You also signify that you have received and read the MassHealth eligibility notice entitled "For Massachusetts Residents Only"- Form #7650-04.** All 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: Please sign and mail all required signature forms to your employer.
Retirees: Please sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (A1)

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