Unum Life Insurance Company of America
Mail to: Long Term Care Operations
2211 Congress Street
Portland, Maine 04122
Phone: 1-800-227-4165
Fax: 1-207-541-7606

Instruction Page For Election To Continue Your Long Term Care Insurance

If you are an insured employee, spouse, domestic partner or former spouse or domestic partner, you may be eligible to continue your long term care insurance coverage after your group coverage terminates. If you wish to continue your coverage, please complete this form and return it to Unum at the address provided above.

This form must be completed and returned within the time period specified in your Long Term Care Certificate. You will be responsible for the entire cost of your coverage.

1. Please read all instructions before completing this form. **Please print legibly.**

2. If you are the employee, please complete **Section 2**. All applicable sections must be completed, signed and dated and you must return the **Protection Against Unintentional Lapse Form.**

3. If your Spouse or Domestic Partner is insured on your Group Long Term Care policy, he or she must complete **Section 3** if he or she wishes to continue Long Term Care coverage. All applicable sections must be completed, signed and dated and you must return the **Protection Against Unintentional Lapse Form.**

4. If you do not select a payment option, Unum will default to quarterly paper billing.

5. If you have chosen monthly billing via checking account you **must** complete, sign and date the **Authorization for Automatic Payment Form** and include a **voided check. If you do not complete this form Unum will default to a quarterly paper bill until this form is received.** *If you elect paper billing, please do not include payment at this time. Unum will send you an initial invoice.

6. If you have any questions concerning these forms please call 1-800-227-4165. Our Customer Contact Center is available Monday-Friday 8:00 am to 8:00 pm EST to assist you.

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ELECTION TO CONTINUE YOUR LONG TERM CARE INSURANCE COVERAGE

SECTION 1 - EMPLOYER SECTION

Policy Number ☐☐☐☐☐☐ Company Name:_____

Company Address:_____
Street City State/Zip

Person Terminating Group Coverage: ☐ Employee ☐ Spouse or Domestic Partner (if applicable)

Employee Name:_____

Employee Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Termination Reason:
☐ Termination of employment ☐ Divorce ☐ Death of Spouse or Domestic Partner
☐ Other _____

Termination Date: ☐☐ / ☐☐ / ☐☐☐☐
(MM) (DD) (YEAR)

Current Monthly Premium Payment: Employee $_____.____/month Spouse $_____.____/month

SIGNATURE OF EMPLOYER: _____ **TODAY'S DATE** _____
(MM/DD/YEAR)

SECTION 2: EMPLOYEE - ALL FIELDS MUST BE COMPLETED, SIGNED AND DATED

Policy Number ☐☐☐☐☐☐ Employee Name:_____

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Mailing Address:_____
Street City State/Zip

Email Address: _____

☐ Male ☐ Female Phone/Cell Number _____

Payment Options:
(Select only one Mode) Note: If a payment option is not selected, Unum will default to Quarterly Billing.

☐ Monthly Automatic Payment (ACH) First of Every Month via Checking Account *if selected, you must complete form 7713-04.

☐ Quarterly Paper Bill (Monthly Premium X 3)

☐ Semi-Annual Paper Bill (Monthly Premium X 6)

☐ Annual Paper Bill (Monthly Premium X 12)

SIGNATURE OF EMPLOYEE: _____ **TODAY'S DATE** _____
(MM/DD/YEAR)

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

Unum Life Insurance Company of America
Long Term Care Operations
2211 Congress Street
Portland, Maine 04122

ELECTION TO CONTINUE YOUR LONG TERM CARE INSURANCE COVERAGE

Policy Number ☐☐☐☐☐☐

SECTION 3 - SPOUSE OR DOMESTIC PARTNER (IF APPLICABLE) - ALL FIELDS MUST BE COMPLETED, SIGNED AND DATED

☐ **Check here if you do not wish to continue your Long Term Care Coverage, Sign and date below.**

Name:_____

Mailing Address:_____
Street City State/Zip

Email Address: _____

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

☐ Male ☐ Female Phone/Cell Number _____

Payment Options (Complete if only the spouse is electing coverage.):
(Select only one Mode) Note: If a payment option is not selected,Unum will default to Quarterly Billing.

☐ Monthly Automatic Payment (ACH) First of Every Month via Checking Account

☐ Quarterly Paper Bill (Monthly Premium X 3)

☐ Semi-Annual Paper Bill (Monthly Premium X 6)

☐ Annual Paper Bill (Monthly Premium X 12)

SIGNATURE OF EMPLOYEE'S SPOUSE OR DOMESTIC PARTNER: _____

TODAY'S DATE _____
(MM/DD/YEAR)

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

Information About Continuing Your Long Term Care Insurance Coverage

Should The Certificate Of Coverage Be Kept?
If you elect to continue your long term care coverage, you should keep your Certificate of Coverage that was issued to you under the group plan. You will not receive a new Certificate of Coverage.

Can Coverage Be Changed?
You may apply at any time to increase coverage by filling out a Benefit Election Form and Evidence of Insurability. Call Unum at (800) 227-4165 for assistance.

Where Should Premium Payments Be Sent?
You must remit all premium payments directly to Unum. The address is:
Unum Life Insurance Company of America
P.O. Box 406933
Atlanta, Georgia 30384-6933

Your Certificate of Coverage sets forth in detail the rights and obligations of both you and the insurer. Please refer to your Certificate for more information including the number of days in your grace period, how long Unum will continue to pay for long term care benefits and when your coverage will terminate.

Authorization and Agreement for Monthly Automatic Payments

Drawn By and Payable To: Unum Life Insurance Company of America
(Hereinafter referred to as "the Company")

Please Print

Policy Number	Insured's Name: Last, First, Middle Initial	Social Security Number
_____	_____	_____

1. Check all that apply:

☐ New authorized payment request ☐ Change in bank ☐ Change in account number

2.

Tape Voided Check Here

If you do not use checks, have starter checks, or you are providing savings account information, you will need to include a letter from your bank reflecting routing transit and account numbers.

3. Please sign and date. I authorize the above named bank to pay and charge my account monthly debit entries for the above insured, including checks, drafts and other orders by electronic or paper means, made by and payable to the Company. Your signature confirms that you have read and agree to the terms and conditions that are reflected on the reverse side of this form.

➧ _____ ➧ _____

Signature of Account Holder **Date of Signature**

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL
Please retain a copy of this form for your records

Terms and Conditions

I (premium payor whose signature appears on the previous 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 previous 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. Payments are typically drawn on the 1st of the month.

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 the Company.

   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.

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.

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/P.O. Box: _____City, State, Zip Code:_____

Name: _____

Address: Street/P.O. 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:
Customer Service/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.

Please retain a copy of this form for your records

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: _____

Please retain a copy of this form for your records