



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

OREGON PUBLIC EMPLOYEES RETIREMENT SYSTEM

Benefit Election Form

Long Term Care - Policy #025757(NEW)

Applicant's Name: (Last Name, First, Middle Initial)		Social Security Number		Date of Birth (MM/DD/YYYY)	
Street Address		Home Telephone # ()		Work Telephone # ()	
City, State, Zip Code			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
PERS Retiree Name	Retiree Social Security No. - - - - -	Retiree Date of Birth / /	PERS Retirement Date / /		
Applicant Is: (This Benefit Election Form must be completed for any selection)					
<input type="checkbox"/> Retiree		<input type="checkbox"/> Retiree's Spouse		<input type="checkbox"/> Eligible Dependents	

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)	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4			
	<ul style="list-style-type: none"> • Long Term Care Facility • Return of Premium • Professional Home Care 	<ul style="list-style-type: none"> • Long Term Care Facility • Return of Premium • Professional Home Care • Total Home Care 	<ul style="list-style-type: none"> • Long Term Care Facility • Return of Premium • Professional Home Care • Simple Inflation 	<ul style="list-style-type: none"> • Long Term Care Facility • Return of Premium • Professional Home Care • Total Home Care • Simple Inflation 			
Facility Monthly Benefit Amount							
(Check one)	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$6,000	<input type="checkbox"/> \$7,000 <input type="checkbox"/> \$8,000
Facility Benefit Duration (Duration of benefits may vary depending on where benefits are received.)							
(Check one)	<input type="checkbox"/> 3 Years		<input type="checkbox"/> 6 Years		<input type="checkbox"/> Unlimited Duration		

Calculate your Premium:

_____	X	_____	÷	\$1,000	=	_____
Your Rate for plan chosen		Facility Monthly Benefit Amount				Your Premium

Retirees and all other eligible Dependents will be billed directly by the insurance company. There will be a \$3.25 fee for each bill mailed.

How would you like to be billed? 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.

Applicant's Signature

_____/_____/_____
Date

All Applicants: Please sign and mail all required signature forms to Unum (address at top of page). Retain a copy for your records. (Q4)

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