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 information you need to understand the long term care (LTC) insurance coverage the employer is offering through Unum including detailed plan information. Be sure to review this information before enrolling.

How to enroll in the plan

Review the Benefit Election Form, Rates, Long Term Care Insurance Applications (medical questionnaire), replacement forms, and other forms that require a signature. Refer to the grid below to determine which forms you need to complete.

	Employee*	Spouse	Other family members	Retired employee & spouse
Benefit Election Form	✔	✔	✔	✔
Long Term Care Application (medical questions)	✔ *	✔	✔	✔
Protection Against Unintentional Lapse			✔	✔
Authorization & Agreement for Automatic Payment			✔ †	✔ †
Personal Worksheet			✔	✔

* 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.

† This form is only required if you wish to have your payment automatically deducted from your checking account.

State forms to review

Please be sure to review all other forms. The state where the group policy was issued requires that this information be included for all consumers.

To review the Shopper's Guide to Long Term Care or the Guide to Health Insurance for People with Medicare, visit http://w3.unum.com/enroll/booklets. To obtain a paper copy of either of these booklets please contact us at the number below.

Call 1-800-227-4165 if you have any questions or need additional forms.

AE-1217 (01/16)

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.

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.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form GLTC04 or contact your Unum representative.

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

unum.com

AMERISAFE, INC.

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 $4,000 and a Facility Benefit Duration of 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 $5,000 or $6,000 coverage. All **Family Members** must complete the Long Term Care Insurance Application (medical questionnaire) and you 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	6 Years
Facility Benefit Amount **Per $1,000 Increments**	$1,000 to $6,000
Assisted Living Facility Percent	60%
Professional Home Care	50%
Non Forfeiture **- Option**	Shortened Benefit Period
Inflation Protection **- Option**	Compound Uncapped

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 & 6 Year Duration, your Lifetime Maximum is calculated as follows, $3,000 per Month X 12 Months X 6 Years = $216,000 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
OUTLINE OF COVERAGE

FOR THE EMPLOYEES OF
AMERISAFE, INC.
(the Policyholder)

Group Master Policy/Certificate Form Number **554197**

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 **Louisiana.**

2. PURPOSE OF OUTLINE OF COVERAGE

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

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

- **RENEWABILITY**

THE POLICY IS GUARANTEED RENEWABLE. This means 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.

- **CONVERTED 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 converted coverage. This means that 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 converted coverage.

  Election for converted 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 converted coverage to be continued.

- **PREMIUM WAIVER**

  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.

5. 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 or UNUM. 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 date.

6. 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.

7. LONG TERM CARE COVERAGE

Plans of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital, such as in 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 you are receiving care while confined in a Long Term Care Facility or Assisted Living Facility. If you purchase Total Home Care or Professional Home Care Services coverage, we will pay you a 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.

8. BENEFITS PROVIDED BY THE POLICY

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

The Schedule of Benefits is attached.

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 written plan of care developed by a Licensed Health Care Practitioner.

If you have an existing loss of ADLs or Severe Cognitive Impairment on your effective date of coverage, that loss or impairment will only be eligible for coverage if you recover from that loss or impairment. We must receive acceptable proof of your ADL or cognitive recovery, such as a physician's statement or an assessment.

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 Schedule of Benefits if Home Care is purchased.

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
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 Amount will increase each year on January 1st by 5% of the Monthly Benefit in effect on that 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 Amount.

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 all types of Inflation, located in Section 10 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 and out of a bed, chair or wheelchair with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support 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 program for six or more individuals, of social and health-related services, provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

"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.

"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, specific to your plan, that you must wait before receiving benefits. The plan's Elimination Period begins once you lose 2 or more Activities of Daily Living or suffer Cognitive Impairment and are receiving care at the level of care in your plan.

For example, if your plan has an Elimination Period of 90 days and Facility care, you must suffer the loss and be receiving care in a Facility for those 90 consecutive days before you will be eligible for benefits.

The Elimination Period needs to be satisfied only once in your lifetime.

"Lifetime Maximum Benefit Amount" is the total dollar amount of benefits that will be paid under the policy. Your Lifetime Maximum Amount is based on the level of coverage and benefit duration you select.

"Respite Care" means formal 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.

"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.

9. 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 the United States, its territories or possessions for longer than 30 days,
- a Disability caused by alcoholism or alcohol abuse,
- 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),
- 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:
  - neurosis,
  - psychoneurosis,
  - psychopathy,
  - psychosis, or
  - mental or emotional disease or disorder.

  However, the Policy does cover losses from conditions that are physical in nature, such as Parkinson's disease, Alzheimer's disease, multi-infarct dementia, brain injury, brain tumors, or other conditions not listed above, involving structural alterations of the brain.

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 you received medical treatment, consultation, care or services, including diagnostic measures for the condition, or took drugs or medicines that were prescribed for the condition, during the six month period right before your coverage began.

UNUM will not make any Monthly Benefit payments to you if your eligibility for the Monthly Benefit is based on Severe Cognitive Impairment or the loss of an ADL that is caused by, contributed to by, or results from a pre-existing condition, and is present during the first six months after your coverage begins.

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

10. 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.

- **ELECTION TO INCREASE COVERAGE**

  You can apply at any time to increase coverage by filling out a new Benefit Election Form and a Long Term Care/Evidence of Insurability Application.

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.

11. 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.

12. PREMIUM

The initial premium charges will be figured at the premium rates as shown on the attached pages. UNUM may change the premium rates when the terms of the policy are changed.

13. ADDITIONAL FEATURES

- Medical underwriting may be required
- Eligibility and Participation
  You are eligible for the plan if you are:
  - an Active Employee of the Policyholder and your Family Members.

14. Senior insurance counseling, senior citizen seminars and other information are available through the **Senior Health Insurance Information Program.** Call with questions to **1-800-59-5301** or the **Louisiana Division of Insurance (504)342-5900**

IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found 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

AMERISAFE, INC.

Benefit Election Form

Long Term Care - Policy # 554197

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)*
☐ Employee's Spouse	☐ Spouse's Parent or Grandparent	☐ Child *(minimum age 18)*

Plans

(Check one)

☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 4**
• Long Term Care Facility • Professional Home Care	• Long Term Care Facility • Professional Home Care • Non Forfeiture	• Long Term Care Facility • Professional Home Care • Compound Inflation	• Long Term Care Facility • Professional Home Care • Non Forfeiture • Compound Inflation

Facility Monthly Benefit Amount

(Check one)

☐ $1,000	☐ $2,000	☐ $3,000	☐ $4,000	☐ **$5,000 ***	☐ **$6,000 ***

Facility Benefit Duration is 6 Years ***(Duration of benefits may vary depending on where benefits are received)***

*** 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 signed Form #6720-03.

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.

All other eligible Family Members: 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 also acknowledge that you have received the **Potential Rate Increase Disclosure Form** and **Personal Worksheet.** 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.
Family Members: Please sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (G6)

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

RATE SHEET
AMERISAFE, INC.

BASE PLAN		***OPTIONS***	
Facility Monthly Benefit	**$1,000**	**Non Forfeiture**	**SHORTENED BENEFIT PERIOD**
Home Monthly Benefit	**$500**	**Inflation Protection**	**COMPOUND UNCAPPED**
Facility Benefit Duration	**6 YEARS**		
Home Benefit	**50%**		
Lifetime Maximum	**$72,000**		
Elimination Period	**90 DAYS**		
Home Care Level	**PROFESSIONAL**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

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

*Semi-Monthly Rates **

	PLAN 1	PLAN 2	PLAN 3	PLAN 4
INSURANCE AGE	BASE PLAN	BASE PLAN WITH NON FORFEITURE OPTION	BASE PLAN WITH COMPOUND INFLAT OPTION	BASE PLAN WITH NON FORFEITURE COMPOUND INFLAT OPTION
18-30	1.50	1.80	4.80	5.80
31	1.55	1.90	4.95	6.00
32	1.55	1.90	5.05	6.10
33	1.60	1.95	5.20	6.30
34	1.65	2.00	5.30	6.45
35	1.70	2.10	5.50	6.65
36	1.75	2.15	5.60	6.80
37	1.85	2.25	5.80	7.00
38	1.90	2.30	6.00	7.25
39	2.00	2.40	6.15	7.35
40	2.05	2.50	6.30	7.55
41	2.15	2.55	6.45	7.75
42	2.25	2.70	6.70	7.95
43	2.35	2.80	6.90	8.20
44	2.50	2.95	7.15	8.50
45	2.65	3.10	7.35	8.70
46	2.75	3.25	7.60	8.95
47	2.90	3.40	7.75	9.15
48	3.05	3.55	8.00	9.40
49	3.15	3.70	8.25	9.65
50	3.30	3.90	8.45	9.90
51	3.50	4.10	8.75	10.25
52	3.70	4.35	9.10	10.60
53	3.95	4.55	9.35	10.85
54	4.15	4.80	9.70	11.25
55	4.45	5.15	10.10	11.75
56	4.70	5.45	10.50	12.20
57	5.05	5.85	11.00	12.75
58	5.40	6.25	11.55	13.40
59	5.80	6.70	12.05	14.00

*** Final premiums may vary due to rounding**

RATE SHEET
AMERISAFE, INC.

BASE PLAN		***OPTIONS***	
Facility Monthly Benefit	**$1,000**	**Non Forfeiture**	**SHORTENED BENEFIT PERIOD**
Home Monthly Benefit	**$500**	**Inflation Protection**	**COMPOUND UNCAPPED**
Facility Benefit Duration	**6 YEARS**		
Home Benefit	**50%**		
Lifetime Maximum	**$72,000**		
Elimination Period	**90 DAYS**		
Home Care Level	**PROFESSIONAL**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Your Rate for plan chosen | Facility Monthly Benefit Amount | Your Premium

*Semi-Monthly Rates **

	PLAN 1	PLAN 2	PLAN 3	PLAN 4
INSURANCE AGE	BASE PLAN	BASE PLAN WITH NON FORFEITURE OPTION	BASE PLAN WITH COMPOUND INFLAT OPTION	BASE PLAN WITH NON FORFEITURE COMPOUND INFLAT OPTION
60	6.20	7.20	12.60	14.60
61	6.80	7.90	13.55	15.70
62	7.45	8.55	14.55	16.75
63	8.15	9.40	15.50	17.85
64	8.95	10.30	16.70	19.20
65	10.15	11.65	18.50	21.30
66	11.25	12.80	20.00	22.80
67	12.45	14.20	21.80	24.85
68	13.80	15.70	23.45	26.75
69	15.25	17.35	25.35	28.90
70	16.85	19.20	27.30	31.15
71	18.70	21.15	29.85	33.75
72	20.70	23.40	32.45	36.65
73	22.90	25.65	35.05	39.25
74	25.30	28.35	38.00	42.55
75	30.45	33.80	44.80	49.75
76	33.45	37.10	48.60	53.95
77	36.65	40.35	52.30	57.50
78	40.20	44.20	56.50	62.15
79	44.05	48.45	60.70	66.75
80	48.30	53.15	65.65	72.25

*** Final premiums may vary due to rounding**

RATE SHEET
AMERISAFE, INC.

BASE PLAN		***OPTIONS***	
Facility Monthly Benefit	**$1,000**	**Non Forfeiture**	**SHORTENED BENEFIT PERIOD**
Home Monthly Benefit	**$500**	**Inflation Protection**	**COMPOUND UNCAPPED**
Facility Benefit Duration	**6 YEARS**		
Home Benefit	**50%**		
Lifetime Maximum	**$72,000**		
Elimination Period	**90 DAYS**		
Home Care Level	**PROFESSIONAL**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Your Rate for plan chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

	PLAN 1	PLAN 2	PLAN 3	PLAN 4
INSURANCE AGE	BASE PLAN	BASE PLAN WITH NON FORFEITURE OPTION	BASE PLAN WITH COMPOUND INFLAT OPTION	BASE PLAN WITH NON FORFEITURE COMPOUND INFLAT OPTION
18-30	3.00	3.60	9.60	11.60
31	3.10	3.80	9.90	12.00
32	3.10	3.80	10.10	12.20
33	3.20	3.90	10.40	12.60
34	3.30	4.00	10.60	12.90
35	3.40	4.20	11.00	13.30
36	3.50	4.30	11.20	13.60
37	3.70	4.50	11.60	14.00
38	3.80	4.60	12.00	14.50
39	4.00	4.80	12.30	14.70
40	4.10	5.00	12.60	15.10
41	4.30	5.10	12.90	15.50
42	4.50	5.40	13.40	15.90
43	4.70	5.60	13.80	16.40
44	5.00	5.90	14.30	17.00
45	5.30	6.20	14.70	17.40
46	5.50	6.50	15.20	17.90
47	5.80	6.80	15.50	18.30
48	6.10	7.10	16.00	18.80
49	6.30	7.40	16.50	19.30
50	6.60	7.80	16.90	19.80
51	7.00	8.20	17.50	20.50
52	7.40	8.70	18.20	21.20
53	7.90	9.10	18.70	21.70
54	8.30	9.60	19.40	22.50
55	8.90	10.30	20.20	23.50
56	9.40	10.90	21.00	24.40
57	10.10	11.70	22.00	25.50
58	10.80	12.50	23.10	26.80
59	11.60	13.40	24.10	28.00

RATE SHEET
AMERISAFE, INC.

BASE PLAN		***OPTIONS***	
Facility Monthly Benefit	**$1,000**	**Non Forfeiture**	**SHORTENED BENEFIT PERIOD**
Home Monthly Benefit	**$500**	**Inflation Protection**	**COMPOUND UNCAPPED**
Facility Benefit Duration	**6 YEARS**		
Home Benefit	**50%**		
Lifetime Maximum	**$72,000**		
Elimination Period	**90 DAYS**		
Home Care Level	**PROFESSIONAL**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

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

Monthly Rates

	PLAN 1	PLAN 2	PLAN 3	PLAN 4
INSURANCE AGE	BASE PLAN	BASE PLAN WITH NON FORFEITURE OPTION	BASE PLAN WITH COMPOUND INFLAT OPTION	BASE PLAN WITH NON FORFEITURE COMPOUND INFLAT OPTION
60	12.40	14.40	25.20	29.20
61	13.60	15.80	27.10	31.40
62	14.90	17.10	29.10	33.50
63	16.30	18.80	31.00	35.70
64	17.90	20.60	33.40	38.40
65	20.30	23.30	37.00	42.60
66	22.50	25.60	40.00	45.60
67	24.90	28.40	43.60	49.70
68	27.60	31.40	46.90	53.50
69	30.50	34.70	50.70	57.80
70	33.70	38.40	54.60	62.30
71	37.40	42.30	59.70	67.50
72	41.40	46.80	64.90	73.30
73	45.80	51.30	70.10	78.50
74	50.60	56.70	76.00	85.10
75	60.90	67.60	89.60	99.50
76	66.90	74.20	97.20	107.90
77	73.30	80.70	104.60	115.00
78	80.40	88.40	113.00	124.30
79	88.10	96.90	121.40	133.50
80	96.60	106.30	131.30	144.50

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

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 or symptoms of: 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 or symptoms of: 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 developed symptoms of the disease AIDS?
G. ❑ 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 G above, DO NOT SUBMIT THIS APPLICATION. Otherwise, please continue.

II. Medical Profile

A. Do you have symptoms of, or 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, 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 Nonforfeiture Benefit in the Outline of Coverage. I Accept ❑ / Reject ❑ this option.

I acknowledge that 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

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 or symptoms of: 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 or symptoms of: 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 developed symptoms of the disease AIDS?
G. ❑ 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 G above, DO NOT SUBMIT THIS APPLICATION. Otherwise, please continue.

II. Medical Profile

A. Do you have symptoms of, or 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, 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 Nonforfeiture Benefit in the Outline of Coverage. I Accept ❑ / Reject ❑ this option.

I acknowledge that 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

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
Mail to: Long Term Care Operations
2211 Congress Street
Portland, ME 04122
Phone – 1-800-227-4165
Fax – 207-541-7606

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

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

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.

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

PROTECTION AGAINST UNINTENTIONAL LAPSE OF LONG TERM CARE INSURANCE ADDITIONAL DESIGNATION TO BE COMPLETED IF YOU ARE BILLED DIRECTLY

You 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 Unum 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 notice will not be sent until 30 days after the premium is due and unpaid.

Instructions

If you are electing a designee, please complete, sign and date **Sections 1 and 2**.

Section 3 must be completed by your designee only if you are a resident of New Jersey or New York, and are age 62 or older.

If you are not electing a designee, please complete, sign and date **Sections 1 and 4**.

SECTION 1- Applicant / Insured - Please Print Legibly

Policy Number _____

Policyholder's/Company's Name:_____

Your Name:_____

Your Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

SECTION 2- Designations - Please Print Legibly

My Designations are as follows:

Name:_____

Address:Street/PO Box _____

City, State, Zip Code:_____

Name:_____

Address:Street/PO Box _____

City, State, Zip Code:_____

Applicant/Insured's Signature:_____Date:_____

PLEASE RETURN THIS FORM TO LTC SERVICE OPERATIONS AT THE ADDRESS LISTED ABOVE

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

PROTECTION AGAINST UNINTENTIONAL LAPSE OF LONG TERM CARE INSURANCE ADDITIONAL DESIGNATION TO BE COMPLETED IF YOU ARE BILLED DIRECTLY

You 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.

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Instructions

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If you are not electing a designee, please complete, sign and date **Sections 1 and 4**.

SECTION 1- Applicant / Insured - Please Print Legibly

Policy Number _____

Policyholder's/Company's Name:_____

Your Name:_____

Your Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

SECTION 2- Designations - Please Print Legibly

My Designations are as follows:

Name:_____

Address:Street/PO Box _____

City, State, Zip Code:_____

Name:_____

Address:Street/PO Box _____

City, State, Zip Code:_____

Applicant/Insured's Signature:_____Date:_____

PLEASE RETURN THIS FORM TO LTC SERVICE OPERATIONS AT THE ADDRESS LISTED ABOVE

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. Unum ceased sales of all Group Long Term Care policies as of February 2012. The company has not raised its rates on the GLTC04 policy series in the last ten years. Unum Life Insurance Company of America raised premium rates on the following policy forms beginning in 2013.

Policy Form	Years Available for Sale	Year of Rate Increase	Percentage Rate
B.LTC	1990-2005 (varies by state)	2013 to present	0-75% (varies by state)
GLTC95	1997-2008 (varies by state)	2013 to present	0-75% (varies by state)

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 median average annual cost of care in a nursing home in 2012 was close to $83,950 [1]*, but this figure varies across the country. In ten years the national average cost would be about $125,930 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] Genworth 2013 Cost of Care Survey, Home Care Providers, Adult Day Health Care Facilities, Assisted Living Facilities and Nursing Homes, 10th Edition, March 22, 2013. (https://www.genworth.com/corporate/about-genworth/industry-expertise/cost-of-care.html)

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

1. **Premium Rate:** The Premium rate that is applicable to your coverage and that will be in effect until a request is made and approved for an increase is shown on your benefit election form.

2. **The premium rate schedule for the group policy under which your coverage is written will be shown on the rate amendment page of the policy.**

3. **Premium Rate Adjustments:** Any change in premium rates will be effective on the group policy anniversary date.

4. **Potential Rate Revisions: Your coverage is Guaranteed Renewable.** This means that the rates for your coverage 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 the one under which you have coverage.

   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 coverage in force as is.
- Reduce your coverage benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option may be available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.*

*Contingent Nonforfeiture

If the premium rate for the group policy under which your coverage is written goes up in the future and the policy does not include nonforfeiture as a standard provision or you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. 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 certificate of coverage was first issued. If you have already received benefits under the group 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 Nonforfeiture option your coverage with this reduced maximum benefit amount will be considered "paid up" with no further premiums due.

Example: You bought this coverage 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 your coverage (not pay any more premiums). Your paid-up benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your coverage).

Contingent Non-Forfeiture

Cumulative Premium Increase over Initial Premium that qualifies for Contingent Nonforfeiture.
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

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 department on aging for more information about the senior health insurance counseling program in your state.

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

ACKNOWLEDGEMENT OF DISCLOSURE OF RATING PRACTICES

Long Term Care insurance regulations require that we provide certain information about policies that may be subject to rate increases in the future. This information can be found in the Potential Rate Increase Disclosure Form and Personal Worksheet that were given to you.

Long Term Care insurance regulations also require that we obtain a signed acknowledgement that you have received this information.

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

Signed:_____ _____
(Applicant) (Date)

_____ _____
(Please Print Name) (Social Security Number)

Complete if applying through Employer offer.

_____ _____
(Name of Employer) (Group Policy Number, if available)

Please sign and return this form to:

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

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.

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.