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

Instruction Page for Election to Continue Group Long Term Care Insurance

You may be eligible to continue your Group Long Term Care insurance after your group coverage terminates if you are an insured employee, spouse, domestic partner or former spouse/domestic partner. If you wish to continue your coverage, please complete this form and return it to Unum at the address provided above.

IMPORTANT NOTE: This form must be completed and returned within the time period specified in your Group Long Term Care certificate.

1. Please read all instructions before completing this form. **Please print legibly.**
2. EMPLOYER: The Employee Current Monthly Premium amount MUST include:
   amount paid by the employer (if applicable) **+** amount paid by the employee = Employee Premium
3. If you are the employee:
   - Complete **Section 2**
   - All applicable sections must be completed, signed and dated.
   - You must return the **Protection Against Unintentional Lapse Form**
4. If you are a Spouse or Domestic Partner electing to continue coverage:
   - Complete **Section 3**
   - All applicable sections must be completed, signed and dated
   - You must return the **Protection Against Unintentional Lapse Form**
5. Payment Options
   - You are responsible for the entire cost of coverage as of the end of active employment.
   - Unum will default to quarterly premium invoices if you do not select a payment option.
   - If you have chosen monthly billing via checking account withdrawal:
     - you MUST complete, sign and date the Authorization for Automatic Payment Form. If this form is not received, Unum will default to quarterly premium invoices until the form is received.
     - Important Note: your first automatic withdrawal could include two or more months of premium.
   - Please do not include payment at this time. Your first automated checking account withdrawal or initial invoice (quarterly, semi-annual or annual mode selection) will be adjusted to account for all premium due.
6. If you have any questions concerning these forms, please call our Customer Contact Center at 1-800-227-4165. Service Representatives are available to assist you Monday – Friday 8:00 am to 8:00 pm EST.

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

ELECTION TO CONTINUE YOUR LONG TERM CARE INSURANCE COVERAGE

SECTION 1 - EMPLOYER SECTION

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

Company Address:_____
Street City State/Zip

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

Employee Name:_____

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

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

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

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

SIGNATURE OF EMPLOYER: _____ **TODAY'S DATE** _____

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

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

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

Mailing Address:_____
Street City State/Zip

Email Address: _____

☐ Male ☐ Female Phone/Cell Number _____

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

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

☐ Quarterly Paper Bill (Monthly Premium X 3)

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

☐ Annual Paper Bill (Monthly Premium X 12)

SIGNATURE OF EMPLOYEE: _____ **TODAY'S DATE** _____

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

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

ELECTION TO CONTINUE YOUR LONG TERM CARE INSURANCE COVERAGE

Policy Number ☐☐☐☐☐☐

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

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

Name:_____

Mailing Address:_____
Street City State/Zip

Email Address: _____

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

☐ Male ☐ Female Phone/Cell Number _____

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

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

☐ Quarterly Paper Bill (Monthly Premium X 3)

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

☐ Annual Paper Bill (Monthly Premium X 12)

SIGNATURE OF EMPLOYEE'S SPOUSE OR DOMESTIC PARTNER: _____ **TODAY'S DATE** _____

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

Information About Continuing Your Long Term Care Insurance Coverage

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

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

Where Should Premium Payments Be Sent?
You must remit all premium payments directly to Unum. The address is:
Unum Life Insurance Company of America
P.O. Box 105570
Atlanta, GA 30348-5570

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

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

The monthly debit date for all payment plans is the 1st of each month.

2. Bank Information
Complete the information below or attach a voided check.

Bank Name _____ Name on Bank Account _____

Routing Number (9-digits) _ _ _ _ _ _ _ _ _ Account Number _ _ _ _ _ _ _ _ _ _ _ _ _ _

Refer to Sample Check image for help in locating your Routing and Account Numbers.

SAMPLE CHECK (bottom of check)

For

_____ _____

⑈0123456789⑈ 0123456789123⑈ 1234

Bank Routing Number **Bank Account Number** **Check Number**

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 (each of the premium payors 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 next page reflects my intent that my account be debited by the Company in the amount necessary to pay premium.

3) No notice of premium due will be furnished while the Authorization is in effect, except, if any check or other debit entry made pursuant to this Authorization is not paid, the Company will send notice of premium past due.

4) It is my responsibility to fund my account in an amount sufficient to pay premium when due and failure to do so may result in lapse of coverage. Payments are typically drawn on the 1st of the month.

5) This Authorization does not waive, alter or amend any provision of coverage under the above policy.

6) No premium shall be deemed paid until the Company receives payment at its Home Office.

7) The Company shall incur no liability as a result of the dishonor of any debit entry or any check, draft or other instrument drawn pursuant to this Authorization Agreement.

8) This Authorization shall remain in effect unless and until the bank, the insured person or premium payor presents written notice of termination to the Company.

   Exception: The Company may terminate this Agreement, by providing written notice thereof, in the event that, within any period of twelve consecutive months, two or more premium debits are not paid upon presentation, or if any time the Company is required to refund to the bank any amount paid pursuant to this Authorization.

9) Upon termination of this Agreement, premiums will be payable at the rate (amount) and mode (frequency) required under the Company's usual rate and mode for coverages not enrolled in the Automatic Payment Plan.

10) Funds must be paid in U.S. dollars and withdrawn from a U.S. bank.

PROTECTION AGAINST UNINTENTIONAL LAPSE
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

Section 3- For New Jersey or New York Residents Age 62 or Older

Per New Jersey Insurance code C.17:29C-1.2 and §3111 of the New York Insurance Laws, this form shall be delivered to Unum by certified mail, return receipt requested along with the completed Designee Acceptance below. Your Designee(s) must accept in writing that they are willing to receive copies of notices of cancellation, non-renewal and conditional renewal from us.

DESIGNEE ACCEPTANCE LONG TERM CARE INSURANCE

This section needs to be completed by the Designee, if the named applicant/insured is age 62 or over and a resident of ***New Jersey or New York.***

Applicant / Insured: Please complete this section prior to providing this form to your Designee for signature.

Applicant/Insured's name _____

Policy Number: ___ ___ ___ ___ ___ ___

Prior to issuing a long term care certificate, the applicant/insured is required to provide Unum with a written designation of at least one person, who is to receive the notice of cancellation of insurance coverage for nonpayment of premium, in addition to the applicant/insured OR sign a waiver electing not to designate a person. You have been listed as one of the designees. Designation does not constitute acceptance of any liability on the part of the designated person or persons for services provided to the applicant/insured.

You must accept in writing that you are willing to receive copies of notices of cancellation, non-renewal and conditional renewal from Unum. Should you desire to terminate the status as a third party designee, you shall provide written notice to both Unum and the policyholder.

⇨ Designee's signature_____

Print name: _____ Date: _____

SECTION 4-Waiver Electing Not To Name An Additional Designation

Protection against Unintentional Lapse. I understand that I have the right to designate at least one person, other than myself, to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. **I elect NOT to designate any person to receive such notice.**

⇨ Applicant/Insured's signature:_____ Date _____

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

Third Party Authorization
Group Long Term Care
Unum Life Insurance Company of America
2211 Congress Street
Portland, ME 04122
Fax: 207-541-7606

For toll-free assistance call: 1-800-227-4165

INSURED NAME	POLICY/BL #	POLICY/BL #

AUTHORIZED INDIVIDUAL(S) NAME	RELATIONSHIP TO THE INSURED	PHONE NUMBER

I authorize Unum Group, its subsidiaries and affiliates* and duly authorized representatives ("Unum") to disclose the following insurance plan and billing information to the person(s) or organization(s) listed above, for the purpose of assisting me with my insurance coverage:

- Information regarding my coverage, including policy provisions and riders;
- Information regarding premium calculation, invoicing and payments.

This authorization does not alter any prior designation made under any law protecting against unintentional lapse of coverage.

This authorization does not allow the authorized individual(s) or organization(s) to make any changes to my coverage.

This Authorization does not allow Unum to share claim or health information including, but not limited to, my medical condition, diagnosis, treatment, or pre-existing condition information; the names of my physicians and other medical providers; or benefit amounts paid to me or on my behalf.

Unum will rely on this authorization until I revoke it in writing.

Unum may provide information in writing, electronically, or by telephone (including voice mail messages).

CERTIFICATION

- **I understand that once information is disclosed to the named authorized Individuals or Organizations, it may no longer be protected by federal privacy regulations.**

- I am not required to sign this authorization and Unum may not condition payment of claims on whether I sign this authorization.

- I am entitled to receive a copy of this authorization.

- I may revoke this authorization in writing at any time, except to the extent that Unum has relied on the authorization prior to notice of revocation.

_____ _____

Insured Signature Date Signed

_____

Print Name

*This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America, First Unum Life Insurance Company and Provident Life and Accident Insurance Company.