unum®

ELECTION TO CONTINUE YOUR LONG TERM CARE INSURANCE COVERAGE

Mail to: Unum Life Insurance Company of America
Customer Service/Group Long Term Care
2211 Congress Street
Portland, Maine 04122

Policy Number: 578655-002

TO BE COMPLETED BY THE EMPLOYER

	Company Name		Plan Number
Company Data:	Milpitas Christian Schools		578655-002
	Street	City	State/Zip
Company Address:			
	Last Name	First Name	Middle Initial
Employee Name:			
	Date of Birth	Social Security Number	☐ Male ☐ Female
Employee Data:			
		Name(s)	☐ Employee ☐ Employee's Spouse or Domestic Partner (if applicable)
Person terminating group coverage:			
		☐ Termination of Employment ☐ Divorce	☐ Death of Spouse or Domestic Partner ☐ Other
Reason person is terminating group coverage:			
	Month	Day	Year
Date group coverage terminates:			
	Employee		Spouse
Current monthly premium payment:	$_____.__/month		$_____.__ /month

Signature of Employer: **Date:**

TO BE COMPLETED BY THE EMPLOYEE

If you are an insured employee, you may be eligible to continue your long term care insurance coverage after your group coverage terminates. If you wish to continue your coverage, please complete this form and return it to the insurer at the address listed above. This form must be completed and returned within the time period specified in your certificate. **You will be responsible for the entire cost of your coverage.** Unum will mail bills to you at the address you provide below.

	Street	City	State/Zip	Telephone
Mailing Address:				

	Monthly	Quarterly (Paper)	Semi-Annually (Paper)	Annually (Paper)
Payment Options:	☐ Automatic payment via checking account	☐ (3x monthly rate)	☐ (6x monthly rate)	☐ (12x monthly rate)

Signature of Employee: **Date:**

TO BE COMPLETED BY THE EMPLOYEE'S SPOUSE OR DOMESTIC PARTNER (IF APPLICABLE)

If you are the insured spouse or domestic partner or former spouse or domestic partner of the above employee, you may be eligible to continue your long term care insurance coverage after your group coverage terminates. If you wish to continue your coverage, please complete this form and return it to the insurer at the address listed above. This form must be completed and returned within the time period specified in your certificate. **You will be responsible for the entire cost of your coverage.** Unum will mail bills to you at the address you provide below.

	Last Name	First Name	Middle Initial
Name:			

	Street	City	State/Zip	Telephone
Mailing Address:				

	Date of Birth	Social Security Number	☐ Male ☐ Female
Data:			

	Monthly	Quarterly (Paper)	Semi-Annually (Paper)	Annually (Paper)
Payment Options:	☐ Automatic payment via checking account	☐ (3x monthly rate)	☐ (6x monthly rate)	☐ (12x monthly rate)

Signature of Employee's Spouse/Domestic Partner: **Date:**

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

Information About Continuing Your Long Term Care Insurance Coverage

Should The Certificate Of Insurance Be Kept?

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

Can Coverage Be Changed?

You may apply at any time to increase coverage by filling out a new application, which includes evidence of insurability. Call Unum at (800) 227-4165 for assistance.

Where Should Premium Payments Be Sent?

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

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

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

Authorization and Agreement for Automatic Payments

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

Please Print

Policy Number	Insured Name	Social Security Number

1. Check all that apply:

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

2. Tape voided check in space provided below. Deposit tickets do not contain all necessary information.

Tape Voided Check Here

I (each of the premium payors whose signature appears on the next 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.
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.

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

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.

3. Please sign. I authorize the bank indicated below to pay and charge to my account monthly debit entries, including checks, drafts and other orders by electronic or paper means, made by and payable to the Company.

Signature(s) of Premium Payor(s)	Signature Date(s)	Bank Information
		Name
		Street
		City State Zip

4. Mail to: Unum Life Insurance Company of America
Attn: Customer Service/Group Long Term Care
2211 Congress Street
P.O. Box 9783
Portland, Maine 04122.

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

PROTECTION AGAINST UNINTENTIONAL LAPSE
ADDITIONAL DESIGNATION
GROUP LONG TERM CARE INSURANCE

Your Name: _____

Your Social Security Number: _____

Policyholder's Name:_____

Policy Number: _____

You, the insured, will receive notice if any coverage for which you are required to pay the cost is about to terminate because you have not paid the required premiums.

You are required to provide your insurer with a written designation of at least one person, in addition to you, who is to receive the notice of cancellation of your coverage for nonpayment of premium OR sign a waiver electing not to designate a person. You have the right to change these designations. Designation does not constitute acceptance of any liability on the part of the designated person or persons for services provided to you. The designated person or persons will not receive the notice until 30 days after the premium is due and unpaid.

My designations are as follows:

Name: _____

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

Name: _____

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

Insured's Signature:_____ Date:_____

WAIVER ELECTING NOT TO NAME AN ADDITIONAL DESIGNATION
FOR PROTECTION AGAINST UNINTENTIONAL LAPSE

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

Insured's Signature:_____ Date:_____

Please return this form to:
Customer Service/Group Long Term Care
Unum Life Insurance Company of America
2211 Congress Street, Portland, Maine 04122

New Jersey and New York Residents – Age 62 and older: Per New Jersey insurance code C.17:29C-1.2 and §3111 of the New York Insurance Laws, this form shall be delivered to Unum by certified mail, return receipt requested along with the completed Designee Acceptance form (on the back page of this form). Your Designee(s) must accept in writing that they are willing to receive copies of notices of cancellation, non-renewal and conditional renewal from us.

Please retain a copy of this form for your records

DESIGNEE ACCEPTANCE

LONG TERM CARE INSURANCE

This form needs to be completed by the Designee, if the named Insured is age 62 or over and a resident of New Jersey or New York.

Insurance Applicant: Please complete this section prior to sending this form to your Designee forsignature.

Insured's Name:_____

Policy Number: _____

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

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

Designee's Signature: _____

Print Name: _____

Date: _____

Please retain a copy of this form for your records