

# 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 all the information you need to understand the long term care (LTC) insurance coverage your employer is offering through Unum.

Please follow the tabs to make sure you complete each section.

## How it works

This includes information about why this coverage is important, detailed plan information, and what is not covered. Be sure to review this information before enrolling.

## How to enroll in the plan

This section includes rates for the plan(s) being offered, Benefit Election Forms, Long Term Care Insurance Applications (medical questionnaire), replacement forms, and other forms that require a signature.

Please refer to the grid below to determine which forms to complete.

	Benefit Election Form	Long Term Care Application (medical questionnaire)	Protection Against Unintentional Lapse	Authorization and Agreement for Automatic Payments	Personal Worksheet
Employee*	✓	✓*			
Spouse <sup>†</sup>	✓	✓			
Other family members	✓	✓	✓	✓ <sup>†</sup>	✓
Retired employee and spouse	✓	✓	✓	✓ <sup>†</sup>	✓

\* 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.

<sup>†</sup> For definition of spouse, please refer to the Benefit Election Form.

† This form is only required if you choose for your payment to be automatically deducted from your checking account.

• Call 1-800-227-4165 if you have any question about the forms.

## State forms to review

These are forms for your review only. There is nothing to fill out. The state where your employer is located requires that this information be included for all consumers.





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.<sup>1</sup>
- About 70% of individuals over age 65 will require some type of long term care services during their lifetime.<sup>2</sup>
- By 2020, 12 million people are projected to need long term care.<sup>3</sup>

## 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:<sup>4</sup>



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.<sup>5</sup>

## 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.<sup>6</sup>

## 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<sup>®</sup> 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.

<sup>1,2,3</sup> 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](http://www.longtermcare.gov/LTC/Main_Site/Understanding_Long_Term_Care/Basics/Basics.aspx), cited November 17, 2009.

<sup>4</sup> Genworth Financial, "2009 Cost of Care Study," April 2009.

<sup>5</sup> American Association for Long Term Care Insurance, "2008 LTCI Sourcebook," February 2008.

<sup>6</sup> 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

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**JEFFERSON BANCSHARES, INC.**  
**SCHEDULE OF BENEFITS / PLAN HIGHLIGHTS**

Your Long Term Care (LTC) insurance plan is listed below.

**Elimination Period:** Your plan's elimination period of 90 days is the amount of time you must wait before benefits become payable. This time period can be accumulated over a period of 730 days and needs to be satisfied only once during the life of your plan.

**Newly Hired Employees:** Once eligible for the plan, will have 31 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 requiring medical underwriting is the later of the Plan Effective Date or the Medical Underwriting Approval Date. *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. **EMPLOYEES:** Your employer funded basic plan, as well as additional benefit amounts of up to and including \$6,000 and a Facility Benefit Duration of 3 or 6 years, is being offered on a Guarantee Issue basis. 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 \$7,000, \$8,000, \$9,000 or the Lifetime Duration coverage. **Spouses** and all **Family Members** must complete the Benefit Election Form, the Long Term Care Insurance Application (medical questionnaire) and 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	3 Years	6 Years	Lifetime
Employee Facility Benefit Amount <b>In Increments of \$1,000</b>	\$2,000 to \$9,000	\$2,000 to \$9,000	\$2,000 to \$9,000
Spouse/Family Facility Benefit Amount <b>In Increments of \$1,000</b>	\$1,000 to \$9,000	\$1,000 to \$9,000	\$1,000 to \$9,000
Assisted Living Facility Percent	100%	100%	100%
Non Forfeiture	3 Yr Shortened Benefit Period	3 Yr Shortened Benefit Period	3 Yr Shortened Benefit Period
Professional Home & Community Care	50%	50%	50%
Total Choice Home Care - <b>Option</b>	50%	50%	50%
Inflation Protection * - <b>Option</b>	Compound	Compound	Compound

*\* If you selected an inflation option, and you terminate that inflation option at a future date, you can purchase the inflated coverage amount at your original age.*

**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 & 3 Year Duration, your Lifetime Maximum is calculated as follows, \$3,000 per Month X 12 Months X 3 Years = \$108,000 Lifetime Maximum.*

**Insurance Age:** Final cost of coverage will be based on your Insurance Age. If you enroll for coverage on or before the group policy effective date, Insurance Age is your age on the group policy effective date. If you enroll for coverage after the group policy 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

**QUALIFIED LONG TERM CARE INSURANCE OUTLINE OF COVERAGE**  
FOR THE EMPLOYEES OF  
**JEFFERSON BANCSHARES, INC. - #136358**  
Group Master Policy/Certificate Form Number GLTC04/CLTC04

**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 responses to the questions on your application. You retained a copy of your Application for Long Term Care Insurance when you applied. If your answers are incorrect or untrue, the company 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, 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 which is issued in the state of **Arkansas**.
2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. **This is not an insurance contract, but only a summary of coverage. Only the group policy contains governing contractual provisions. This means that the group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR CERTIFICATE CAREFULLY!**
3. **FEDERAL TAX CONSEQUENCES.** The policy is intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.
4. **TERMS UNDER WHICH THE CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED**
  - a. **RENEWABILITY - THE CERTIFICATE IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of the policy to continue your coverage as long as premium for your coverage is paid 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.
  - b. **CONTINUATION OF COVERAGE.** If your group long term care coverage ends for reasons other than non-payment of premium or your choice to have premium payments stopped for your coverage, you may elect continuation of 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 continued coverage. Election for continued coverage must be made within 60 days of the date your group coverage would otherwise end. Any premium that applies must be paid directly to Unum by you for any coverage to be continued.
  - c. **WAIVER OF PREMIUM.** We will waive payment of premium for your coverage during any period of time that you are receiving benefits under the policy. However, premium payments will not be waived if you are only receiving Respite Care or Additional Care Benefits.

5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS. WE HAVE A LIMITED RIGHT TO CHANGE PREMIUMS.** We reserve the right to change any and all premiums. Any change in premium must apply to all similar policies issued on this policy form and in the state in which the policy is or certificates are situated. Premiums cannot be increased because of any change in the age or health of the persons covered under the policy. We cannot discontinue the policy except where required by law or as a result of non-payment of premium.
6. **TERMS UNDER WHICH THE CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.**
- a. You may cancel your coverage for any reason within 30 days after it is delivered to you or your representative. Simply return your certificate, within 30 days of its receipt, to us. If this is done, your certificate will be canceled from the beginning and all premiums paid for your coverage will be refunded.
  - b. If you die while insured under the policy, we will refund any pro rata portion of any premium paid covering the period after your death. We will make the refund within 30 days after we receive written notice of your death. Payment will be made to your estate.
7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the insurance company. Neither Unum nor its agents represent Medicare, the federal government or any state government.
8. **LONG TERM CARE COVERAGE.** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, 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.
- The policy provides coverage in the form of a fixed dollar indemnity benefit if you are Chronically Ill and you are receiving care while confined in a Long Term Care Facility. If the policy includes coverage for Professional Home and Community Care or Total Choice Home Care and you elect such coverage, we will pay you a benefit if you choose to receive care at home or in the community. Coverage is subject to the policy limitations, benefit maximums and elimination period requirements.
9. **BENEFITS PROVIDED BY THE POLICY.** Refer to the attached **SUMMARY OF BENEFITS** for the benefits available under the Policyholder's plan.

#### **Eligibility for Benefits**

You will be eligible for a benefit if, on or after the effective date of your coverage and while your coverage is in effect, you become Chronically Ill.

#### **Conditions for Payment of Benefits**

To receive benefits under the policy, the following conditions must be met:

- you must satisfy the Elimination Period, if applicable;
- you must be receiving Qualified Long Term Care Services;
- the treatment for your Chronic Illness must be provided pursuant to a written Plan of Care; and
- we must approve your claim.

You must also provide us with a Licensed Health Care Practitioner's Certification that you are unable to perform (without Substantial Assistance from another individual) two or more Activities of Daily Living for a period of at least 90 days, or that you require Substantial Supervision by another individual to protect you from threats to your health or safety due to Severe Cognitive Impairment. You will be required to submit a Licensed Health Care Practitioner's Certification every 12 months.



### **Limitations on Payment of Benefits**

We will not pay benefits in excess of any coverage amounts you choose or for coverages that you have not elected. Benefits paid will reduce your Lifetime Maximum Benefit and will no longer be available once your Lifetime Maximum has been reached. We will not pay benefits for Qualified Long Term Care Services you receive during the Elimination Period, except as described in the Respite Care Benefit and the Additional Care Benefit provisions. The policy only pays benefits if you are receiving Qualified Long Term Care services.

### **LTC Facility Benefit Payment**

You must give us proof that you are receiving Qualified Long Term Care Services in a LTC Facility before a LTC Facility Monthly Benefit is paid. If you are eligible for benefits for a period of less than one month, we will pay you 1/30<sup>th</sup> of the monthly benefit for each day that you are Chronically Ill and receiving Qualified Long Term Care Services in a LTC Facility. (Refer to the **OPTIONAL BENEFITS PROVIDED BY THE POLICY** section of this Outline of Coverage for information on benefit payments for home care).

### **Additional Care Benefit:**

Once you are eligible for a benefit payment, you will have access to Additional Care designed to assist you in living at home or in other residential housing. You do not need to complete your Elimination Period for an Additional Care Benefit payment to begin. The Additional Care must be:

- appropriate for your Chronic Illness and conform with generally accepted medical standards;
- provided pursuant to a written Plan of Care;
- recommended by a Licensed Health Care Practitioner; and
- approved by us prior to receipt of Additional Care.

### **Bed Reservation Benefit**

If you are receiving a LTC Facility Monthly Benefit and your stay in the facility is interrupted due to a stay in an acute care facility, or due to a temporary absence and a charge is made to reserve your LTC Facility accommodations, you will be eligible for a Bed Reservation Benefit. We will pay you 1/30<sup>th</sup> of the LTC Facility Monthly Benefit for each day you are absent from the LTC Facility:

- up to 90 days per calendar year if your absence is due to a stay in an acute care facility; or
- up to 30 days per calendar year for a temporary absence not related to a stay in an acute care facility.

In no event will the maximum number of Bed Reservation days exceed 90 days per calendar year. Bed Reservation Benefit payments will reduce your Lifetime Maximum Benefit and will no longer be available once your Lifetime Maximum Benefit has been reached. If your stay in a LTC Facility is interrupted while you are satisfying your Elimination Period, such days will be used to help satisfy your Elimination Period.

### **Respite Care Benefit**

If you are Chronically Ill and receiving Respite Care but you are not receiving a LTC Facility Monthly Benefit (or a Home Care Monthly Benefit if your coverage includes a home care benefit) you will be eligible to receive a Respite Care Benefit. The Respite Care Benefit you will receive is equal to 1/30<sup>th</sup> of your LTC Facility Monthly Benefit for each day you have Respite Care for up to 21 days each calendar year. You do not need to complete your Elimination Period for Respite Care payments to begin and the days you are receiving Respite Care will count toward satisfying your Elimination Period.

### **Words That Have A Special Meaning**

Activities of Daily Living (ADLs) are bathing, dressing, toileting, transferring, continence and eating.

Additional Care means special services; equipment or caregiver training designed to assist you in living at home or in other residential housing. Additional Care may include:

- assistance in locating long term care providers and caregivers in your area (this service is also available even if you are not eligible for benefits);
- a visit from a Licensed Health Care Practitioner who will develop your Plan of Care;
- a visit from a home safety expert who will assess your residence and offer suggestions for increased personal safety;
- purchase or rental of a medical alert service;
- purchase or rental of durable medical equipment;
- home modifications for your support; or
- caregiver training.

Chronic Illness and Chronically Ill means you are unable to perform, without Substantial Assistance from another individual, two or more Activities of Daily Living; or you require Substantial Supervision by another individual to protect you from threats to your health and safety due to Severe Cognitive Impairment.

Elimination Period means the number of days during which you are Chronically Ill and you are receiving services appropriate for your Chronic Illness, but no benefit is payable.

Lifetime Maximum Benefit means the total dollar amount of benefits that will be paid under the policy, excluding any Additional Care Benefit.

Long Term Care (LTC) Facility means a facility (such as a nursing facility, an assisted living facility, a hospice facility, a rehabilitation facility, an Alzheimer's facility or a residential care facility) that is licensed by the appropriate federal or state agency to engage primarily in providing care and services sufficient to support your needs resulting from Chronic Illness.

Plan of Care means a written plan prescribed by a Licensed Health Care Practitioner, based upon an assessment that evaluates your level of functional capacity.

Qualified Long Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services and maintenance or personal care services that are required by you.

Respite Care means short-term or periodic Qualified Long Term Care Services which are required to maintain your health or safety and to give temporary relief to your primary caregiver from his or her caregiving duties.

Severe Cognitive Impairment means a severe deterioration or loss in your short or long term memory; your orientation as to person, place, or time; or your deductive or abstract reasoning as reliably measured by clinical evidence and standardized tests. Such loss can result from a sickness, injury, advanced age, Alzheimer's disease or similar form of dementia.

Substantial Assistance means stand-by or hands-on assistance without which you would not be able to safely and completely perform the ADL. Stand-by assistance means the presence of another person within arm's reach of you while you are performing the ADL. Hands-on assistance means physical assistance (minimal, moderate or maximal) without which you would not be able to perform the ADL.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures or other demonstrations) by another individual for the purpose of protecting you from threats to your health or safety.

**OPTIONAL BENEFITS PROVIDED BY THE POLICY -- EACH OF THE FOLLOWING OPTIONAL BENEFITS IS AVAILABLE UNDER THE POLICYHOLDER'S PLAN. OPTIONAL BENEFITS MAY BE AVAILABLE AT AN ADDITIONAL COST TO YOU. YOU MAY ALSO REFER TO THE ATTACHED SUMMARY OF BENEFITS TO DETERMINE AVAILABLE OPTIONAL BENEFITS.**

## **Home Care Options:**

### **Professional Home and Community Care Benefit:**

If your coverage includes the Professional Home and Community Care Benefit, we will pay 1/30<sup>th</sup> of the Home Care Monthly Benefit you elected for each day you receive Professional Home and Community Care Services. Professional Home and Community Care Services may be provided anywhere other than a LTC Facility, an acute care facility or other location excluded by the policy. You must provide written proof indicating the number of days you received Professional Home and Community Care Services before a benefit is paid.

Professional Home and Community Care Services means Qualified Long Term Care Services provided to you for at least one hour or more per day by or through a Licensed Home Health Care Agency; by a Licensed Health Care Professional; or in an Adult Day Care Facility.

Professional Home and Community Care Services include nursing care; physical, respiratory, and occupational or speech therapy; homemaker services; hospice care; or other services pursuant to your Plan of Care.

Included in the Professional Home and Community Care Benefit is an International Benefit. You may be eligible to receive International Benefits if you become Chronically Ill and are receiving Qualified Long Term Care Services while traveling outside of the United States, its territories or possessions, or Canada. International Benefits will be paid on an indemnity basis.

### **Total Choice Home Care Benefit:**

If your coverage includes the Total Choice Home Care Benefit, we will pay 1/30<sup>th</sup> of the Home Care Monthly Benefit you elected for each day you receive Total Choice Home Care Services. Total Choice Home Care Services may be provided anywhere other than a LTC Facility, an acute care facility or other location excluded by the policy.

Total Choice Home Care Services means Qualified Long Term Care Services provided to you by anyone, including a Family Member, by or through a Licensed Home Health Care Agency; by a Licensed Home Health Care Professional; in an Adult Day Care Facility; or by an informal caregiver. Total Choice Home Care Services include nursing care; physical, respiratory, and occupational or speech therapy; homemaker services; hospice care; or other services pursuant to your Plan of Care.

Included in the Total Choice Home Care Benefit is an International Benefit. You may be eligible to receive International Benefits if you become Chronically Ill and are receiving Qualified Long Term Care Services while traveling outside of the United States, its territories or possessions, or Canada. International Benefits will be paid on an indemnity basis.

## **Inflation Protection and Benefit Increase Options:**

### **5% Compound Inflation Protection:**

If your coverage includes this option, your LTC Facility Monthly Benefit will increase each year on the Coverage Effective Date by 5% of your LTC Facility Monthly Benefit in effect on that date. Increases will be automatic and will occur regardless of your health and whether or not you are eligible for or are receiving benefit payments. Your premium will not increase due to automatic increases in your LTC Facility Monthly Benefit.

## **Non-Forfeiture Benefit Options:**

### **Shortened Benefit Period:**

If premium payments are stopped after your Shortened Benefit Non-Forfeiture has been in force for at least three (3) full years from your Coverage Effective Date, you will be eligible for a Non-Forfeiture Benefit. This means that your coverage will continue automatically with the same level of benefits, except for a reduction in your Lifetime Maximum Benefit Amount. Your Lifetime Maximum Benefit Amount under this Non-Forfeiture Benefit will be equal to the total premium paid up to the date premium payment stopped minus the total amount of benefits already paid to you.

## 10. **LIMITATIONS AND EXCLUSIONS**

We will not provide benefits for:

- a Chronic Illness caused by war or any act of war, whether declared or undeclared, that occurs while your coverage is in force.
- a Chronic Illness caused by intentionally self-inflicted injuries or attempted suicide, while sane.
- a Chronic Illness caused by the commission of a crime for which you have been convicted under law, or caused by your attempt to commit a crime under law.
- a Chronic Illness caused by alcoholism, alcohol abuse, drug addiction or drug abuse.
- any period of time while you are Chronically Ill and you are confined in a hospital, other than if you are confined to a LTC Facility that is a distinctly separate part of a hospital. This exclusion does not apply to those periods covered under the Bed Reservation Benefit.
- any period of time that you are Chronically Ill and you are outside the United States, its territories or possessions or Canada for 30 consecutive days or longer if a home care benefit is not selected.
- a Chronic Illness resulting from an ADL loss or Severe Cognitive Impairment caused by, contributed by or resulting from a Pre-existing Condition This exclusion applies to coverage that is not medically underwritten. (This exclusion does not apply if you were required to apply for coverage by completing a Long Term Care Insurance Application and we approved your application).

### **Pre-existing Condition Exclusion**

A pre-existing condition is any condition for which medical advice, treatment, care or services, including consultation or diagnostic measures or prescription drugs were received or recommended in the six (6) months just prior to your Coverage Effective Date; or you took prescribed drugs in the six (6) months just prior to your Coverage Effective Date.

We will not consider for any purposes an ADL loss or onset of Severe Cognitive Impairment that occurs in the six (6) months after your Coverage Effective Date if the ADL loss or Severe Cognitive Impairment is caused by, contributed to by or results from a pre-existing condition.

If you were required to apply for coverage by completing a Long Term Care Insurance Application and we approved your application the Pre-existing Condition Exclusion provision will not apply to you.

## **THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.**

11. **RELATIONSHIP OF COST OF CARE AND BENEFITS.** Because the cost of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted.

- If the plan provides an Inflation Protection or Benefit Increase Option and you have chosen the option, your LTC Facility Monthly Benefit will increase each year on the Coverage Effective Date. Increases will be automatic and will occur regardless of your health and whether or not you are Chronically Ill. Your premium will not increase due to the automatic increases in your LTC Facility Monthly Benefit.
- After your coverage is in force, you will be allowed to increase your coverage based on the benefits available under the Policyholder's plan. To do so, you must complete a new benefit election form and a Long Term Care Insurance Application. No increased or additional coverage will become effective unless we approve your Long Term Care Insurance Application for such change. Premiums for your coverage may be adjusted due to changes or increase in your coverage based on your age on the date you apply to change or increase your coverage.

12. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.**

The policy provides for coverage of 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 Severe Cognitive Impairment are: Alzheimer's disease, multi-infarct dementia, brain injury, brain tumors or other such structural alterations of the brain.

13. **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.

14. **ADDITIONAL FEATURES**

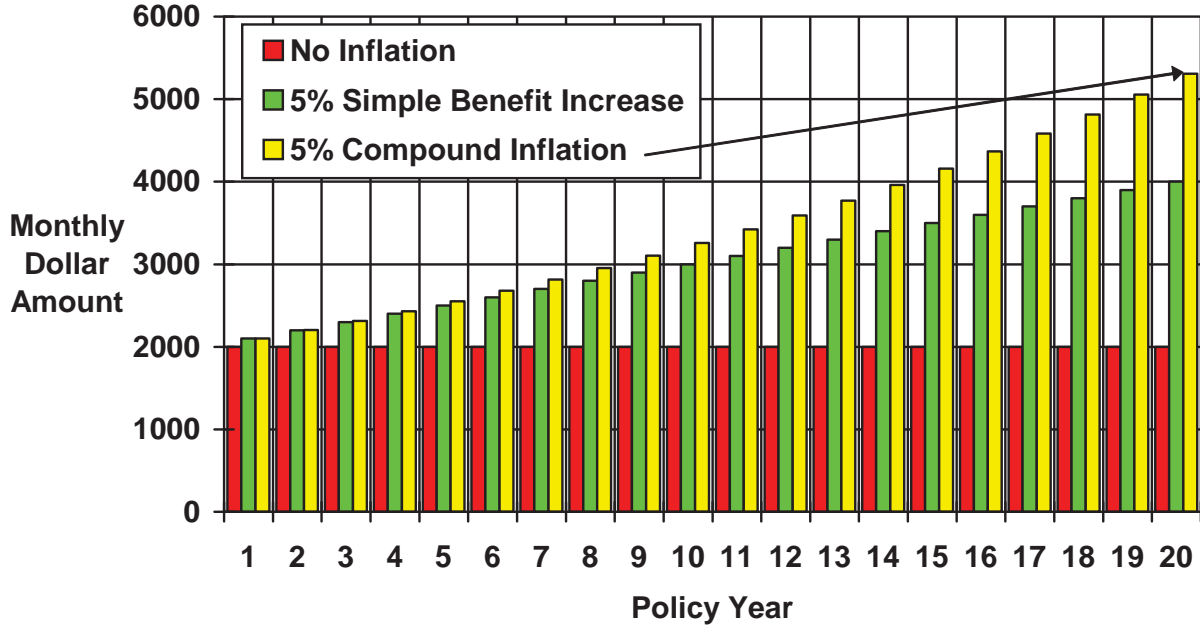
- Medical underwriting may be required.
- Eligibility and Participation

You are eligible for the plan if you are: an Active Employee of the Policyholder and your Family Members.

15. **CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT US IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE CERTIFICATE.**

# Long Term Care

## Comparison of Benefits for Simple and Compound Inflation Protection



Monthly Premium Based On the Following:

- Issue Age 65
- LTC Facility with Professional Home and Community Care (50%)
- 90 Day Elimination Period
- Lifetime Maximum Benefit Period

Monthly Premium Without Inflation Protection: \$253.12

Monthly Premium With 5% Simple Benefit Increase: \$379.67

Monthly Premium With 5% Compound Inflation Protection: \$440.42

Premium will remain level; it will not increase due to automatic increases in benefit amounts.



**IMPORTANT INSTRUCTIONS:** Prior to submitting this form, all applicants must review the important disclosures and information found on <http://www.unuminfo.com/jeffersonbancshares> or 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

**JEFFERSON BANCSHARES, INC.**  
**Employee/Spouse Benefit Election Form**  
**Long Term Care - Policy #136358**

**(one form to be completed by each applicant)**

Your Name: (Last Name, First, Middle Initial)	Social Security Number ____-____-____	Date of Birth (MM/DD/YYYY) ____/____/____	
Street Address	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Hire (MM/DD/YYYY) ____/____/____	
City, State, Zip Code	Home Telephone # (    )	Work Telephone # (    )	
Applicant's Email Address:			
<b>Spouses complete the following:</b>			
Employee's Name	Employee Social Security No. ____-____-____	Employee Date of Birth ____/____/____	Employee Date of Hire ____/____/____

Is this a change to existing coverage?    Yes     No

If yes, please note that all elections made below will replace existing coverage upon underwriting approval, if applicable.

**Funded Plan (Employer Paid)**

Level of Care:	Long Term Care Facility and 50% Professional Home & Community Care
Monthly Benefit:	\$2,000 Long Term Care Facility/ 50% Professional Home & Community Care
Benefit Duration:	3 Years Long Term Care Facility/ 50% Professional Home & Community Care
Non Forfeiture:	3 Year Shortened Benefit Period
<input type="checkbox"/> <b>Employee</b> - Your employer is funding <u>Plan 1</u> . You may purchase additional coverage. Please make your selections below.	
<input type="checkbox"/> <b>Spouse</b> - You may choose any plan listed below. **	

**Plans – Check one (this Benefit Election Form must be completed for any selection).**

<input type="checkbox"/> <b>Plan 1</b> (Funded for Employees Only)	<input type="checkbox"/> <b>Plan 2</b>	<input type="checkbox"/> <b>Plan 3</b>	<input type="checkbox"/> <b>Plan 4</b>
<ul style="list-style-type: none"> <li>• Long Term Care Facility</li> <li>• Professional Home &amp; Community Care</li> <li>• 3 Year SBP</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care Facility</li> <li>• Total Choice Home Care</li> <li>• 3 Year SBP</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care Facility</li> <li>• Professional Home &amp; Community Care</li> <li>• Compound Inflation</li> <li>• 3 Year SBP</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care Facility</li> <li>• Total Choice Home Care</li> <li>• Compound Inflation</li> <li>• 3 Year SBP</li> </ul>

**Employee Facility Monthly Benefit Amount – Check one**

<input type="checkbox"/> \$2,000 (Funded for Employees Only)	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$6,000	<input type="checkbox"/> \$7,000 *	<input type="checkbox"/> \$8,000 *	<input type="checkbox"/> \$9,000 *
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**Spouse Facility Monthly Benefit Amount – Check one**

<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$6,000	<input type="checkbox"/> \$7,000	<input type="checkbox"/> \$8,000	<input type="checkbox"/> \$9,000
----------------------------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------

**Facility Benefit Duration – Check one**    Duration of benefits may vary depending on where benefits are received.

<input type="checkbox"/> 3 Years (Funded for Employees Only)	<input type="checkbox"/> 6 Years	<input type="checkbox"/> <b>Lifetime *</b>
--	----------------------------------	--

Form is continued on reverse side.

- **\* Employees: These options exceed the Guarantee Issue limits** and their selection will require completion of the Long Term Care Insurance Application (medical questionnaire).
- **All active employees and newly hired employees** who enroll after the Guarantee Issue enrollment period or choose benefits over the Guarantee Issue limits must complete the Long Term Care Insurance Application (medical questionnaire).
- **\*\* Spouses** must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire) for any selection.
- A signed Authorization to Request Medical Information (form #6720-03 in the kit) must accompany all medical questionnaires.

**Calculate Your Premium:**

Please refer to rate sheet in your kit to determine the rate for the plan chosen.

_____	X	_____	÷	<b>\$1,000</b>	=	_____	(A)
Rate for plan chosen		Monthly benefit amount				Your premium	
<b>For Employees Only:</b>							
_____	X	<b>2</b>			=	_____	(B)
Rate for funded Plan 1 (3 Year duration)		(Based on Funded Amount)				Employer Paid Amount	
<b>A MINUS B</b>						_____	
							<b>EMPLOYEE'S COST</b>

**Disclosures:**

**Massachusetts Residents:** You also signify that you have received and read the MassHealth eligibility notice entitled "For Massachusetts Residents Only" - Form #7650-04. The notice is contained in your kit.

**Note: We may have the right to deny benefits or rescind insurance if any of the information provided on this enrollment form is incorrect.**

**REQUEST FOR SIGNATURE:** Must check either accept or reject. Please read this entire form carefully before signing below.

**Accept/Reject Inflation Protection Option**

I have reviewed the Outline of Coverage and the graphs that compare benefits and premiums for this insurance with and without the 5% Compound Inflation Protection option and:

I Accept Compound Inflation

I Reject Compound Inflation

7616-04

I certify that all statements are true to the best of my knowledge and belief. I have read and understand that, for coverage that does not require me to submit evidence of insurability, loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after my effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to my coverage.

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

**Employee & Spouse:** Your signature below authorizes your employer to deduct the required premium from your paycheck. Final cost of coverage will be based on your Insurance Age. If you enroll for coverage on or before the group policy effective date, Insurance Age is your age on the group policy effective date. If you enroll for coverage after the group policy effective date, Insurance Age is your age on the date you sign this enrollment form.

**Your premium:** \$ \_\_\_\_\_ (transfer from calculation above)

_____	_/_/____	_____	_/_/____
<i>Applicant's Signature</i>	<i>Date</i>	<i>Employee's Signature</i> (Required for Spouse Coverage)	<i>Date</i>

**Please sign and mail all required signature forms to your employer.  
Retain a copy for your records. (A4)**

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



**IMPORTANT INSTRUCTIONS:** Prior to submitting this form, all applicants must review the important disclosures and information found on <http://www.unuminfo.com/jeffersonbancshares> or 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.



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 Unum Life Insurance Company of America  
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 Portland, Maine 04122

**JEFFERSON BANCSHARES, INC.**  
**Family Benefit Election Form**  
**Long Term Care - Policy #136358**

Your Name: (Last Name, First, Middle Initial)		Social Security Number ____-____-____	Date of Birth (MM/DD/YYYY) ____/____/____
Street Address		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Hire (MM/DD/YYYY) ____/____/____
City, State, Zip Code		Home Telephone # (    )    (    )	Work Telephone # (    )    (    )
Applicant's Email Address:			
Employee's Name	Employee Social Security No. ____-____-____	Employee Date of Birth ____/____/____	Employee Date of Hire ____/____/____

Is this a change to existing coverage?    Yes     No

If yes, please note that all elections made below will replace existing coverage upon underwriting approval, if applicable.

**All applicants must complete this form. Applicant is:**

<input type="checkbox"/> Employee's Parent or Grandparent	<input type="checkbox"/> Sibling ( <i>minimum age 18</i> )
<input type="checkbox"/> Spouse's Parent or Grandparent	<input type="checkbox"/> Child ( <i>minimum age 18</i> )

**Plans – Check one**

<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4
<ul style="list-style-type: none"> <li>• Long Term Care Facility</li> <li>• Professional Home &amp; Community Care</li> <li>• 3 Year SBP</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care Facility</li> <li>• Total Choice Home Care</li> <li>• 3 Year SBP</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care Facility</li> <li>• Professional Home &amp; Community Care</li> <li>• Compound Inflation</li> <li>• 3 Year SBP</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care Facility</li> <li>• Total Choice Home Care</li> <li>• Compound Inflation</li> <li>• 3 Year SBP</li> </ul>

**Facility Monthly Benefit Amount – Check one**

<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$6,000	<input type="checkbox"/> \$7,000	<input type="checkbox"/> \$8,000	<input type="checkbox"/> \$9,000
----------------------------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------

**Facility Benefit Duration – Check one.**    **Note: Duration of benefits may vary depending on where benefits are received.**

<input type="checkbox"/> 3 Years	<input type="checkbox"/> 6 Years	<input type="checkbox"/> Lifetime
----------------------------------	----------------------------------	-----------------------------------

- **All applicants** must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire) for any selection.
- A signed Authorization to Request Medical Information (form #6720-03 in the kit) must accompany all medical questionnaires.

**Form is continued on reverse side.**

**Calculate Your Premium:**

Please refer to rate sheet in your kit to determine the rate for the plan chosen.

$$\underline{\hspace{2cm}} \times \underline{\hspace{2cm}} \div \$1,000 = \underline{\hspace{2cm}}$$

Rate for plan chosen      Monthly benefit amount      Your premium

**Disclosures:**

**Massachusetts Residents:** You also signify that you have received and read the MassHealth eligibility notice entitled "For Massachusetts Residents Only" - Form #7650-04. The notice is contained in your kit.

**Note: We may have the right to deny benefits or rescind insurance if any of the information provided on this enrollment form is incorrect.**

**REQUEST FOR SIGNATURE:** Must check either accept or reject. Please read this entire form carefully before signing below.

**Accept/Reject Inflation Protection Option**

I have reviewed the Outline of Coverage and the graphs that compare benefits and premiums for this insurance with and without the 5% Compound Inflation Protection option and:

- I Accept Compound Inflation
- I Reject Compound Inflation

7616-04

I certify that all statements are true to the best of my knowledge and belief. I have read and understand that loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after my effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to my coverage.

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

Final cost of coverage will be based on your Insurance Age. If you enroll for coverage on or before the group policy effective date, Insurance Age is your age on the group policy effective date. If you enroll for coverage after the group policy effective date, Insurance Age is your age on the date you sign this enrollment form.

**All 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

**Your premium:** \$\_\_\_\_\_ (transfer from calculation above)

\_\_\_\_\_                      \_\_\_\_/\_\_\_\_/\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_/\_\_\_\_/\_\_\_\_  
*Applicant's Signature*                      *Date*                      *Employee's Signature*                      *Date*

**Please sign and mail all required signature forms to Unum (address at top of page). Retain a copy for your records. (A4)**

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



# JEFFERSON BANCSHARES, INC.

Rates Shown are for \$1,000 Facility Monthly Benefit

(Employee you may choose from \$2,000-\$9,000 in Facility Monthly Benefit)

(Spouse & family you may choose from \$1,000 - \$9,000 in Facility Monthly Benefit)

Bi-Weekly Rates*	Plan 1 Long Term Care Facility Prof Home-Comm Care 50% 3 Year SBP			Plan 2 Long Term Care Facility Total Home Care 50% 3 Year SBP			Plan 3 Long Term Care Facility Prof Home-Comm Care 50% Compound Inflation 3 Year SBP			Plan 4 Long Term Care Facility Total Home Care 50% Compound Inflation 3 Year SBP		
	Benefit Duration	3 YR	6 YR	Lifetime	3 YR	6 YR	Lifetime	3 YR	6 YR	Lifetime	3 YR	6 YR
AGE												
18 - 30	1.15	1.48	2.22	1.85	2.35	3.51	7.75	10.48	13.57	10.71	14.49	18.74
31	1.20	1.57	2.26	1.94	2.49	3.55	7.98	10.80	13.98	11.03	14.91	19.34
32	1.25	1.62	2.31	2.03	2.58	3.65	8.22	11.12	14.40	11.40	15.42	19.94
33	1.34	1.71	2.35	2.12	2.72	3.74	8.49	11.49	14.86	11.77	15.88	20.58
34	1.38	1.80	2.45	2.22	2.86	3.88	8.77	11.86	15.32	12.14	16.38	21.23
35	1.48	1.89	2.54	2.31	3.00	4.02	9.05	12.23	15.78	12.55	16.94	21.88
36	1.52	1.98	2.58	2.45	3.14	4.15	9.37	12.60	16.29	12.92	17.45	22.57
37	1.62	2.08	2.68	2.58	3.28	4.29	9.65	13.02	16.85	13.38	18.05	23.31
38	1.71	2.17	2.77	2.72	3.46	4.43	9.97	13.43	17.35	13.80	18.60	24.05
39	1.80	2.31	2.91	2.86	3.65	4.62	10.29	13.89	17.95	14.26	19.20	24.83
40	1.89	2.40	3.00	3.00	3.83	4.80	10.66	14.35	18.51	14.72	19.85	25.62
41	2.08	2.63	3.28	3.32	4.20	5.26	11.58	15.55	20.12	16.02	21.55	27.88
42	2.17	2.77	3.42	3.46	4.38	5.40	11.86	15.88	20.54	16.38	21.97	28.43
43	2.26	2.86	3.51	3.60	4.52	5.58	12.14	16.25	21.05	16.80	22.52	29.12
44	2.35	2.95	3.65	3.74	4.71	5.82	12.46	16.66	21.60	17.26	23.08	29.86
45	2.45	3.09	3.78	3.92	4.94	6.00	12.83	17.08	22.15	17.77	23.68	30.65
46	2.58	3.23	3.92	4.11	5.12	6.23	13.15	17.49	22.71	18.18	24.23	31.43
47	2.68	3.37	4.06	4.29	5.35	6.46	13.38	17.77	23.08	18.55	24.60	31.94
48	2.86	3.55	4.34	4.57	5.68	6.88	14.03	18.65	24.14	19.43	25.80	33.46
49	3.05	3.83	4.62	4.89	6.09	7.29	14.82	19.57	25.38	20.49	27.09	35.17
50	3.28	4.06	4.89	5.22	6.51	7.75	15.55	20.58	26.68	21.55	28.48	36.92
51	3.74	4.66	5.58	5.95	7.43	8.91	17.49	23.03	29.82	24.18	31.89	41.31
52	4.06	5.03	6.05	6.46	8.03	9.65	18.51	24.37	31.48	25.66	33.74	43.57
53	4.29	5.35	6.46	6.83	8.54	10.25	19.20	25.20	32.54	26.58	34.89	45.05
54	4.57	5.72	6.88	7.25	9.09	10.94	19.89	26.08	33.65	27.55	36.14	46.57
55	4.89	6.09	7.38	7.75	9.69	11.72	20.68	27.05	34.85	28.62	37.48	48.28
56	5.17	6.51	7.85	8.26	10.34	12.51	21.46	28.06	36.09	29.72	38.86	49.98
57	5.54	6.92	8.40	8.77	11.03	13.34	22.20	28.98	37.29	30.74	40.15	51.60
58	5.95	7.48	9.05	9.46	11.91	14.40	23.35	30.42	39.00	32.31	42.14	54.05
59	6.42	8.08	9.83	10.25	12.88	15.60	24.69	32.12	41.12	34.15	44.45	56.91
60	6.97	8.82	10.66	11.12	13.98	16.98	26.17	33.97	43.43	36.23	47.08	60.14
61	8.03	10.11	12.32	12.78	16.11	19.62	29.68	38.63	49.25	41.08	53.49	68.22
62	8.77	11.03	13.52	13.94	17.54	21.46	31.80	41.58	52.85	44.03	57.55	73.15
63	9.46	11.91	14.63	15.05	18.92	23.26	33.51	43.94	55.75	46.38	60.83	77.17
64	10.15	12.78	15.78	16.20	20.31	25.11	35.31	46.43	58.75	48.88	64.34	81.37
65	11.86	14.86	18.51	18.83	23.63	29.40	38.58	50.91	64.89	53.45	70.48	89.82
66	12.69	15.88	19.85	20.17	25.29	31.57	40.75	53.91	68.54	56.40	74.63	94.89
67	14.08	17.63	22.11	22.43	28.06	35.17	44.63	59.26	75.09	61.80	82.02	103.94
68	15.28	19.11	24.05	24.32	30.37	38.22	47.77	63.60	80.31	66.09	88.06	111.18
69	16.52	20.63	26.03	26.26	32.82	41.40	50.95	68.08	85.62	70.52	94.25	118.57
70	17.95	22.38	28.34	28.57	35.63	45.05	54.69	73.34	91.89	75.74	101.58	127.25
71	19.71	24.55	31.06	31.34	39.09	49.38	58.25	78.05	97.66	80.68	108.09	135.23
72	21.88	27.23	34.34	34.80	43.34	54.65	62.72	83.95	104.86	86.86	116.26	145.20
73	24.18	30.09	37.89	38.45	47.86	60.23	67.25	89.95	112.11	93.09	124.52	155.26
74	26.77	33.28	41.77	42.55	52.89	66.46	72.23	96.51	120.09	100.02	133.62	166.25
75	30.23	37.52	47.45	48.09	59.72	75.42	75.74	100.98	126.78	104.86	139.85	175.57
76	33.83	41.95	52.94	53.82	66.74	84.18	82.38	109.75	137.58	114.05	151.98	190.52
77	38.08	47.22	59.45	60.60	75.09	94.57	90.23	120.14	150.28	124.94	166.38	208.06
78	42.14	52.15	65.54	67.02	82.94	104.22	97.11	129.14	161.12	134.45	178.85	223.06
79	46.62	57.69	72.37	74.17	91.75	115.06	104.49	138.88	172.85	144.69	192.32	239.35
80	51.32	63.46	79.34	81.60	100.94	126.18	111.88	148.62	184.34	154.94	205.75	255.23

\*Final premiums may vary due to rounding.





## JEFFERSON BANCSHARES, INC.

*Rates Shown are for \$1,000 Facility Monthly Benefit*

*(Employee you may choose from \$2,000-\$9,000 in Facility Monthly Benefit)*

*(Spouse & family you may choose from \$1,000 - \$9,000 in Facility Monthly Benefit)*

Monthly Rates	Plan 1 Long Term Care Facility Prof Home-Comm Care 50% 3 Year SBP			Plan 2 Long Term Care Facility Total Home Care 50% 3 Year SBP			Plan 3 Long Term Care Facility Prof Home-Comm Care 50% Compound Inflation 3 Year SBP			Plan 4 Long Term Care Facility Total Home Care 50% Compound Inflation 3 Year SBP			
	Benefit Duration	3 YR	6 YR	Lifetime	3 YR	6 YR	Lifetime	3 YR	6 YR	Lifetime	3 YR	6 YR	Lifetime
AGE													
18 - 30	2.50	3.20	4.80	4.00	5.10	7.60	16.80	22.70	29.40	23.20	31.40	40.60	
31	2.60	3.40	4.90	4.20	5.40	7.70	17.30	23.40	30.30	23.90	32.30	41.90	
32	2.70	3.50	5.00	4.40	5.60	7.90	17.80	24.10	31.20	24.70	33.40	43.20	
33	2.90	3.70	5.10	4.60	5.90	8.10	18.40	24.90	32.20	25.50	34.40	44.60	
34	3.00	3.90	5.30	4.80	6.20	8.40	19.00	25.70	33.20	26.30	35.50	46.00	
35	3.20	4.10	5.50	5.00	6.50	8.70	19.60	26.50	34.20	27.20	36.70	47.40	
36	3.30	4.30	5.60	5.30	6.80	9.00	20.30	27.30	35.30	28.00	37.80	48.90	
37	3.50	4.50	5.80	5.60	7.10	9.30	20.90	28.20	36.50	29.00	39.10	50.50	
38	3.70	4.70	6.00	5.90	7.50	9.60	21.60	29.10	37.60	29.90	40.30	52.10	
39	3.90	5.00	6.30	6.20	7.90	10.00	22.30	30.10	38.90	30.90	41.60	53.80	
40	4.10	5.20	6.50	6.50	8.30	10.40	23.10	31.10	40.10	31.90	43.00	55.50	
41	4.50	5.70	7.10	7.20	9.10	11.40	25.10	33.70	43.60	34.70	46.70	60.40	
42	4.70	6.00	7.40	7.50	9.50	11.70	25.70	34.40	44.50	35.50	47.60	61.60	
43	4.90	6.20	7.60	7.80	9.80	12.10	26.30	35.20	45.60	36.40	48.80	63.10	
44	5.10	6.40	7.90	8.10	10.20	12.60	27.00	36.10	46.80	37.40	50.00	64.70	
45	5.30	6.70	8.20	8.50	10.70	13.00	27.80	37.00	48.00	38.50	51.30	66.40	
46	5.60	7.00	8.50	8.90	11.10	13.50	28.50	37.90	49.20	39.40	52.50	68.10	
47	5.80	7.30	8.80	9.30	11.60	14.00	29.00	38.50	50.00	40.20	53.30	69.20	
48	6.20	7.70	9.40	9.90	12.30	14.90	30.40	40.40	52.30	42.10	55.90	72.50	
49	6.60	8.30	10.00	10.60	13.20	15.80	32.10	42.40	55.00	44.40	58.70	76.20	
50	7.10	8.80	10.60	11.30	14.10	16.80	33.70	44.60	57.80	46.70	61.70	80.00	
51	8.10	10.10	12.10	12.90	16.10	19.30	37.90	49.90	64.60	52.40	69.10	89.50	
52	8.80	10.90	13.10	14.00	17.40	20.90	40.10	52.80	68.20	55.60	73.10	94.40	
53	9.30	11.60	14.00	14.80	18.50	22.20	41.60	54.60	70.50	57.60	75.60	97.60	
54	9.90	12.40	14.90	15.70	19.70	23.70	43.10	56.50	72.90	59.70	78.30	100.90	
55	10.60	13.20	16.00	16.80	21.00	25.40	44.80	58.60	75.50	62.00	81.20	104.60	
56	11.20	14.10	17.00	17.90	22.40	27.10	46.50	60.80	78.20	64.40	84.20	108.30	
57	12.00	15.00	18.20	19.00	23.90	28.90	48.10	62.80	80.80	66.60	87.00	111.80	
58	12.90	16.20	19.60	20.50	25.80	31.20	50.60	65.90	84.50	70.00	91.30	117.10	
59	13.90	17.50	21.30	22.20	27.90	33.80	53.50	69.60	89.10	74.00	96.30	123.30	
60	15.10	19.10	23.10	24.10	30.30	36.80	56.70	73.60	94.10	78.50	102.00	130.30	
61	17.40	21.90	26.70	27.70	34.90	42.50	64.30	83.70	106.70	89.00	115.90	147.80	
62	19.00	23.90	29.30	30.20	38.00	46.50	68.90	90.10	114.50	95.40	124.70	158.50	
63	20.50	25.80	31.70	32.60	41.00	50.40	72.60	95.20	120.80	100.50	131.80	167.20	
64	22.00	27.70	34.20	35.10	44.00	54.40	76.50	100.60	127.30	105.90	139.40	176.30	
65	25.70	32.20	40.10	40.80	51.20	63.70	83.60	110.30	140.60	115.80	152.70	194.60	
66	27.50	34.40	43.00	43.70	54.80	68.40	88.30	116.80	148.50	122.20	161.70	205.60	
67	30.50	38.20	47.90	48.60	60.80	76.20	96.70	128.40	162.70	133.90	177.70	225.20	
68	33.10	41.40	52.10	52.70	65.80	82.80	103.50	137.80	174.00	143.20	190.80	240.90	
69	35.80	44.70	56.40	56.90	71.10	89.70	110.40	147.50	185.50	152.80	204.20	256.90	
70	38.90	48.50	61.40	61.90	77.20	97.60	118.50	158.90	199.10	164.10	220.10	275.70	
71	42.70	53.20	67.30	67.90	84.70	107.00	126.20	169.10	211.60	174.80	234.20	293.00	
72	47.40	59.00	74.40	75.40	93.90	118.40	135.90	181.90	227.20	188.20	251.90	314.60	
73	52.40	65.20	82.10	83.30	103.70	130.50	145.70	194.90	242.90	201.70	269.80	336.40	
74	58.00	72.10	90.50	92.20	114.60	144.00	156.50	209.10	260.20	216.70	289.50	360.20	
75	65.50	81.30	102.80	104.20	129.40	163.40	164.10	218.80	274.70	227.20	303.00	380.40	
76	73.30	90.90	114.70	116.60	144.60	182.40	178.50	237.80	298.10	247.10	329.30	412.80	
77	82.50	102.30	128.80	131.30	162.70	204.90	195.50	260.30	325.60	270.70	360.50	450.80	
78	91.30	113.00	142.00	145.20	179.70	225.80	210.40	279.80	349.10	291.30	387.50	483.30	
79	101.00	125.00	156.80	160.70	198.80	249.30	226.40	300.90	374.50	313.50	416.70	518.60	
80	111.20	137.50	171.90	176.80	218.70	273.40	242.40	322.00	399.40	335.70	445.80	553.00	



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				Group Division Number									
<input type="checkbox"/> Male <input type="checkbox"/> Female																									
Applicant Marital Status				Applicant Date of Birth				Applicant Daytime Telephone Number																	
<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed				Month/Day/Year				( ) -																	

How to enroll

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				Employee Date of Hire									
Month/Day/Year												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

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Applicant Name:	Applicant Social Security Number
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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)? <input type="checkbox"/> Yes <input type="checkbox"/> No
-------------------	-------------------	---

Have you (applicant) had any change in weight in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Gain _____ lbs. <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use mechanical devices, such as: a wheelchair, walker, quad cane, crutches, hospital bed, dialysis machine, oxygen, or stairlift?
B. <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently need or receive help in doing any of the following: bathing; eating; dressing; toileting; transferring; maintaining continence?
C. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been diagnosed and/or treated by a member of the medical profession for HIV+?
F. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you developed symptoms of the disease AIDS?
G. <input type="checkbox"/> Yes <input type="checkbox"/> 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? <b>Please circle condition(s) for all "YES" answers.</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> 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.
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Polyp, benign tumor, leukemia, lymphoma, cancer, melanoma, or a disorder of the immune system.
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Diabetes, thyroid problems, or any glandular disease or disorder.
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Intestines, liver or disease or disorder of the stomach or digestive system.
<input type="checkbox"/> Yes <input type="checkbox"/> 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
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<input type="checkbox"/> Yes <input type="checkbox"/> 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.
<input type="checkbox"/> Yes <input type="checkbox"/> 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.
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Lung disorder, shortness of breath, or any disease or disorder of the respiratory system.
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Falls, dizziness, imbalance, or any disease or disorder of the eyes or ears.
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Seizures, tremors, stroke, transient ischemic attack (TIA), paralysis or any other disease or disorder of the brain or nervous system.
<input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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.			
<b>Test(s) Performed</b>	<b>Date (mm/dd/yyyy)</b>	<b>Reason</b>	<b>Results</b>	<b>Name, Address &amp; Telephone Number of Medical Advisor Requesting Test(s)</b>
D. <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you live alone? If no, who lives with you? _____			
E. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you covered by Medicaid? (If yes, details.) _____ _____
B. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you receiving any disability benefits? (If yes, provide details including health condition(s)) _____ _____
C. <input type="checkbox"/> Yes <input type="checkbox"/> 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? _ / _ / _ _ _ _
D. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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: (Mth/ Day/ Yr) _ / _ / _ _ _ Reason for Denial? _____
G. <input type="checkbox"/> Yes <input type="checkbox"/> 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 acknowledge that I have received the Potential Rate Increase Disclosure Form and Personal Worksheet.

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this insurance with and without inflation protection. I have reviewed the Compound Inflation Protection option and

I  accept  reject **Compound Inflation Protection.**

#### 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 \_\_\_\_\_  
Applicant's Signature

Date: \_\_\_\_\_  
(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 is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

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				Group Division Number								
<input type="checkbox"/> Male <input type="checkbox"/> Female																								
Applicant Marital Status				Applicant Date of Birth				Applicant Daytime Telephone Number																
<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed				Month/Day/Year				( ) -																

How to enroll

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				Employee Date of Hire								
Month/Day/Year												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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you (applicant) had any change in weight in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Gain _____ lbs. <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use mechanical devices, such as: a wheelchair, walker, quad cane, crutches, hospital bed, dialysis machine, oxygen, or stairlift?
B. <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently need or receive help in doing any of the following: bathing; eating; dressing; toileting; transferring; maintaining continence?
C. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been diagnosed and/or treated by a member of the medical profession for HIV+?
F. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you developed symptoms of the disease AIDS?
G. <input type="checkbox"/> Yes <input type="checkbox"/> 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? <b>Please circle condition(s) for all "YES" answers.</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> 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.
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Polyp, benign tumor, leukemia, lymphoma, cancer, melanoma, or a disorder of the immune system.
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Diabetes, thyroid problems, or any glandular disease or disorder.
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Intestines, liver or disease or disorder of the stomach or digestive system.
<input type="checkbox"/> Yes <input type="checkbox"/> 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
-----------------	----------------------------------

<input type="checkbox"/> Yes <input type="checkbox"/> 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.
<input type="checkbox"/> Yes <input type="checkbox"/> 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.
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Lung disorder, shortness of breath, or any disease or disorder of the respiratory system.
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Falls, dizziness, imbalance, or any disease or disorder of the eyes or ears.
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Seizures, tremors, stroke, transient ischemic attack (TIA), paralysis or any other disease or disorder of the brain or nervous system.
<input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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.			
<b>Test(s) Performed</b>	<b>Date (mm/dd/yyyy)</b>	<b>Reason</b>	<b>Results</b>	<b>Name, Address &amp; Telephone Number of Medical Advisor Requesting Test(s)</b>
D. <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you live alone? If no, who lives with you? _____			
E. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you covered by Medicaid? (If yes, details.) _____ _____
B. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you receiving any disability benefits? (If yes, provide details including health condition(s)) _____ _____
C. <input type="checkbox"/> Yes <input type="checkbox"/> 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? _ / _ / _ _ _ _
D. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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: (Mth/ Day/ Yr) _ / _ / _ _ _ Reason for Denial? _____
G. <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____ _____ _____

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Applicant Name:

Applicant Social Security Number

#### IV. Acknowledgement

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

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this insurance with and without inflation protection. I have reviewed the Compound Inflation Protection option and

I  accept  reject **Compound Inflation Protection.**

#### 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 \_\_\_\_\_  
Applicant's Signature

Date: \_\_\_\_\_  
(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.

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

**NOTICE TO APPLICANT REGARDING REPLACEMENT  
OF ACCIDENT AND SICKNESS 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, 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, 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.

How to enroll

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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 on space provided below. Deposit tickets do not contain all necessary information.

**Tape  
Voided Check  
Here**

How to enroll

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 Unum.

**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

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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  
2211 Congress Street  
Portland Maine 04122



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

**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/PO Box \_\_\_\_\_ City, State, Zip Code: \_\_\_\_\_

Name: \_\_\_\_\_

Address: Street/PO 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:**  
 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.

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

**DESIGNEE ACCEPTANCE  
 LONG TERM CARE INSURANCE**

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

**Insurance Applicant: Please complete this section prior to sending this form to your Designee for signature.**

Insured's Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

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

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

Designee's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

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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. The company has not raised its rates on these or similar policy forms in the last ten years.]

**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 average annual cost of care in a nursing home in [2006] was close to [\$74,460]<sup>1</sup>, but this figure varies across the country. In ten years the national average cost would be about [\$115,512] 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.

How to enroll

<sup>1</sup> "Using Medicaid to Pay for Nursing Home Care: County Differences Emerge." Agency for Health Care Research and Quality News Release, April, 2009]

**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 than \$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: \_\_\_\_\_



**Group Long Term Care Insurance  
Potential Rate Increase Disclosure Form**

1. **Premium Rate:** The premium rate sheet that is applicable to you and that will be in effect until a request is made and filed / approved for an increase (depending on state law or regulation) can be found in your enrollment kit.
2. **The premium for your coverage will be shown on your schedule of benefits or confirmation of coverage, whichever is applicable.**
3. **Premium Rate Adjustments:** Any change in premium rate 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 non-forfeiture option if purchased. (This option may be available for purchase for an additional premium.)
- Exercise your contingent non-forfeiture rights.\*

**\*Contingent Non-Forfeiture**

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 non-forfeiture as a standard provision or you didn't buy a non-forfeiture option, you may be eligible for contingent non-forfeiture. If your coverage includes a contingent non-forfeiture provision, here is 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.

State forms to review

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 non-forfeiture 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).

**Cumulative Premium Increase over Initial Premium that qualifies for Contingent Non-Forfeiture.**

*Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.*

<b>Issue Age</b>	<b>Percent Increase Over Initial Premium</b>	<b>Issue Age</b>	<b>Percent Increase Over Initial Premium</b>
29 and under	200%	72	36%
30-34	190%	73	34%
35-39	170%	74	32%
40-44	150%	75	30%
45-49	130%	76	28%
50-54	110%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

If your coverage is under a policy effective on or after July 1, 2008 and includes a 5 – Year; 10 – Year; To Age 65; or The Greater of 10 Years or to Age 65 Accelerated Payment Option provision, in addition to the contingent non-forfeiture benefits described above, the following reduced “paid-up” contingent non-forfeiture benefit is an option even if you selected a non-forfeiture benefit when you purchased your coverage. If both the reduced “paid-up” benefit AND the contingent benefit described above are triggered by the same rate increase, you can chose either of the two benefits.

You are eligible for the reduced “paid-up” contingent non-forfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the rate increase exceeds your original premium by the same percentage or more shown in the chart below:

**TRIGGERS FOR A SUBSTANTIAL PREMIUM INCREASE -**

<b>Issue Age</b>	<b>Percent Increase Over Initial Premium</b>
Under 65	50%
65 – 80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND
3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option, your coverage will be converted to a reduced “paid-up” status. This means there will be no additional premiums required. Your benefits will change in the following ways:

- (a) The total lifetime amount of benefits your reduced “paid-up” coverage will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the coverage becomes “paid-up” by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.
- (b) The monthly benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the monthly benefit amounts you purchased will be adjusted by the applicable ratio.

**Example:**

- You bought the coverage at age 65 with an annual premium payable for 10 years.
- In the sixth (6<sup>th</sup>) year, you receive a rate increase of 35% and you decided to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your “paid-up” coverage benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to benefits in the reduced “paid-up” coverage.

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**Things You Should Know Before You Buy Long Term Care Insurance**

<b>Long Term Care Insurance</b>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.</li> </ul>
<b>Medicare Medicaid</b>	<ul style="list-style-type: none"> <li>• Medicare does not pay for most of long term care.</li> <li>• 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.</li> <li>• Many people become eligible for Medicaid after they have used up their own financial resources by paying for long term care services.</li> <li>• 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.</li> <li>• 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.</li> </ul>
<b>Shopper’s Guide</b>	<ul style="list-style-type: none"> <li>• Make sure the insurance company or producer gives you a copy of a booklet called the National Association of Insurance Commissioners’ “Shoppers Guide to Long Term Care Insurance”. 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.</li> </ul>
<b>Counseling</b>	<ul style="list-style-type: none"> <li>• Free counseling and additional information about long term care insurance are available through your state’s insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.</li> </ul>
<b>Facilities</b>	<ul style="list-style-type: none"> <li>• Some long term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long term care policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.</li> </ul>

State forms to review

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FOR MASSACHUSETTS RESIDENTS ONLY

**Re: Long-Term Care Insurance Policies Issued in Massachusetts that are Intended to Qualify Insureds for Certain MassHealth Exemptions**

The purpose of this notice is to describe the minimum coverage requirements needed to potentially qualify for exemptions from some MassHealth eligibility and recovery rules. Information about these coverage requirements is also available in the publication *Your Options for the Financing of Long-Term Care: A Massachusetts Guide*. The Commissioner of Insurance has instructed all long-term care insurance carriers to provide this notice to clarify the coverage requirements associated with MassHealth exemptions.

Buying long-term care insurance in Massachusetts that meets certain standards may qualify the insured for exemptions from some of the eligibility and recovery rules under the Massachusetts MassHealth (Medicaid) Program. **It is important to note that MassHealth minimum coverage requirements are based upon benefits available as of the day the individual enters a nursing home, not what is available on the day the person buys a policy.**

One of the existing requirements to qualify for MassHealth exemptions is that an individual's long-term care insurance must have benefits available to pay at least \$125 per day for at least 730 days (2 years) of nursing home care as of the day the individual enters a nursing home.

Although a long-term care insurance policy may satisfy the MassHealth minimum coverage requirements at the time it is purchased, if the insured uses the policy to pay for non-nursing home benefits (e.g., home health care, personal care or assisted living benefits), the amount of benefits available to pay for nursing home care may be reduced. Depending upon the original maximum benefit and other benefits that may have been used, the policy may not meet the MassHealth minimum coverage requirements as of the day the individual enters a nursing home.

For example: a person purchased a policy with 730 days of nursing home and home health care coverage and, prior to entering the nursing home, used 100 days of coverage to pay for home health care services. On the day the individual enters the nursing home, the person would have 630 days of coverage left to pay for nursing home care. This is less than the minimum 730 days of nursing home coverage required for certain MassHealth exemptions.

It should also be noted that a long-term care policy with an inflation protection benefit may ultimately satisfy the MassHealth minimum coverage requirements, even if the policy failed to meet the MassHealth minimum coverage requirements on the day it was purchased. For example, a policy that initially had a \$100 per day benefit with an annual inflation adjustment could potentially increase over time to meet the MassHealth minimum coverage requirements as of the day the person enters a nursing home.

Qualifying for insurance benefits is independent from qualifying for an exemption under MassHealth. For more information, contact your agent or read *Your Options for Financing Long-Term Care: A Massachusetts Guide*.

Please be aware that laws may change and the exemptions and the MassHealth minimum coverage requirements that exist today may not necessarily be the same in the future (or might not exist at all).

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## **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.