unum
Better benefits at work.

Long term care insurance

Everything you need to apply for coverage for yourself and your family members

How it works

How to enroll

State forms to review

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*	✓	✓			
Other family members	✓	✓	✓	✓†	✓
Retired employee and spouse	✓	✓	✓	✓†	✓

* 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.

* 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.

Underwritten by:
Unum Life Insurance Company of America

Long term care insurance

The purpose of this communication is the solicitation of insurance. Contact will be made by an insurance agent or insurance company.

Who controls your future?

Be prepared with long term care insurance from Unum.

Your life, your choice

There are plenty of decisions to make for retirement...

- Fishing or golf?
- Motor home or long-awaited cruise?
- A house at the beach — or close to the grandchildren?

Long term care insurance may help you avoid a far more difficult decision: whether to exhaust your savings or liquidate your assets to pay for a period of long term care. This policy may help you be prepared for the financial realities and help you maintain control of some important decisions, such as:

- Who would take care of me?
- Where can I choose to receive care?
- Would I be a burden on my children if my savings couldn't cover my care?

What is long term care?

Whether it's due to a motorcycle accident or a serious illness, it is the type of care you may need if you couldn't independently perform the basic activities of daily living: bathing, dressing, using the toilet, transferring from one location to another, continence and eating, or if you suffered severe cognitive impairment from a condition such as Alzheimer's disease.

Who's at risk?

Long term care insurance is not just for the elderly.

- 40% of people currently receiving long term care are working-age adults 18 to 64 years old.[1]
- About 70% of individuals over age 65 will require some type of long term care services during their lifetime.[2]
- By 2020, 12 million people are projected to need long term care.[3]

How does this coverage help?

Here are some examples of how you may use a long term care benefit of $3,000 per month, based on the national averages for care:[4]

Home health:	
Long term care annual benefit	$36,000
Home health aide ($18.50/hour)	– $24,050/year*
Left over for out-of-pocket expenses	= $11,950
Assisted living:	
Long term care annual benefit	$36,000
Assisted living ($2,825.25/month)	– $33,903/year
Left over for out-of-pocket expenses	= $2,097
Private nursing home:	
Long term care annual benefit	$36,000
Private nursing home ($203.31/day)	– $74,208.15/year
The cost of care that you will pay out of pocket	= –$38,208.15

*Based on receiving care five hours a day/five days a week at $18.50/hour. For illustrative purposes only.

How to apply

Your benefit enrollment is coming soon. To learn more, watch for information from your employer.

How it works

Get the coverage you need.

Won't my other insurance pay for long term care? Unfortunately, no.

- Medical insurance and Medicare are designed to pay for specific care for acute conditions — not for long term help with daily living.
- Medicaid only helps with long term care expenses after you have depleted virtually all of your assets. The exact amount varies by state but usually leaves just a few thousand dollars in total assets.

  Only long term care insurance may cover those costs and allow you to maintain as much of your assets as possible.

Do I need to be in a nursing home to use my LTC insurance?

All Unum plans include a home health option. This allows you to use your benefit to pay for an aide to come to your home, so you can remain in your residence as long as possible. For an extra premium, some plans allow you to pay a family member or friend to take care of you.

Why buy now?

People often buy long term care insurance at an early age, because the younger you are, the more affordable the rates.

In fact, 63% of the people who buy group LTC insurance are under age 55.[5]

Why buy coverage at work?

1. You may get more affordable rates when you buy this coverage through your employer and you may extend your coverage to your parents and spouse.

2. Depending on your plan, you may be able to pay your premiums through convenient payroll deduction.

3. Your employer has selected coverage from Unum, the leading provider of group LTC insurance for employees in the U.S.[6]

Additional help for caregivers

Even if you don't need long term care in the immediate future, you may be a caregiver for someone you love. Your plan includes LTC Connect® service, which gives you access to counselors who can help you find long term care providers in your area, a support group, or other assistance you may need. This service also provides discounts for medical equipment such as walkers, hearing aids, wheelchairs, and other related needs.

1,2,3 U.S. Department of Health and Human Services, "National Clearinghouse for Long-Term Care Information," updated October 2008. Available at: http://www.longtermcare.gov/LTC/Main_Site/Understanding_Long_Term_Care/Basics/Basics.aspx, cited November 17, 2009.
4 Genworth Financial, "2009 Cost of Care Study," April 2009.
5 American Association for Long Term Care Insurance, "2008 LTCI Sourcebook," February 2008.
6 LIMRA, 2008 Group LTC Report, 2009. Based on inforce cases. Excluding federal and California-specific Group LTC plans, Unum also ranks first in number of employees enrolled.

Nursing home care based on 24-hour care for one year. Assisted living based on 12 months care. Home care based on five hours of care per day, five days per week for Non-Medicaid Certified home health aide services.

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

unum.com

EN-1168 (2-11) FOR EMPLOYEE INFORMATION

TOWN OF WAYLAND
PLAN HIGHLIGHTS / SCHEDULE OF BENEFITS

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

Elimination Period: Your plan's Elimination Period of 90 consecutive days is the amount of time you must wait before benefits become payable. This time period must be satisfied only once during the life of your plan.

Newly Hired Employees – once eligible for the plan, will have 30 days to sign up for Guarantee Issue coverage. Please check with your employer for your effective date.

All Active Employees & Newly Hired Employees – who enroll after the Guarantee Issue enrollment period or choose benefits over the Guarantee Issue limits will be required to fill out a medical questionnaire.

Medical Underwriting Effective Date - The effective date for those applicants passing medical underwriting between the 1st and 15th of the month is the first of the month following their date of approval. For those approved between the 16th and the end of the month, their effective date is the first of the second month following their date of approval.
Medical Underwriting means that you must answer all questions on a medical questionnaire. In some cases, an interview may also be necessary.

Delayed Effective Date – If you are absent from work because you are injured, sick, temporarily laid off or on a leave of absence, your coverage will not begin on your otherwise expected effective date.

Medical Underwriting for Employees and Family: (Completion of the Benefit Election Form is required for enrollment) As an **Employee** you are eligible for benefit amounts on a Guarantee Issue basis of up to and including $4,000 and a Facility Benefit Duration of 3 or 6 years. This does not require completion of the Long Term Care Insurance Application (medical questionnaire) if you apply during your initial eligibility period. The Long Term Care Insurance Application (medical questionnaire) is required if enrolling after your initial eligibility period or if you choose to buy the $5,000 or $6,000 coverage. **Retirees** and all **Family Members** must complete 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
Facility Benefit Amount **Per $1,000 Increments**	$2,000 to $6,000	$2,000 to $6,000
Assisted Living Facility Percent	60%	60%
Professional Home & Community Care Services	50%	50%
Total Home Health Care - **Option**	50%	50%
Inflation Protection * - **Option**	Simple Uncapped	Simple Uncapped

** 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: Insurance Age is used to determine the cost of your coverage. Insurance Age is your age on the plan effective date if you enroll for coverage prior to the plan effective date. If you enroll for coverage on or after the plan effective date, insurance age is your age on the date you sign the enrollment form.

Questions: Please call 1-800-227-4165 with questions regarding your Long Term Care Insurance.

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

LONG TERM CARE INSURANCE
OUTLINE OF COVERAGE
FOR THE EMPLOYEES OF
TOWN OF WAYLAND
(the Policyholder)
Group Master Policy/Certificate Form Number **536051**

Caution: If you must complete an Application for Long Term Care Insurance which includes evidence of insurability, the issuance of a long term care insurance certificate will be based on your response to the questions in your application. A copy of your Application for Long Term Care Insurance was retained by you when you applied. If your answers are incorrect or untrue, UNUM may have the right to deny benefits or rescind your coverage. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact UNUM at this address: UNUM Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122.

NOTICE TO BUYER: This plan may not cover all of the costs associated with long term care which you may incur during the period of coverage. You are advised to review carefully all coverage limitations.

1. The policy is a group policy of insurance which was issued in **Massachusetts**.

2. **PURPOSE OF OUTLINE OF COVERAGE**

   This outline of coverage provides a brief description of the important features of the plan, You should compare this outline of coverage to outlines of coverage for other plans available to you.

   This is not an insurance contract, but only a summary of coverage. Only the Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both you and UNUM. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR CERTIFICATE CAREFULLY!**

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

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

   - **RENEWABILITY**

     THE POLICY IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of the policy, to continue this coverage as long as you pay your premiums on time. UNUM cannot change any of the terms of the policy on its own except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

   - **WHEN COVERAGE WILL END**

     Your coverage will end on the earliest of these dates;
     - the date the Policy ends,
     - the date you are no longer an Active Employee with the Policyholder,
     - the date you no longer work for the Policyholder,
     - the end of the period for which premiums were last paid to UNUM for
     - your coverage,
     - the date your total benefit payments equal your Lifetime Maximum
     - Amount, or
     - the date you die.

If you are absent from work at the Policyholder for any reason, you will continue to be covered for group coverage if the Policyholder continues to pay premiums to UNUM.

- **CONVERTED COVERAGE**

  If your group long term care coverage ends, for reasons other than your choice to have premium payments stopped for your coverage, you may elect converted coverage. This means that the same coverage you had under this plan can continue on a direct billed basis. If you are already direct billed, your coverage will automatically transfer to converted coverage.

  Election for converted coverage must be made within 31 days of the date the group coverage would otherwise end. Any premium that applies must be paid directly to UNUM by you for any converted coverage to be continued.

- **PREMIUM WAIVER**

  When benefits become payable, there will be no more cost for your coverage as long as you continue to be eligible for a monthly benefit.

  If your plan includes Professional Home and Community Care Services and you do not receive these services for a period of 30 days, premium payments will again become due.

  Premiums are not waived while you are receiving a payment for Respite Care.

- **RIGHT TO CHANGE PREMIUMS**

  The rate will not increase because you grow older or because of your use of the benefits. However, the rate schedule may change in the future depending on the overall use of the benefits of all covered persons or changes in the benefit levels, plan design or other risk factors. Any such change will be made on a class basis according to UNUM's underwriting risk studies under this type of insurance.

5. TERMS UNDER WHICH THE CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED

- You have a 30 day right to examine the certificate. If, after examining the certificate, you are not satisfied for any reason, you may withdraw your enrollment in the plan by returning your certificate within 30 days of its delivery to you. The certificate, together with a written request for withdrawal must be sent to the Plan Administrator or UNUM. Upon receipt, your insurance will be deemed void from its effective date and any premium contribution(s) paid will be returned.

- Premiums for additional, increased or terminated insurance may cause a pro-rata adjustment on the next premium due date.

6. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from UNUM. You may obtain a copy of the Guide by calling 1-800-227-4165. UNUM Life Insurance Company of America is not representing Medicare, the federal government or any state government.

7. LONG TERM CARE COVERAGE

Plans of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This plan provides coverage in the form of a fixed dollar indemnity monthly benefit if you become Disabled and you are receiving care while confined in a Long Term Care Facility or Assisted Living Facility. If you purchase Total Home Care or Professional Home and Community Care Services coverage, we will pay you a benefit if you elect to receive care other than in a Long Term Care Facility or Assisted Living Facility.

Coverage is subject to policy limitations, benefit maximums and elimination periods.

8. BENEFITS PROVIDED BY THE POLICY

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

You are eligible for a monthly benefit after:

- you become Disabled;
- you are receiving services in a Long Term Care Facility or Assisted Living Facility; or Professional Home and Community Care Services if your plan includes a Professional Home and Community Care Services benefit; or Total Home Care if your plan includes a Total Home Care benefit;
- you have satisfied your Elimination Period; and
- a Physician has certified that you are unable to perform, without Substantial Assistance from another individual, two or more ADLs for a period of at least 90 days, or that you require Substantial Supervision by another individual to protect you and others from threats to health or safety due to Severe Cognitive Impairment. You will be required to submit a Physician certification every 12 months.

A monthly benefit will become payable once all of these requirements are met.

The treatment and services you receive for your Disability must be provided pursuant to a written plan of care developed by a Licensed Health Care Practitioner.

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

After you satisfy the Elimination Period, we will pay you:

the Long Term Care Facility Benefit Amount if you receive care while confined in a Long Term Care Facility. Your confinement must be because you are receiving care and need either: (1) Substantial Assistance from another person to perform 2 or more Activities of Daily Living (ADLs); or (2) Substantial Supervision because you suffer from Severe Cognitive Impairment, or

the Assisted Living Facility Benefit Amount if you are Disabled and are receiving services in an Assisted Living Facility.

The Assisted Living Facility Benefit Amount will be the greater of:

(1) 60% of the Long Term Care Facility Benefit Amount; or

(2) the Total Home Care or Professional Home and Community Care Services Benefit Amount shown on the Schedule of Benefits if Home Care is purchased.

Professional Home and Community Care Services Benefit:

We will pay you 1/30th of the Monthly Professional Home and Community Care Services Benefit Amount for each day you receive Professional Home and Community Care Services if:

a. you are Disabled; and

b. you choose to receive care anywhere other than in a Long Term Care Facility, or Assisted Living Facility.

This care can be provided at any type of facility, such as an Adult Day Care Facility, or your home by/through a licensed Home Health Care Provider.

OPTIONAL BENEFITS AVAILABLE

Total Home Health Care Benefit:

We will pay you the Monthly Total Home Care Benefit Amount if you are Disabled and receiving care and you choose to receive care anywhere other than in a Long Term Care Facility or Assisted Living Facility.

This care can be provided at any type of facility, such as an Adult Day Care Facility or your home. Care can be provided to you by:

a. a formal caregiver, such as a licensed Home Health Care Provider, a registered nurse, a licensed practical nurse, or

b. an informal caregiver, such as a friend or relative.

Inflation Protection Provision - 5% Simple Inflation With No Cap

Your Monthly Benefit Amount will increase each year on January 1st by 5% of the Monthly Benefit in effect on that January 1st. Increases will be automatic and will occur regardless of your health and whether or not you are Disabled. Your premium will not increase due to automatic increases in your Monthly Benefit Amount.

The benefit paid is subject to the Lifetime Maximum Benefit Amount. Benefits are not paid during the Elimination Period.

Refer to the graphic Comparison Chart of all types of Inflation, located in Section 10 of this Outline of Coverage

IMPORTANT TERMS YOU SHOULD KNOW:

"Activities of Daily Living" (ADLs) are:

- BATHING - washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower with or without equipment or adaptive devices.
- DRESSING - putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- TOILETING - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- TRANSFERRING - moving into and out of a bed, chair or wheelchair with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
- CONTINENCE - the ability to maintain control of bowel or bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- EATING - feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

"Adult Day Care" means a community-based program offering nursing services, occupational therapy, physical therapy, speech therapy, social, recreational, and educational events designed to improve each participant's self-awareness and level of functioning, and training and assistance in dressing, grooming, personal hygiene, use of special aids, accident-prevention, and Activities of Daily Living. Adult Day Care can be provided by an Adult Day Care Facility or a Home Health Care Provider.

"Adult Day Care Facility" means a facility that provides Adult Day Care and operates under state licensing laws and any other laws that apply, and meets the following tests:

- operates a minimum of 5 days a week;
- remains open for at least 6 hours a day;
- maintains a written record of care on each patient;
- includes a plan of care and record of services provided;
- has a staff that includes a full-time director and at least one registered nurse who are there during operating hours for at least 4 hours per day;
- has established procedures for obtaining appropriate aid in the event of a medical emergency; and
- provides a range of physical and social support services to adults; and
- whose program does not include overnight stays

"Assessment" means an interview of you done by UNUM or our representative to assist in the determination of your insurability at the time of application, or the determination of Disability at the time of your claim.

"Assisted Living Facility " means:

- a facility that is primarily engaged in providing on going care and services to a minimum of 3 inpatients in one location and meets all of the following tests:
  - provides 24 hour a day care; and
  - provides custodial services and personal care assistance to support needs as a result of a Disability; and
  - has an employee on duty at all times who is awake, trained and ready to provide care; and
  - provides at least one meal a day, including special dietary requirements; and
  - operates under state licensing laws and any other laws that apply; and
  - has formal arrangements for services of a Physician or nurse to furnish medical care in the event of an emergency; and
  - is authorized to administer medication to patients on order of a Physician; and
  - is not, other than incidentally, a home for alcoholic or drug abusers, or a hotel; or
- an assisted living residence as certified by the Executive Office of Elder Services; or
- a similar facility approved by UNUM.

NOTE: These requirements are typically met by Assisted Living Facilities that are either free standing facilities or part of a life care community. In general, they are not met by individual residences, boarding homes or independent living units.

"Disability" and "Disabled" mean:

- you are unable to perform, without Substantial Assistance from another individual, at least two Activities of Daily Living; or
- you require Substantial Supervision by another individual to protect you from threats to health and safety due to Severe Cognitive Impairment.

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

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

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

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

"Respite Care" means short-term or periodic care which is required to maintain your health or safety and to give temporary relief to your primary, informal caregiver from his or her caregiving duties. Respite Care can be provided in your home, a Long Term Care Facility, an Assisted Living Facility, an Adult Day Care Facility, or a similar facility approved by UNUM.

"Severe Cognitive Impairment" means a severe deterioration or loss in intellectual capacity, as reliably measured by clinical evidence and standardized tests in:

- short or long term memory;
- orientation to people, places or time; and
- deductive or abstract reasoning.

"Substantial Assistance" means stand-by assistance by another person without which you would not be able to safely and completely perform the ADL.

"Substantial Supervision" means the presence of another individual for the purpose of protecting you from harming yourself or others.

9. LIMITATIONS AND EXCLUSIONS

UNUM will not make long term care payments to you for:

- a Disability caused by war or any act of war, whether declared or not, while your insurance is in force;
- a Disability caused by intentionally self-inflicted injuries or attempted suicide;
- a Disability caused by a commission of a crime for which you have been convicted under state or federal law or attempting to commit a crime under state or federal law,
- a Disability caused by alcohol abuse,
- services provided for alcohol or drug detoxification or alcohol or drug rehabilitation;
- a Disability caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you by a Physician. ("Controlled substance" is defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments),
- Disabilities or confinements during which you are outside the United States, its territories or possessions for longer than 30 days,

- a period in which you are confined in a hospital other than if you are confined in a Long Term Care Facility that is a distinctly separate part of a hospital (this exclusion does not apply to those periods covered under the Bed Reservation Benefit), or

Pre-existing Conditions Exclusion

If you do not have to complete an Application for Long Term Care Insurance, which includes evidence of insurability, a pre-existing conditions exclusion may apply to you.

"Pre-Existing Condition" means any condition that exists for which you received medical treatment, consultation, care or services, including diagnostic measures for the condition, or took drugs or medicines that were prescribed for the condition, during the six month period right before your coverage began.

UNUM will not make any payments to you for a Disability that is caused by, contributed to by, or results from a pre-existing condition, and begins during the first six months after your coverage begins.

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

10. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted.

- **COST**

  The premium rate paid for your coverage over the duration of your initial coverage or for any increases is based on your insurance age.

- **ELECTION TO INCREASE COVERAGE**

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

INFLATION PROTECTION COMPARISON

The following chart is an example comparison of monthly benefits with and without the Simple Inflation Protection Option.

Policy Year	Without Inflation Protection Monthly Benefit	With 5% Simple Inflation Protection Monthly Benefit
1	$2000.	$2100.
2	$2000.	$2200.
3	$2000.	$2300.
4	$2000.	$2400.
5	$2000.	$2500.
6	$2000.	$2600.
7	$2000.	$2700.
8	$2000.	$2800.
9	$2000.	$2900.
10	$2000.	$3000.
11	$2000.	$3100.
12	$2000.	$3200.
13	$2000.	$3300.
14	$2000.	$3400.
15	$2000.	$3500.
16	$2000.	$3600.
17	$2000.	$3700.
18	$2000.	$3800.
19	$2000.	$3900.
20	$2000.	$4000.

11. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

The policy provides coverage for Severe Cognitive Impairment. Severe Cognitive Impairment is not related to the inability to perform ADLs. Rather, Severe Cognitive Impairment means that you have lost the ability to reason and suffer a decrease in awareness, intuition and memory. Examples of conditions which may cause Severe Cognitive Impairment are: Alzheimer's disease, multi-infarct dementia, brain injury, brain tumors, and other such structural alterations of the brain.

12. PREMIUM

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

13. ADDITIONAL FEATURES

- Medical underwriting may be required
- Eligibility and Participation

  You are eligible for the plan if you are:

  – an Active employee of the Policyholder and your family members.

IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/wayland 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

TOWN OF WAYLAND
Benefit Election Form
Long Term Care - Policy #536051

Your Name: (Last Name, First, Middle Initial)	Social Security Number ___ - ___ - ___	Date of Birth (MM/DD/YYYY) ___/___/___
Street Address	Gender ☐ Male ☐ Female	Date of Hire (MM/DD/YYYY) ___/___/___
City, State, Zip Code	Home Telephone # ( )	Work Telephone # ( )
Applicant's Email Address:		

Complete the following only if applicant is not the employee:

Employee's Name	Employee Social Security No. ___ - ___ - ___	Employee Date of Birth ___/___/___	Employee Date of Hire ___/___/___

Applicant is: (This Benefit Election Form must be completed for any selection)

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

Plans

(Check one)

☐ Plan 1	☐ Plan 2	☐ Plan 3	☐ Plan 4
• Long Term Care Facility • Professional Home & Community Care Services	• Long Term Care Facility • Professional Home & Community Care Services • Total Home Health Care	• Long Term Care Facility • Professional Home & Community Care Services • Simple Inflation	• Long Term Care Facility • Professional Home & Community Care Services • Total Home Health Care • Simple Inflation

Facility Monthly Benefit Amount

(Check one)

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

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

(Check one)

☐ 3 Years	☐ 6 Years

*** EMPLOYEES: Selection of this option exceeds the Guarantee Issue limits and requires completion of the Long Term Care Insurance Application (medical questionnaire). ALL OTHER APPLICANTS must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire) for any selection. ALL Medical Questionnaires must accompany a signed Authorization to Request Medical Information Form #6720-03 located in the enrollment kit.**
***NOTE TO EMPLOYEES:* All Active Employees & Newly Hired Employees – who enroll after the Guarantee Issue enrollment period or choose benefits over the Guarantee Issue limits will be required to fill out a medical questionnaire and signed Form #6720-03.**

Active Employee or Spouse: Your premium will be paid through the Employee's payroll deduction. Employee must sign below to authorize the Employer to make the payroll deduction.
All other Eligible Family Members or Retirees: Please select payment method: ☐ Monthly Automatic Payments (deducted from your checking account – complete Authorization/Agreement for Automatic Payments), **OR**
Billed directly (paper) by the insurance company: ☐ Quarterly ☐ Semi-Annually ☐ Annually
Caution: if your answers on this Enrollment Form are incorrect or untrue, we may have the right to deny benefits or rescind your insurance.
By signing below, you signify that you have read and understand that loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after your effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to your coverage. All information is contained in your kit.

Your Premium: $_____ ***(Transfer the premium amount from the calculation on the rate sheet)***

_____	___/___/_____	_____	___/___/_____
Applicant's Signature	*Date*	*Employee's Signature (Required for Spouse Coverage)*	*Date*

Employees & Spouses: Please sign and mail all required signature forms to your employer.
Family Members/Retirees: Please sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (J4)

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

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RATE SHEET
TOWN OF WAYLAND

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Simple Uncapped**
Facility Benefit Duration	**3 Years**		
Home Benefit	**50%**		
Lifetime Maximum	**$36,000**		
Elimination Period	**90 Days**		
Home Care Level	**Professional**		

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

Calculate your Premium:

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

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Simple Inflation Option	Plan 4 Base Plan With Total Home Care Simple Inflation Option
18-30	3.80	5.80	6.20	9.40
31	3.80	5.80	6.50	9.70
32	3.80	5.90	6.50	9.80
33	3.90	6.10	6.90	10.30
34	4.00	6.20	7.20	10.60
35	4.20	6.40	7.40	10.90
36	4.30	6.50	7.60	11.20
37	4.40	6.80	8.00	11.80
38	4.60	7.10	8.40	12.40
39	4.90	7.40	8.90	12.90
40	5.10	7.70	9.20	13.30
41	5.40	8.00	9.70	14.10
42	5.50	8.30	9.90	14.50
43	5.80	8.70	10.50	15.20
44	6.10	9.10	11.00	15.90
45	6.40	9.50	11.60	16.60
46	6.70	10.00	12.00	17.40
47	7.00	10.50	12.50	18.20
48	7.40	11.20	13.20	19.30
49	7.80	11.80	13.70	20.10
50	8.10	12.50	14.40	21.10
51	8.70	13.30	15.10	22.30
52	9.20	14.20	16.00	23.70
53	9.70	15.00	16.80	24.90
54	10.20	15.80	17.40	26.00
55	10.90	16.90	18.50	27.30
56	11.60	17.90	19.60	28.80
57	12.50	19.30	20.80	30.70
58	13.40	20.60	22.00	32.30
59	14.40	22.10	23.50	34.40

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RATE SHEET
TOWN OF WAYLAND

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Simple Uncapped**
Facility Benefit Duration	**3 Years**		
Home Benefit	**50%**		
Lifetime Maximum	**$36,000**		
Elimination Period	**90 Days**		
Home Care Level	**Professional**		

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

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Rate for Plan Chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Simple Inflation Option	Plan 4 Base Plan With Total Home Care Simple Inflation Option
60	15.50	23.60	25.10	36.60
61	16.90	25.50	27.10	39.20
62	18.70	28.00	29.60	42.50
63	20.40	30.20	32.00	45.60
64	22.40	32.90	34.80	49.10
65	25.60	36.90	39.40	54.40
66	28.30	40.00	43.10	58.90
67	31.60	43.80	47.30	63.60
68	34.90	47.80	51.50	68.60
69	38.70	52.10	56.30	74.00
70	42.90	57.00	61.50	79.80
71	47.60	62.40	67.60	86.80
72	52.80	68.30	74.50	94.40
73	58.60	75.00	81.40	102.40
74	64.70	82.00	89.40	111.10
75	78.00	97.80	106.30	131.10
76	85.70	106.40	115.30	140.90
77	94.00	115.60	125.60	152.10
78	103.20	125.70	135.80	163.30
79	113.30	136.70	147.80	176.10
80	124.50	148.90	160.10	189.40
81	137.10	162.40	175.10	205.20
82	152.20	178.90	191.10	222.60
83	168.00	196.50	209.50	242.80
84	185.20	215.30	227.30	262.20

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RATE SHEET
TOWN OF WAYLAND

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Simple Uncapped**
Facility Benefit Duration	**6 Years**		
Home Benefit	**50%**		
Lifetime Maximum	**$72,000**		
Elimination Period	**90 Days**		
Home Care Level	**Professional**		

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

Calculate your Premium:

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

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Simple Inflation Option	Plan 4 Base Plan With Total Home Care Simple Inflation Option
18-30	4.90	7.70	8.30	12.60
31	5.00	7.80	8.50	12.90
32	5.10	8.00	8.90	13.40
33	5.30	8.20	9.30	13.90
34	5.40	8.40	9.50	14.40
35	5.70	8.80	10.00	15.00
36	5.80	8.90	10.30	15.30
37	6.00	9.20	10.80	16.00
38	6.30	9.70	11.30	16.80
39	6.60	10.00	11.70	17.30
40	6.70	10.40	12.10	18.00
41	7.00	10.70	12.60	18.70
42	7.40	11.40	13.30	19.80
43	7.70	11.80	13.90	20.50
44	8.10	12.40	14.80	21.70
45	8.60	13.00	15.30	22.50
46	9.00	13.80	16.00	23.50
47	9.40	14.40	16.70	24.70
48	10.00	15.40	17.60	26.10
49	10.30	16.10	18.30	27.30
50	10.80	17.00	19.10	28.70
51	11.50	18.10	20.10	30.30
52	12.20	19.20	21.10	31.90
53	12.90	20.50	22.20	33.80
54	13.60	21.70	23.20	35.30
55	14.40	23.00	24.40	37.00
56	15.30	24.50	25.80	39.20
57	16.50	26.30	27.40	41.70
58	17.60	28.20	28.90	43.90
59	18.90	30.20	30.80	46.80

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RATE SHEET
TOWN OF WAYLAND

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Simple Uncapped**
Facility Benefit Duration	**6 Years**		
Home Benefit	**50%**		
Lifetime Maximum	**$72,000**		
Elimination Period	**90 Days**		
Home Care Level	**Professional**		

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

Calculate your Premium:

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

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Simple Inflation Option	Plan 4 Base Plan With Total Home Care Simple Inflation Option
60	20.20	32.30	32.60	49.50
61	22.20	35.10	35.40	53.60
62	24.30	38.30	38.30	57.80
63	26.60	41.60	41.80	62.60
64	29.20	45.30	45.10	67.10
65	33.10	50.70	50.70	74.50
66	36.70	55.40	55.60	80.90
67	40.70	60.60	60.80	87.20
68	45.00	66.00	66.30	94.30
69	49.70	72.00	72.10	101.40
70	54.90	78.70	78.80	109.70
71	61.10	86.40	86.50	119.40
72	67.60	94.60	95.20	129.70
73	74.70	103.60	103.70	140.70
74	82.60	113.40	113.80	152.60
75	99.30	135.30	135.00	180.00
76	109.10	147.20	146.20	193.50
77	119.70	160.20	159.20	209.10
78	131.20	174.30	172.20	224.80
79	143.80	189.60	187.20	242.70
80	157.70	206.30	202.20	260.50
81	173.30	225.00	220.60	282.20
82	191.90	247.70	240.60	306.40
83	211.60	271.90	263.20	333.70
84	232.50	297.70	284.90	360.50

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

FOR HOME OFFICE USE ONLY
FN _____ MI ___ LN _____
PN _____ SN _____

Group Long Term Care Insurance Application
Evidence of Insurability

Please complete all sections, answer all questions and sign and date where indicated. Processing will be delayed if this form is incomplete.

Send fully completed form to your plan administrator or Unum Life Insurance Company of America, Attn: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122-2295

Alterations to the pre-printed text will void this application. To ensure timely handling of this application, the applicant's name and social security number must be added at the top of each page.

As the applicant, or person applying for this coverage, you are required to answer all of the following questions.

Policyholder Name (e.g. Employer Name)

Group Policy No. or ID

Applicant First Name:

M.I.

Last Name

Number and Street Address / P.O. Box Number

City

State

Zip Code

Applicant Social Security Number

Applicant Gender
❑ Male ❑ Female

Group Division Number

Applicant Marital Status
❑ Married ❑ Divorced
❑ Single ❑ Widowed

Applicant Date of Birth
Month/Day/Year

Applicant
Daytime Telephone Number

Is the Applicant an employee of this group? ❑ Yes ❑ No If Yes, please indicate ❑ Active ❑ Retired

If you are the employee, you may skip this section and turn to the top of the next page. Otherwise, please complete the following:

Employee First Name:

M.I.

Employee Last Name

Employee Social Security Number

Employee Date of Birth
Month/Day/Year

Employee Date of Hire
Month/Day/Year

What is your relationship to this employee (please select from the options below):
❑ Spouse ❑ Domestic Partner ❑ Parent/Parent In-law ❑ Grandparent/Grandparent In-law
❑ Sibling/Sibling In-law ❑ Spouse of Sibling In-law ❑ Adult Child/Spouse of Adult Child

RETAIN A COMPLETED COPY FOR YOUR RECORDS

How to enroll

Applicant Name:	Applicant Social Security Number

Are you (applicant) presently working? ❑ Yes ❑ No If yes, list occupation:			
Applicant Height:	Applicant Weight:	Have you (applicant)used tobacco products in the last 12 months (chew or smoke - circle applicable activity)? ❑ Yes ❑ No	
Have you (applicant) had any change in weight in the last 12 months? ❑ Yes ❑ No	❑ Gain _____lbs. ❑ Loss _____lbs.	Reason for Weight Change:	
Primary Physician's Name:		Date Last Consulted Month __ __ / Year__ __ __ __	
Primary Physician's Address: Street:		Date of Last Physical Exam Month __ __ / Year__ __ __ __	
Primary Physician's Address: City, State, Zip Code:		Primary Physician's Telephone Number: ( )	

I. Insurability Profile

As the Applicant, or person applying for this coverage, you are required to answer the following questions:

A. ❑ Yes ❑ No	Do you use mechanical devices, such as: a wheelchair, walker, quad cane, crutches, hospital bed, dialysis machine, oxygen, or stairlift?
B. ❑ Yes ❑ No	Do you currently need or receive help in doing any of the following: bathing; eating; dressing; toileting; transferring; maintaining continence?
C. ❑ Yes ❑ No	Do you currently have, or have you ever had a diagnosis for or symptoms of: Alzheimer's disease, dementia, loss of memory, or organic brain syndrome?
D. ❑ Yes ❑ No	Do you currently have, or have you ever had a diagnosis for or symptoms of: Multiple Sclerosis, Muscular Dystrophy, ALS (Lou Gehrig's Disease) or Parkinson's Disease?
E. ❑ Yes ❑ No	Have you been diagnosed and/or treated by a member of the medical profession for HIV+ (Human Immunodeficiency Virus)?
F. ❑ Yes ❑ No	Have you developed symptoms of the disease AIDS (Acquired Immune Deficiency Syndrome)?
G. ❑ Yes ❑ No	Have you been diagnosed and/or treated by a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome)?

STOP HERE! If you answered "Yes" to any part of questions A through G above, DO NOT SUBMIT THIS APPLICATION. Otherwise, please continue.

II. Medical Profile

A. Do you have symptoms of, or within the last five (5) years have you received medical advice, been diagnosed, treated or consulted with a member of the medical profession or other health care professional for any of the following conditions? **Please circle condition(s) for all "YES" answers.**

❑ Yes ❑ No	1. High blood pressure, irregular heart beat, atrial fibrillation, coronary artery disease, or other diseases or disorders of the heart or circulatory system, blood or blood vessels.
❑ Yes ❑ No	2. Polyp, benign tumor, leukemia, lymphoma, cancer, melanoma, or a disorder of the immune system.
❑ Yes ❑ No	3. Diabetes, thyroid problems, or any glandular disease or disorder.
❑ Yes ❑ No	4. Intestines, liver or disease or disorder of the stomach or digestive system.
❑ Yes ❑ No	5. Bowel, rectum, kidney, bladder, prostate, urinary tract, or reproductive system.

RETAIN A COMPLETED COPY FOR YOUR RECORDS

Applicant Name:	Applicant Social Security Number

❑ Yes ❑ No	6. Mental disorder, depression, bulimia, anorexia or other eating disorder, alcohol abuse, drug addiction or any psychological or emotional condition or disorder; or been advised to limit, reduce or discontinue the use of alcohol; been arrested in connection with use of alcohol or drugs; or been advised to seek or receive counseling for alcoholism or drug abuse.
❑ Yes ❑ No	7. Arthritis, osteoporosis, any chronic pain condition, or chronic fatigue or any other disease or disorder of the back, spine, joints, muscles or neck.
❑ Yes ❑ No	8. Lung disorder, shortness of breath, or any disease or disorder of the respiratory system.
❑ Yes ❑ No	9. Falls, dizziness, imbalance, or any disease or disorder of the eyes or ears.
❑ Yes ❑ No	10. Seizures, tremors, stroke, transient ischemic attack (TIA), paralysis or any other disease or disorder of the brain or nervous system.
❑ Yes ❑ No	11. Any other conditions or diseases not mentioned above? Please describe in this area _____ _____ _____

If you answered "Yes" to any of the questions in section IIA, please indicate question number from IIA and provide full details on the condition, treatment dates and the name, address and telephone number of your medical advisor.

Ques No.	Date of Last Visit (mm/dd/yyyy)	Reason/ Name of Condition	Treatment Given	Medical Advisor's Full Name, Address & Telephone Number

B. ❑ Yes ❑ No	Have you taken any prescription/non-prescription medications in the past 24 months, including all prescription/non-prescription medications you are currently taking? Please list the medication and details.

Date Last Taken (mm/dd/yyyy)	Name of Medication	Dosage/ Frequency	Reason/Name of Condition	Prescribing Physician

RETAIN A COMPLETED COPY FOR YOUR RECORDS

Applicant Name:	Applicant Social Security Number

C. ☐ Yes ☐ No — Have you been hospitalized, been advised to have, or had surgery, medical care, EKG, x-ray, diagnostic test or been confined to any facility in the last five (5) years? If yes, provide details.

Test(s) Performed	Date (mm/dd/yyyy)	Reason	Results	Name, Address & Telephone Number of Medical Advisor Requesting Test(s)

D. ☐ Yes ☐ No — Do you live alone? If no, who lives with you?
_____

E. ☐ Yes ☐ No — Do you drive? If no, why?
_____

F. Please describe your daily routine, i.e. work, exercise, travel, socializing, physical/recreational activities, etc.:
_____

III. Insurance History

A. ☐ Yes ☐ No — Are you covered by Medicaid? (If yes, details.)
_____
_____

B. ☐ Yes ☐ No — Are you receiving any disability benefits? (If yes, provide details including health condition(s))
_____
_____

C. ☐ Yes ☐ No — Have you had another long-term care insurance policy or certificate in force during the last 12 months? If yes — Name of Company: _____
If it lapsed, when did it lapse? (mm/dd/yyyy) _____

D. ☐ Yes ☐ No — Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract?) If yes —
Name of Company: _____ Policy Number: _____ Type and Amount of Benefits: _____

E. ☐ Yes ☐ No — Do you intend to replace any of your long term care, medical or health coverage with the coverage applied for? If yes —
Name of Company: _____ Policy Number: _____ Type and Amount of Benefits: _____

F. ☐ Yes ☐ No — Have you been denied coverage for medical insurance, disability insurance, long-term care insurance, nursing home insurance, life insurance or received substandard coverage? If yes –
Name of Company:_____ Coverage:_____
Date Denied: (mm/dd/yyyy) _____ Reason for Denial? _____

G. ☐ Yes ☐ No — Have you signed and activated a Power of Attorney authorizing another individual to manage your personal affairs? If yes, please provide the date _____ and reason _____
_____
_____

RETAIN A COMPLETED COPY FOR YOUR RECORDS

Applicant Name:	Applicant Social Security Number

IV. Applicant's Signature

I agree that payment of premium is my responsibility. If any other person or entity collects, pays or forwards any part of the premium for this coverage, the person or entity acts as my agent and not an agent of Unum Life Insurance Company of America.

Payroll Deduction: If applicable, I authorize my employer to deduct the premiums for this insurance from my earnings.

I have read this application and I understand that: Unum Life Insurance Company of America will rely on the information provided in this application and any medical exams or tests and other questionnaires including a face to face assessment, if required, to determine whether to provide the coverage I have requested. All these documents shall form a part of my certificate of insurance and any coverage based on such information is contestable in accordance with the provisions of the Policy.

The statements I have made on this application are true to the best of my knowledge and belief.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, UNUM LIFE INSURANCE COMPANY OF AMERICA MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR INSURANCE.

Notice: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be prosecuted for insurance fraud.

X_____ Date: _____
Applicant's Signature (mm/dd/yyyy)

_____
Signed at (City/State)

RETAIN A COMPLETED COPY FOR YOUR RECORDS

Printed Name of Applicant: _____
(First Name) (MI) (Last Name)

Social Security Number: _____

Policy Number: _____

NOTE: The Health Insurance Portability and Accountability Act (HIPAA) requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or process your application. Please sign and return this authorization to: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory or other medically related facility or service; insurance company; insurance service provider; third party administrator; producer; and employer that has information about my health; employment; or other insurance coverage, claims and benefits to disclose any and all of this information to persons who evaluate and process applications for Unum, Unum Life Insurance Company of America, and duly authorized representatives ("Unum"). Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information Unum obtains pursuant to this authorization will be used for evaluating and processing my application for coverage. I further understand that the information is subject to redisclosure and might not be protected by HIPAA.

This authorization is valid for two (2) years from the date below. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Unum has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Unum may not be able to evaluate or process my application and this may be the basis for denying my application. I may revoke this authorization by sending written notice to: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or process my application and this may be the basis for denying my application.

_____ _____
(Applicant Signature) (Date Signed (mm/dd/yyyy)

I, _____, signed on behalf of the applicant as the applicant's Personal Representative. Please circle the type of Personal Representative: Power of Attorney Designee, Guardian, Conservator; and attach a copy of the document granting authority.

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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS, NURSING HOME OR LONG-TERM CARE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

Do you intend to lapse or otherwise terminate existing accident and sickness, nursing home or long term care insurance and replace it with group long term care insurance to be issued by Unum Life Insurance Company of America? If so, you should review this new coverage carefully, comparing it with all accident and sickness, nursing home or long term care insurance coverage you now have, and terminate your present insurance only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

Your new certificate provides thirty (30) days within which you may decide, without cost, whether you desire to keep the insurance. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new certificate.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new insurance. This could result in denial or delay in payment of benefits under the new insurance, whereas a similar claim might have been payable under your present insurance.

2. 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.

3. If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Unum Life Insurance Company of America
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

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.

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: _____

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.

State forms to review

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.

Town of Wayland provides you with benefits that are important to you and your family. This year, we are pleased to announce our upcoming Annual Enrollment Program. Beginning May 5th, all employees will have an opportunity to enroll in these valuable benefits being offered to eligible employees.

Benefits offered:

Long Term Disability Insurance

Long term disability insurance protects a portion of your income. It can pay you a monthly benefit if you can't work — for an extended period of time — due to a covered injury or illness. Long term disability insurance can pay a benefit as long as you are considered disabled according to your policy. The amount of benefit you receive from the plan may be reduced or offset by income from other sources — such as Social Security Disability Insurance. The length of time you can receive benefits is based on your age when you become disabled.

Long Term Care Insurance

Long Term Care is the type of care received by someone who needs assistance performing the basic Activities of Daily Living (ADLs) or needs assistance because of severe cognitive impairment. Disabilities that require LTC can be caused by accidents, acute illnesses or chronic illnesses as a result of advanced aging. Long Term Care insurance will provide benefits when an insured person suffers a severe Cognitive Impairment or loses the ability to perform two of the following Activities of Daily Living: Bathing, Dressing, Toileting, Transferring, Continence and Eating.

How does this plan work? You will be able to create a plan that will offer you protection in the event that you suffer a qualified long term care loss that is expected to last 90 days or longer as certified by a licensed health practitioner.

Plan Options:

- **Benefit Options:** $2,000 - $3,000 - $4,000 - $5,000* - $6,000*
- **Benefit Duration Options:** 3 years or 6 years
- **Simple Inflation Option**

** Medical Underwriting is required. It is also required for all Family Members.*

Annual Enrollment Period
5/5/15 – 5/22/15

Last Day to Enroll during this Open Enrollment Period is Friday May 22nd. Please see Human Resources with any questions.

To learn more about the Long Term Care Benefit, please log-on to:

http://unuminfo.com/wayland

Don't miss out on these valuable benefits!

unum
Better benefits at work.