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

SEATTLE HOUSING AUTHORITY
Benefit Election Form
Long Term Care - Policy #570855

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/ Domestic Partner	☐ Spouse's/Domestic Partner's Parent or Grandparent	☐ Child *(minimum age 18)*	☐ Retiree's Spouse

(Check one)	☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 4**
	•Long Term Care Facility •Professional Home Care	•Long Term Care Facility •Professional Home care •Total Home Care	•Long Term Care Facility •Professional Home care •Compound Inflation	•Long Term Care Facility •Professional Home care •Total Home Care •Compound 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	☐ **Unlimited Duration ***

* **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. You acknowledge that you have received the **Potential Rate Increase Disclosure Form** and **Personal Worksheet**. All information is contained in your kit.

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

_____	__ __/__ __/__ __ __ __	_____	__ __/__ __/__ __ __ __
Applicant's Signature	*Date*	*Employee's Signature (Required for Spouse/ Domestic Partner Coverage)*	*Date*

Employees & Spouses/ Domestic Partners: Please sign and mail all required signature forms to your employer.
Domestic Partners must also complete and submit Form #1434-97 located in kit.
Family Members/Retirees: Please sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (M5)

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

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 administer 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

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Applicant Name:	Applicant Social Security Number

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

I. Insurability Profile

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

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

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

II. Medical Profile

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

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

RETAIN A COMPLETED COPY FOR YOUR RECORDS

Applicant Name:	Applicant Social Security Number

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

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

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

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

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

RETAIN A COMPLETED COPY FOR YOUR RECORDS

Applicant Name:	Applicant Social Security Number

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

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

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

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

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

III. Insurance History

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

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

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

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

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

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

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

RETAIN A COMPLETED COPY FOR YOUR RECORDS

Applicant Name:	Applicant Social Security Number

IV. 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. IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

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

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

_____
Signed at (City/State)

RETAIN A COMPLETED COPY FOR YOUR RECORDS

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

Social Security Number: _____

Policy Number: _____

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

Authorization

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

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

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

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

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

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

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

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

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

Social Security Number: _____

Policy Number: _____

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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.

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_____ _____
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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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2211 Congress Street, Portland, ME 04122