



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

## Instruction Page for Election to Continue Group Long Term Care Insurance

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

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

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



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

**ELECTION TO CONTINUE YOUR LONG TERM CARE INSURANCE COVERAGE**

**SECTION 1 - EMPLOYER SECTION**

Policy Number  Company Name: \_\_\_\_\_

Company Address: \_\_\_\_\_  
 Street City State/Zip

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

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

Employee Social Security Number  -  -

Termination Reason:  
 Termination of employment  Divorce  Death of Spouse or Domestic Partner  
 Other \_\_\_\_\_

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

Current Monthly Premium Payment: Employee \$\_\_\_\_\_.\_\_\_\_\_/month Spouse \$\_\_\_\_\_.\_\_\_\_\_/month

**SIGNATURE OF EMPLOYER:** \_\_\_\_\_ **TODAY'S DATE** \_\_\_\_\_

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

Policy Number  Employee Name: \_\_\_\_\_

Social Security Number  -  -

Mailing Address: \_\_\_\_\_  
 Street City State/Zip

Email Address: \_\_\_\_\_

Male  Female Phone/Cell Number \_\_\_\_\_

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

- Monthly Automatic Payment (ACH) First of Every Month via Checking Account \*if selected, you must complete form 7713-04.
- Quarterly Paper Bill (Monthly Premium X 3)
- Semi-Annual Paper Bill (Monthly Premium X 6)
- Annual Paper Bill (Monthly Premium X 12)

**SIGNATURE OF EMPLOYEE:** \_\_\_\_\_ **TODAY'S DATE** \_\_\_\_\_

**PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS**



## Authorization and Agreement for Monthly Automatic Payments

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

**Please Print**

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

\_\_\_\_\_  
Insured's Name: Last, First, Middle Initial

\_\_\_\_\_  
Social Security Number

**1. Check all that apply:**

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

**2.**

### Tape Voided Check Here

If you do not use checks, have starter checks, or you are providing savings account information, you will need to include a letter from your bank reflecting routing transit and account numbers.

- 3. Please sign and date.** I authorize the above named bank to pay and charge my account monthly debit entries for the above insured, including checks, drafts and other orders by electronic or paper means, made by and payable to the Company. Your signature confirms that you have read and agree to the terms and conditions that are reflected on the reverse side of this form.



\_\_\_\_\_  
Signature of Account Holder



\_\_\_\_\_  
Date of Signature

**A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL**

Please retain a copy of this form for your records

## Terms and Conditions

I (premium payor whose signature appears on the previous page) have **carefully read** the terms of this authorization, and I **understand** and **agree** that:

- 1) This Authorization applies to coverage provided under the policy listed above and to any coverage subsequently added.
- 2) My signature on the previous page reflects my intent that my account be debited by the Company in the amount necessary to pay premium.
- 3) No notice of premium due will be furnished while the Authorization is in effect, except, if any check or other debit entry made pursuant to this Authorization is not paid, the Company will send notice of premium past due.
- 4) It is my responsibility to fund my account in an amount sufficient to pay premium when due and failure to do so may result in lapse of coverage. Payments are typically drawn on the 1<sup>st</sup> of the month.
- 5) This Authorization does not waive, alter or amend any provision of coverage under the above policy.
- 6) No premium shall be deemed paid until the Company receives payment at its Home Office.
- 7) The Company shall incur no liability as a result of the dishonor of any debit entry or any check, draft or other instrument drawn pursuant to this Authorization Agreement.
- 8) This Authorization shall remain in effect unless and until the bank, the insured person or premium payor presents written notice of termination to the Company.

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

- 9) Upon termination of this Agreement, premiums will be payable at the rate (amount) and mode (frequency) required under the Company's usual rate and mode for coverages not enrolled in the Automatic Payment Plan.
- 10) Funds must be paid in U.S. dollars and withdrawn from a U.S. bank.

**PROTECTION AGAINST UNINTENTIONAL LAPSE  
OF LONG TERM CARE INSURANCE  
ADDITIONAL DESIGNATION TO BE COMPLETED IF YOU ARE BILLED DIRECTLY**

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

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

**Instructions**

If you are electing a designee, please complete, sign and date **Sections 1 and 2**.

**Section 3** must be completed by your designee only if you are a resident of New Jersey or New York, and are age 62 or older.

If you are not electing a designee, please complete, sign and date **Sections 1 and 4**.

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**SECTION 1- Applicant / Insured - Please Print Legibly**

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

Policyholder's/Company's Name: \_\_\_\_\_

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

Your Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

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**SECTION 2- Designations - Please Print Legibly**

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**My Designations are as follows:**

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

Address: Street/PO Box \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

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

Address: Street/PO Box \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

 Applicant/Insured's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

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

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

**DESIGNEE ACCEPTANCE LONG TERM CARE INSURANCE**

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

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

Applicant/Insured's name \_\_\_\_\_

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

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

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

 Designee's signature \_\_\_\_\_

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

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**SECTION 4-Waiver Electing Not To Name An Additional Designation**

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

 Applicant/Insured's signature: \_\_\_\_\_ Date \_\_\_\_\_

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