



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

**LONG TERM CARE
MEMBER BENEFIT ELECTION FORM**
Los Angeles Police Relief Association, Inc.
Policy Number: 096797-001

IMPORTANT: Complete this form ONLY if you are electing an LTC coverage amount over the Core Benefit that is funded by LAPRA.

Your Name: (Last Name, First Name, Initial)	Social Security Number ____ - ____ - ____	Date of Birth (MM/DD/YYYY) __ / __ / ____
Street Address	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Hire (MM/DD/YYYY) __ / __ / ____
City, State, Zip Code	Home Telephone # ()	Work Telephone # ()
Email Address		

LAPRA is paying for the following Core Benefit	
Level of Care:	100% Facility, Home and Community-Based Care
Benefit Duration:	2 Years Facility / 100% Home and Community-Based Care
Monthly Benefit:	\$1,500 Facility/ 100% Home and Community-Based Care
Inflation Protection:	None
Elimination Period:	90 Days

Choose a Plan (Check One)		
<input type="checkbox"/> Plan 1 (Funded by LAPRA) 100% Facility, Home and Community-Based Care, No Inflation Protection	<input type="checkbox"/> Plan 2 100% Facility, Home and Community-Based Care, 5% Simple Inflation	<input type="checkbox"/> Plan 3 100% Facility, Home and Community-Based Care, 5% Compound Inflation

Choose a Benefit Duration (Check One)		
<input type="checkbox"/> 2 Years (Funded by LAPRA)	<input type="checkbox"/> 5 Years	<input type="checkbox"/> Lifetime*

Choose a Facility Monthly Benefit Amount (Check One)							
<input type="checkbox"/> \$1,500 (Funded by LAPRA)	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$3,500	<input type="checkbox"/> \$4,500	<input type="checkbox"/> \$5,500	<input type="checkbox"/> \$6,500	<input type="checkbox"/> \$7,500*	<input type="checkbox"/> \$8,500*

Write the per pay period cost in the space below. You can find your per pay period cost on page 2 of your Enrollment Instructions & Personalized Rates Insert included in your enrollment packet.

Active Member's Cost:	\$
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* **Note to Members:** Selection of this LTC option exceeds the Guarantee Issue limits and requires completion of a Long Term Care Insurance Application and a signed Authorization to Request Medical Information Form #6720-03-CA. You can download a Long Term Care Insurance Application from the LAPRA website (www.lapra.org/activeltc.html), or you can call LAPRA at 888-252-7721 to request a Long Term Care Insurance Application be mailed to you. All active LAPRA members and new recruits who enroll after the initial offer period or choose benefits over the Guarantee Issue limits will be required to fill out a Long Term Care Insurance Application and signed Form #6720-03-CA.

(continued on reverse side)



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ACTIVE MEMBER BENEFIT ELECTION FORM**

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Request for Signature (Please read this entire form carefully before signing below.)

I certify that, prior to submitting this form; I have reviewed the materials listed below which can be found on the LAPRA website (www.lapra.org/activeitc.html) or the Unum website (w3.unum.com/enroll/LAPRA).
To request a paper copy of the materials listed below, call LAPRA at 888-252-7721.

CALIFORNIA REGULATIONS (7600-04) require Unum Life Insurance Company of America to provide you with the following forms. Please advise if you have received these forms by checking each box next to the item. Your signature on this form confirms that you have read and understand these items.

- **Outline of Coverage** Yes No
- **HICAP Notice (Item 13 in the Outline of Coverage)** Yes No
- **A Consumer’s Guide to Long Term Care** Yes No
- **Things You Should Know Before You Buy Long Term Care** Yes No
- **Notice to Applicant Regarding Replacement of Accident and Sickness, Nursing Home or Long Term Care Insurance** Yes No

Your signature below authorizes LAPRA to deduct premium from your paycheck, if applicable. Your premium will be deducted from your paycheck and your signature below authorizes the Association to deduct it. Your premium is based on your insurance age. Insurance age is your age on 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. Please verify your name, Social Security number and date of birth before signing. **Please Note: Member signature is required. Retain a copy for your records.**

Caution: If your answers on this Member Benefit Election Form are incorrect or untrue, we may have the right to deny benefits or rescind your insurance.

MA Residents Only: You also signify that you have received and read the MassHealth eligibility notice entitled “For Massachusetts Residents Only” – Form #7650-04.

Active Member Signature

Date

**If you have any questions about long term care coverage, please call Unum’s toll free number:
1-800-227-4165.**

Return this form to LAPRA or email it to benefits@lapra.org.