



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

## LONG TERM CARE MEMBER SPOUSE/RDP\* BENEFIT ELECTION FORM

**Los Angeles Police Relief Association, Inc.**  
**Policy Number: 096797-001**

**Note to Spouse/Registered Domestic Partner: You must complete this Benefit Election Form and the Long Term Care Insurance Application for any long term care insurance coverage.**

### Information About Your Spouse or Registered Domestic Partner

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		

### Information About the Active Member

Member Name:	Member Social Security Number ____ - ____ - _____	Member Date of Birth __ / __ / ____	Member Date of Hire __ / __ / ____
--------------	--	--	---------------------------------------

### Choose a Plan (Check One)

<input type="checkbox"/> <b>Plan 1</b> 100% Facility, Home and Community-Based Care, No Inflation Protection	<input type="checkbox"/> <b>Plan 2</b> 100% Facility, Home and Community-Based Care, 5% Simple Inflation	<input type="checkbox"/> <b>Plan 3</b> 100% Facility, Home and Community-Based Care, 5% Compound Inflation
---	---	---

### Choose a Benefit Duration (Check One)

<input type="checkbox"/> 2 Years	<input type="checkbox"/> 5 Years	<input type="checkbox"/> Lifetime
----------------------------------	----------------------------------	-----------------------------------

### Choose a Facility Monthly Benefit Amount (Check One)

<input type="checkbox"/> \$1,500	<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
----------------------------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------

### Calculate the Premium for Your Spouse or Registered Domestic Partner Coverage

To calculate the premium for spouse/registered domestic partner coverage:

1. Use the Spouse/RDP\* LTC Premium Worksheet.
2. Fill in the numbers below. See the example on the Spouse/RDP\* Premium Worksheet.

$$\underline{\hspace{2cm}} \quad \times \quad \underline{\hspace{2cm}} \quad / \quad \$1,000 \quad = \quad \underline{\hspace{2cm}} \quad (A)$$

Rate per \$1,000 for Plan Chosen
Monthly Benefit Amount
Per Pay Period Premium

You can also use the online premium calculator on the Unum long-term care insurance website for LAPRA members at [w3.unum.com/enroll/LAPRA](http://w3.unum.com/enroll/LAPRA).

\* Registered Domestic Partner



**LONG TERM CARE  
ACTIVE MEMBER SPOUSE/RDP\*  
BENEFIT ELECTION FORM**

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

**Los Angeles Police Relief Association, Inc.  
Policy Number: 096797-001**

**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/activeltc.html](http://www.lapra.org/activeltc.html)) or the Unum website ([w3.unum.com/enroll/LAPRA](http://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.

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| • <b>Outline of Coverage</b>  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • <b>HICAP Notice (Item 13 in the Outline of Coverage)</b>  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • <b>A Consumer's Guide to Long Term Care</b>   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • <b>Things You Should Know Before You Buy Long Term Care</b>   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • <b>Notice to Applicant Regarding Replacement of Accident and Sickness, Nursing Home or Long Term Care Insurance</b> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Note to Member:** Your signature below authorizes LAPRA to deduct premium from your paycheck.

Your premium is based on the insurance age of your spouse or registered domestic partner. Insurance age is the age of your spouse or registered domestic partner on the plan effective date. If you enroll your spouse or registered domestic partner for coverage on or after the plan effective date, insurance age is the age of your spouse or registered domestic partner on the date this election form is signed. Please verify your name, Social Security number and date of birth before signing. **Please Note: Spouse or registered domestic partner and Member signatures are required. Retain a copy for your records.**

**Caution:** If your answers on this 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.

\_\_\_\_\_  
Spouse or Registered Domestic Partner Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
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 all forms to LAPRA or email to [benefits@lapra.org](mailto:benefits@lapra.org).**

\* Registered Domestic Partner