

Underwritten by:
 First UNUM Life Insurance Company
 666 Third Avenue
 New York, NY 10017

PACE UNIVERSITY
Benefit Election Form
Long Term Care - Policy #221124

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 ____/____/____
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Applicant Is: (This Benefit Election Form must be completed for any selection)

Employee	Employee's Parent or Grandparent	Retiree
Employee's Spouse	Spouse's Parent or Grandparent	Retiree's Spouse

(Check one)	Plans			
	Plan 1	Plan 2	Plan 3	Plan 4
	<ul style="list-style-type: none"> • Long Term Care Facility • Professional Home Care 	<ul style="list-style-type: none"> • Long Term Care Facility • Professional Home Care • Total Home Care 	<ul style="list-style-type: none"> • Long Term Care Facility • Professional Home Care • Compound Inflation 	<ul style="list-style-type: none"> • Long Term Care Facility • Professional Home Care • Total Home Care • Compound Inflation
	Facility Monthly Benefit Amount			
(Check one)	\$4,000	\$5,000		

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- NY 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- NY.

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), Aer(e i BT/TT0 1 Tf12 -0 0