

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 administrator 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			Group Division Number					
						<input type="checkbox"/> Male <input type="checkbox"/> Female								
Applicant Marital Status			Applicant Date of Birth				Applicant Daytime Telephone Number							
<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed			Month/Day/Year				() -							

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			Employee Date of Hire				
Month/Day/Year						Month/Day/Year			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
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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)? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Have you (applicant) had any change in weight in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Gain _____ lbs. <input type="checkbox"/> Loss _____ lbs.	Reason for Weight Change:
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Primary Physician's Name:	Date Last Consulted Month ____ / Year ____
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Primary Physician's Address: Street:	Date of Last Physical Exam Month ____ / Year ____
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Primary Physician's Address: City, State, Zip Code:	Primary Physician's Telephone Number: ()
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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 Within the last five (5) years, have you received medical advice, been diagnosed or treated by a member of the medical profession or other health care professional for: Alzheimer's disease, dementia, loss of memory, or organic brain syndrome?
- D. Yes No Within the last five (5) years, have you received medical advice, been diagnosed or treated by a member of the medical profession or other health care professional for: 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 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 F above, DO NOT SUBMIT THIS APPLICATION. Otherwise, please continue.

II. Medical Profile

- A. Within the last five (5) years have you received medical advice, been diagnosed or been treated by 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.

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Applicant Name:	Applicant Social Security Number
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C. Yes No Have you been hospitalized, been medically 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, provide details.) If you are eligible or covered by Medicaid, you may not need to purchase the policy or certificate since it may duplicate benefits.

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 _____

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Applicant Name:

Applicant Social Security Number

IV. Acknowledgement

I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this insurance with and without Inflation Protection. I have reviewed the Compound Inflation Protection option and

I Accept Reject Compound Inflation Protection

I have received the Potential Rate Increase Disclosure Form and Personal Worksheet.

V. 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.

Notice: Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

X _____
Applicant's Signature

Date: _____
(mm/dd/yyyy)

Signed at (City/State)

UNINTENTIONAL LAPSE:

You, the insured, 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 your insurer 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 designated person or persons will not receive the notice until 30 days after the premium is due and unpaid.

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