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GROUP LONG TERM CARE REQUEST TO CHANGE COVERAGE

Use this form to change your voluntary Group Long Term Care (GLTC) insurance coverage amount.

SECTION 1: INSURED INFORMATION SECTION (Complete all fields)
Policy or BL#
Group Policyholder Name:
Group Policyholder Address:
Insured Name:
Insured's Mailing Address:
Social Security Number:
Relationship to Employee (if applicable): Employee Name:
Email Address: Daytime Telephone Number
under the group policy. TO CANCEL coverage, complete the following: □ CANCEL all Voluntary Group Long Term Care Coverage
TO DECREASE coverage complete the following (check all that apply):
□ Decrease my benefit amount to: □ Decrease my benefit duration to:
□ Decrease my plan design to: □ Decrease my coverage to the employer funded plan, if any.
To PURCHASE inflated benefit, complete the following:
Increase my coverage: add \$ to my current monthly coverage. (the added coverage amount must not be greater than the existing inflated value, and will be rounded to the nearest \$100.00 increment. I understand that my benefit will not continue to inflate.)
To CHANGE my billing mode, complete the following:
🗆 Annual premium 🛛 Semi-annual premium 🖓 Quarterly premium
Monthly automated checking account withdrawal (UNUM ACH election form must be attached - Form #7715-04.)
Insured Signature: Date:
The effective date of this change will be based on your signature date and terms of your policy.
Retain a copy of this form for your records. Return completed form to the address reflected at the top of the form. Please contact Unum's Customer Service Center @ 1-800-227-4165 if you have any questions.

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