



Unum Long-Term Care (LTC) Cancellation and Change Form

| Office use only |
|-----------------------|
| Approved by: _____ |
| Approved date: _____ |
| Effective date: _____ |

See the Summary Plan Description for more information on benefits at www.oregon.gov/OHA/PEBB. Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/pebb.

| Employee Information (you must complete all fields) | | | | |
|---|---|------------------------|-------------------------------------|---------|
| Group policy number 025758 | Agency name (ex. Oregon Health Authority) | | Agency number (5-digit agency code) | |
| PEBB benefit number (P#) | | Hire Date | | |
| Last name | First name | Middle name or initial | | |
| Date of birth (mm/dd/yyyy) | Gender | | M | F Other |
| Please, check the following box if this is a new address. | | | | |
| Contact address | Apartment # | City | State | ZIP |
| Phone number | Email address | | | |

| Covered individual is: |
|---|
| <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner |

| Applicant Information (You must complete all fields) | | | |
|--|---------------|----|--|
| Last name | First name | MI | |
| Date of birth (mm/dd/yyyy) | Gender | | <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other |
| Phone number | Email address | | |

Premiums Rate information can be found at: www.unuminfo.com/pebb/calculator.aspx

Application Reason:

Change

Cancel (Skip to signature line)

Facility Benefit Duration (check one):

3 years

6 Years

Unlimited Duration

Facility Monthly Benefit Amount (check one):

\$1,000

\$2,000

\$3,000

\$4,000

\$5,000

\$6,000

Available Plans (check one):

Plan 1

- Long-Term Care Facility
- Professional Home Care

 Plan 2

- Long-Term Care Facility
- Professional Home Care
- Total Home Care

 Plan 3

- Long-Term Care Facility
- Professional Home Care
- Simple inflation Uncapped

Plan 4

- Long-Term Care Facility
- Professional Home Care
- Total Home Care
- Simple Inflation Uncapped

Current Employees

All coverages will be subject to approval of a medical questionnaire, which will need to be sent directly to Unum.

Cancellations

Coverage will end the first of the month following the date of receipt of this signed and dated form.

Signature and authorization

I declare that the individuals listed on the form and I are eligible for the coverage requested. I understand the benefit elections made on this application are in effect for as long as I continue to meet PEBB's eligibility requirements, or until I elect to change them subject to the provisions of PEBB's plan. I have read the benefit materials and I understand the limitations and qualifications of the PEBB benefits program.

I understand that:

- Knowingly making a false statement may subject me to termination of enrollment, denial of future enrollment, imprisonment, fines, or civil damages.
- If your answers on this Cancellation and Change form are incorrect or untrue, we may have the right to deny or rescind your insurance. Any alteration of this form may result in it being ineffective.
- This form supersedes all forms and submissions I previously made for Unum LTC coverage.
- I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that they are subject to penalty for false claims.
- You also acknowledge that I have reviewed the Potential Rate Increase Disclosure Form and Personal Worksheet which can be found at: <https://unuminfo.com/pebb/index.aspx>.
- By signing below, you signify that you have read and understand that loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after your effective date of coverage under this LTC plan in order to be covered, and that certain limitations and exclusions apply to your coverage.
- Your premium will be paid through the employee's payroll deduction. Employee must sign below to authorize the employer to make the payroll deduction.

Employee Signature (required for Spouse/Domestic Partner coverage)

Date

Applicant's Signature (if different from employee)

Date

Submitting forms:

1. Unum's Evidence of Insurability Medical Questionnaire should be sent directly to Unum.
 - a. Visit: <http://unuminfo.com/pebb/enrollment.aspx> for more information.
2. Send this form (only) to PEBB.
 - a. Due to HIPAA, any copies received by PEBB will be shredded.
 - b. Always keep copies for your records.

Mail: PEBB Member Services
500 Summer Street NE E89
Salem, OR 97301-1063

Fax: 503-373-1654

Email: pebb.benefits@odhsoha.oregon.gov