GROUP LONG TERM CARE
REQUEST TO CHANGE COVERAGE

Return Form to:
Long Term Care Operations
2211 Congress Street
Portland, ME 04122
Fax: 207-541-7606

Use this form to change your voluntary Group Long Term Care (GLTC) insurance coverage amount. If you wish to increase your coverage, you will need to complete a Benefit Election Form and Evidence of Insurability if applicable.

SECTION 1: INSURED INFORMATION SECTION (Complete all fields)

Policy or BL# ☐☐☐☐☐☐☐☐ Div# ☐☐☐☐

Group Policyholder Name: _____

Group Policyholder Address: _____

Insured Name: _____

Insured's Mailing Address: _____
Street City State/Zip

Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

Relationship to Employee (if applicable): _____ Employee Name: _____

Email Address: _____ Daytime Telephone Number _____

SECTION 2: CHANGE IN COVERAGE SECTION
(Complete all applicable fields, sign and date the form)

Refer to your certificate of insurance or enrollment kit for coverage options and rates available to you under the group policy.

TO CANCEL coverage, complete the following:
☐ CANCEL all 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 EXERCISE Non-Forfeiture Option:
☐ I wish to exercise the non-forfeiture option in my plan.
Please select the appropriate non-forfeiture option below:
☐ Shorten Benefit Period ☐ Reduced Paid Up ☐ Contingent, if applicable

To TERMINATE your Inflation provision, complete the following:
☐ I wish to terminate the Inflation provision included in my coverage. Once terminated, I understand that my coverage will no longer receive automatic inflation credits. (Note: Terminating the inflation provision is an option that is only available to you if the group policy through which your coverage was issued offers a coverage option that does not include the Inflation provision.)

To CHANGE your 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 #7713-04.)

Insured Signature: _____ Date: _____

The effective date of this change will be based on your signature date and/or the 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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