Underwritten by Continental Casualty Company

University of Nebraska

Policy Number: 9885 TQ

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Group Long Term Care Enrollment Form

Instructions: *1) Complete information in Sections I and II.*
2) Read and Sign Section III.

SECTION I - EMPLOYEE INFORMATION

Name: First, Middle Initial, Last			**Social Security Number**	**Date of Hire**
Date of Birth	**Sex** (M or F)	**Daytime Phone Number**	**Evening Phone Number**	
Home Address: Number and Street	**City**	**State**	**Zip code**	
Employee Personnel Number:			**Payroll Frequency** *(Select One):* ☐ Bi-weekly ☐ Monthly	

Select *ONE* Administrative Unit (Campus):

☐ **UNL** ☐ **UNK**

☐ **UNMC** ☐ **UNCA**

☐ **UNO**

(OR)

Select *ONE* Administrative Unit (Ancillary):	☐ **Nebraska Crop Improvement Association**
☐ **University of Nebraska Alumni**	☐ **Board of Regents**
☐ **University of Nebraska Foundation**	☐ **University of Nebraska Federal Credit Union**
☐ **4-H Youth Foundation**	☐ **UNMC Physicians**
☐ **Nebraska SPF Swine Accrediting Agency**	☐ **Ximerex, Inc.**
☐ **Nebraska Pork Producers Association**	☐ **Other**________________________________

NEXT PAGE, PLEASE

SECTION II - BENEFIT SELECTION

Select *ONE* Daily Benefit Amount:

☐ **$100** ☐ **$150** ☐ **$200**

Select *ONE* Lifetime Maximum Amount:

☐ **3 Year Lifetime Maximum**
☐ **5 Year Lifetime Maximum**

Select *ONE* Inflation Protection Option:

☐ **Guaranteed Benefit Increase Option**
☐ **Lifetime Automatic Benefit Increase Option**

Select Any Combination of the Options Below:

☐ **Benefit Account**
☐ **Return of Premium at Death**
☐ **Caregiver Benefit**

Inflation Protection Rejection: I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this insurance with and without inflation protection, and I reject the Lifetime Automatic Benefit Increase Option.

EMPLOYEE'S Signature ____ **Date** _______________

SECTION III - ELIGIBILITY AND AUTHORIZATION

To the best of my knowledge and belief, the information on this Enrollment Form is true and complete. I understand that the insurance I have selected for myself will begin on the Certificate Effective Date shown in my Certificate of Insurance provided that I am actively at work on that date with the **University of Nebraska.** If I am not actively at work on that date, my insurance will not take effect until the first day of the month after I return and remain actively at work. I understand that actively at work means I am at my usual place of employment on the effective date of coverage.

I authorize **University of Nebraska** to make the appropriate **payroll deductions** for the above specified coverage and release other necessary information to the administrators of this program.

____ ___________________________________

EMPLOYEE'S Signature **Date**