Continental Casualty Company

Southern Methodist University

Policy Number: 9953-IS

Group Long-Term Care
Enrollment Form

If any part of Sections 1 through 4 is blank, we cannot process your enrollment form.

SECTION 1 – FACULTY/STAFF INFORMATION

Applicant's Name: First, Middle Initial, Last	**Date of Birth:**	**Sex:** (M or F)
Applicant's Address: Number and Street	**Social Security Number:**	
City:	**State:**	**Zip Code:**
Daytime Phone Number:	**Evening Phone Number:**	
Date of Hire:	**Pay Cycle** ***(please circle one)*****:** **Monthly** **Bi-Weekly**	**Pay Frequency** ***(please circle one)*****:** **8 month** **9 month** **10 month** **12 month**

SECTION 2 – BENEFIT SELECTIONS

Select ***ONE*** Daily Benefit/ Lifetime Maximum:

Two Year (730x) Lifetime Maximum

- ❑ $100 Daily Benefit/ $73,000 Lifetime Maximum
- ❑ $120 Daily Benefit/ $87,600 Lifetime Maximum
- ❑ $140 Daily Benefit/ $102,200 Lifetime Maximum
- ❑ $160 Daily Benefit/ $116,800 Lifetime Maximum

Five Year (1825x) Lifetime Maximum

- ❑ $100 Daily Benefit/ $182,500 Lifetime Maximum
- ❑ $120 Daily Benefit/ $219,000 Lifetime Maximum
- ❑ $140 Daily Benefit/ $255,500 Lifetime Maximum
- ❑ $160 Daily Benefit/ $292,000 Lifetime Maximum

SECTION 3 – OTHER INSURANCE COVERAGES

Do you currently have long-term care insurance in force or have you recently applied for such insurance? **YES** ☐ **NO** ☐

If yes**, please list all such coverages in the space provided below. Indicate if you intend to replace any medical or health insurance coverage, including health care service contract or health maintenance organization with the insurance applied for with this application.**

Company Name	Company Address	Policy Number	Is coverage to be replaced?	When
			YES ❑ NO ❑	

OVER, PLEASE

SECTION 4 – FACULTY/STAFF 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 **Southern Methodist University**. 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 that I am at my usual place of employment on the effective date of the coverage.

I authorize **Southern Methodist University** to make the appropriate **payroll deduction** for the above-specified coverage and release other necessary information to the administrators of the program.

Signature _____ **Date** ____/____/____