

# Applying is easy!

Just follow these simple instructions. *Send no money now.*

Complete the **Employee Enrollment Form** if you are a ***new employee*** enrolling within your initial eligibility period.

## **TIPS**

1. Complete each section carefully. Answering each question completely. If any part is left blank, CNA cannot process your enrollment form.
2. Select **ONE** Plan. Then, select **ONE** Daily Maximum Benefit Amount.
3. Read and sign Section 4.
4. Mail your completed enrollment form to CNA at::

**CNA**  
**P. O. Box 946760**  
**Maitland, FL 32794**

5. CNA may telephone you if your information is unclear.
6. CNA will send your certificate via First Class Mail.

**Questions?**  
**Just call a CNA customer service representative at**  
**1-888-825-0353**



INSURANCE IN TOUCH WITH BUSINESS



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# Group Long Term Care Employee Enrollment Form

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

## SECTION 1 – EMPLOYEE INFORMATION

<b>Applicant's Name:</b> First, Middle Initial, Last	<b>Date of Birth</b> / /	<b>Sex</b> (M or F)
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<b>Applicant's Address:</b> Number and Street	<b>Social Security Number:</b>
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<b>City</b>	<b>State</b>	<b>Zip Code</b>
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<b>Daytime Phone Number</b> ( ) ( )	<b>Evening Phone Number</b> ( ) ( )
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<b>Date of Hire:</b>	<b>Select <u>ONE</u> Payroll Mode:</b> <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly
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*I am employed by the Component stated below (Select ONE Component):*

<input type="checkbox"/> The University of Texas System Administration	<input type="checkbox"/> The University of Texas at San Antonio
<input type="checkbox"/> The University of Texas at Arlington	<input type="checkbox"/> The University of Texas at Tyler
<input type="checkbox"/> The University of Texas at Austin	<input type="checkbox"/> The University of Texas Southwestern Medical Center at Dallas
<input type="checkbox"/> The University of Texas at Brownsville	<input type="checkbox"/> The University of Texas Medical Branch at Galveston
<input type="checkbox"/> The University of Texas at Dallas	<input type="checkbox"/> The University of Texas Health Science Center at Houston
<input type="checkbox"/> The University of Texas at El Paso	<input type="checkbox"/> The University of Texas Health Science Center at San Antonio
<input type="checkbox"/> The University of Texas-Pan American	<input type="checkbox"/> The University of Texas M.D. Anderson Cancer Center
<input type="checkbox"/> The University of Texas-Permian Basin	<input type="checkbox"/> The University of Texas Health Center at Tyler

## SECTION 2 – BENEFIT SELECTIONS

**Select ONE Plan:**

**Plan A - Basic Benefits with Guaranteed Benefit Increase Option**

**Plan B - Basic Benefits with Automatic Benefit Increase Option (Increases With Inflation)**

**Select ONE Daily Maximum Benefit:**

\$100 Daily Maximum Benefit

\$125 Daily Maximum Benefit

\$150 Daily Maximum Benefit

*If you select Plan A, read and sign the Automation Inflation Protection Rejection below.*

**Automatic Inflation Protection Rejection:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this insurance with the Future Protection Option and with the Automatic Inflation Protection Benefit. I realize that based on current health care cost trends, the benefits provided by a long-term care plan without meaningful inflation protection may be significantly diminished in terms of real value to me, depending on the amount of time which elapses between the date I purchase this coverage and the date on which I first become eligible for benefits. I have reviewed the coverage and I reject the Automatic Inflation Protection Benefit.

**Applicant's Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**OVER, PLEASE**

### 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 <input type="checkbox"/> NO <input type="checkbox"/>	

### SECTION 4 – EMPLOYEE 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 Texas System**. 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 **The University of Texas System** to make the appropriate payroll deduction for the above specified coverage and release other necessary information to the administrators of the program.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_