PROTECTION AGAINST UNINTENTIONAL LAPSE
LONG TERM CARE PLAN
VA SICKNESS AND DISABILITY PROGRAM AND VA LOCAL DISABILITY PROGRAM

Former participants who elected to continue Long Term Care coverage complete and submit this form with the Authorization of Coverage Retention. Completing this form ensures you receive written notice of termination if your long term care coverage is about to terminate because you have not paid the required premium. In addition to sending you a copy of the notice, a copy can be sent to another person you designate; however, this person will not be responsible for paying the premium.

Send your completed form to: Long Term Care Plan, PO Box 64011, St. Paul, MN 55164-0011, or fax the form to 952-833-5410. For questions about completing this form, contact illumifin Corp. at 800-761-4057.

PART A. PARTICIPANT INFORMATION

1. Name (First, Middle Initial, Last)

2. Address (Street, City, State and ZIP+4)

3. Long Term Care Provided Under: (Indicate your program)

❑ Virginia Sickness and Disability Program (VSDP) (State employees only)

❑ Virginia Local Disability Program (VLDP)

4. Date of Birth (mm/dd/yyyy)

5. Phone Number

PART B. DESIGNATION OPTIONS

Select one option:

❑ I wish to designate the person listed below to receive notification my long term care coverage is about to terminate due to nonpayment of the required premium. I understand that this person will not be liable for the payment of the premium.

Name of Designated Individual: ______________________________

Address: ______________________________

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❑ I elect NOT to designate a person to receive this notice. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of my long term care insurance coverage for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

PART C. PARTICIPANT CERTIFICATION

I understand this designation will continue in force until I complete and submit another Long Term Care Plan Protection Against Unintentional Lapse form.

______________________________ ______________________________

Participant Signature Date