

# VSDP LONG-TERM CARE PLAN PROTECTION AGAINST UNINTENTIONAL LAPSE

Former VSDP participants who elected to continue VSDP 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 VSDP 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: VSDP Long-Term Care Plan, P.O. Box 64011, St. Paul, MN 55164-0011. If you have any questions about completing this form, contact VSDP Long-Term Care Group at 800-761-4057.

## PART A. PARTICIPANT INFORMATION

<b>1. Name</b>	(First)	(MI)	(Last)	(Jr./Sr.)
<b>2. Address</b>	(Street)		(City)	(State) (Zip+4)
<b>3. Date of Birth</b>	(mm/dd/yyyy)	<b>4. Daytime Phone</b>	<b>5. Home Phone</b>	

## PART B. DESIGNATION OPTIONS

**Select one option:**

- I wish to designate the person listed below to receive notification my VSDP 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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- 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 VSDP 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. I elect NOT to designate a person to receive this notice.

## PART C. PARTICIPANT CERTIFICATION

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

\_\_\_\_\_  
 Participant Signature \_\_\_\_\_ Date