

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

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

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

