Group Long Term Care Insurance Plan
Underwritten by Aetna Life Insurance Company
(For VRS members who participate in VSDP)
Coverage Retention Form

To retain the long-term care insurance with Aetna Life Insurance Company (Aetna), complete this form and return it to Aetna in the enclosed postage paid envelope by September 28, 2007. If this form is NOT RECEIVED BY Aetna by September 28, you forfeit your right to retain the Aetna Long Term Care Insurance coverage.

_____ **(Please initial)** I choose to retain the Aetna Long Term Care Insurance coverage (Policy # 727514). By selecting this option, I understand that:

- I will now be responsible for paying the premium for coverage under the Aetna policy. I will be billed directly by, and submit premium directly to, Aetna.
- I will be given the opportunity to buy additional coverage under the Inflation Protection Increase feature.
- No further plan enhancements will be offered to me by Aetna in the future.
- **The following information MUST be completed to process your request.**

  Full Name: _____

  Street Address: _____

  City/State/&Zip: _____

  Phone Number: _____

  Social Security Number: _____

_____ _____
Signature Date

If you have any questions regarding this form, please call 877-796-1927, Monday through Friday, 8:00 a.m. – 8:00 p.m. (ET).

Please select a direct billing option below:

____Monthly by Automatic Deduction From Your Checking Account (EFT)
(You must complete and return the enclosed authorization form and attach a voided check.)

____ Quarterly

____ Semi-Annually

____ Annually

Please Do Not Include Any Payment At This Time.

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Electronic Funds Transfer Authorization

I authorize Aetna Life Insurance Company, or its designated agent, and the bank named below to initiate monthly withdrawals from my checking account. This authority will remain in effect until I notify Aetna Life Insurance Company, or its designated agent, and my bank in writing to cancel it.

I understand that if the necessary funds are not on deposit in my account on the day the automatic withdrawal is scheduled to be executed, I will be subject to the premium collection terms shown in the Policy.

Please deduct my monthly premium from my checking account on the 5th business day of the month.

Checking Account Number_____

Bank/Financial Institution Name _____

Bank Address_____

_____

Bank Telephone_____

Your Full Name: _____

Street Address: _____

City/State/&Zip: _____

Phone Number: _____

Social Security Number: _____

_____ _____ _____

Name (please print) Signature Date

PLEASE ATTACH A VOIDED CHECK