

Long Term Care Insurance Consumer Application Booklet

INDIVIDUAL/AFFILIATION

CareDirections
Simplicity[®]

Offered by
MedAmerica Insurance Company (Home Office: Pittsburgh, PA)

MEDAmerica
INSURANCE COMPANY
An Excellus Company Home Office: Pittsburgh, PA

PRIVACY NOTICE

Thank you for selecting MedAmerica as your long term care insurance company. Although your application is our initial source of information, we may also need to obtain information about you from doctors, hospitals, health care providers who have information about you or your mental or physical health or from a medical examination we may ask you to take; an in-person health interview; or the Medical Information Bureau (MIB). We will treat any information we obtain as confidential. We will not disclose information to anyone unless we are permitted to do so by law without your express written permission. It may be necessary to share information we obtain with an individual or organization performing a function for us.

We will provide you with any information contained in our files upon your request. If you wish to correct, amend or delete any of the information in the file you dispute, please contact us and we will advise you of the required procedures.

Please refer the Authorization to Disclose Protected Health Information form for further details.

LTC Privacy Officer
PO Box 41930
Rochester, NY 14604
LTCPrivacy.Officer@MedAmericaltc.com
1-800-544-0327 Ext. 3413

Administrative Offices:
165 Court Street
Rochester, NY 14647
1-800-544-0327

Long Term Care Insurance
TAX QUALIFIED COVERAGE

STANDARD APPLICATION
SPL-336

NEW POLICY
COVERAGE INCREASE
Indicate your current policy number here:

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I. APPLICANT INFORMATION

1. PLAN TYPE: AFFILIATION SPL-336 YES NO INDIVIDUAL SPL-336 YES NO
If YES, Affiliation/Employer Name: _____ Company Assigned Number: _____

2. a) Mr. Mrs. Ms. Other: _____
Applicant Name (First, MI, Last) Social Security Number

Street Address (No P.O. Box allowed) City County State ZIP

DOB (MM/DD/YYYY) Age () - () -
Daytime Phone Evening Phone
Best Time to Call Email Address

b) SEX Male Female
c) MARITAL STATUS Married Widowed Widowed with Care Partner* Single Single with Care Partner*
* If you are Widowed or Single and applying for the Care Partner Premium, the Care Partner Statement must be signed.

3. CARE PARTNER (Spouse/Domestic Partner) INFORMATION
(a) Is your Care Partner (Spouse/Domestic Partner) applying for coverage? YES* NO If YES, answer (c)
(b) Does your Care Partner have a MedAmerica policy? YES NO If YES, answer (c)
(c) Care Partner name and SS# : _____
Name (First, MI, Last) Social Security Number
* Single or Widowed Care Partners must complete the Care Partner Statement.

4. ALTERNATE EFFECTIVE DATE: Same as Care Partner Other * _____
*May not be more than 60 days after enrollment

5. ALTERNATE BILLING ADDRESS (Address of person paying premium who is other than Applicant.)
Name (First, MI, Last) Phone Number
Street Address (No P.O. Box allowed) City State ZIP

6. BENEFICIARY: A Beneficiary is a person or entity that the Applicant may elect to receive premiums paid that may be due in the event of the Applicant's death.
Name (First, MI, Last) Relationship Phone Number
Street Address (No P.O. Box allowed) City State ZIP

OFFICE USE ONLY: App. Rec: _____ App Status: _____ Eff. Date: _____ UW Date: _____ Init: _____
 Preferred Standard Modified

II. INSURANCE HISTORY

1. Are you covered by a state assistance program (Medicaid)?
**If yes, as a Medicaid recipient you should probably not apply for this coverage.
We recommend ending the application at this point.**
2. Do you currently or have you had in the last 12 months another nursing home, home health care, long term care insurance policy, rider or certificate in force? If Yes, please provide the following information.
COMPANY: _____ **ADDRESS:** _____
POLICY #: _____ **POLICY TYPE:** _____
If Lapsed, Date of Lapse: _____
3. Are you allowing any other nursing home, home health care, long term care insurance policy, rider or certificate to lapse or do you intend to replace any other nursing home, home health care, long term care insurance policy, rider or certificate with this policy?
- If you checked question 3. YES, you must sign both Notice Regarding Replacement of Accident and Sickness or Long Term Care Insurance Form s that follow. Submit Company Copy with this Application and retain the Applicant Copy.**
COMPANY: _____ **ADDRESS:** _____
POLICY #: _____ **POLICY TYPE:** _____
If Lapsed, Date of Lapse: _____

YES

YES

YES

NOTICE REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE FORM COMPANY COPY

MedAmerica Insurance Company
Administrative Offices: 165 Court Street, Rochester, NY 14647

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with the long term care insurance policy delivered herewith issued by MedAmerica Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.


1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to MedAmerica Insurance Company, 165 Court Street, Rochester, NY 14647 within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

The above notice was delivered to me on (Date): _____

 **APPLICANT SIGNATURE:** _____ **DATE:** _____

 **AGENT SIGNATURE:** _____ **DATE:** _____

Typed or Printed Name of Agent, Broker, or Other Representative: _____

**NOTICE REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR
LONG TERM CARE INSURANCE FORM
APPLICANT COPY**

MedAmerica Insurance Company
Administrative Offices: 165 Court Street, Rochester, NY 14647

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The above notice was delivered to me on (Date): _____

 APPLICANT SIGNATURE: _____ DATE: _____

 AGENT SIGNATURE: _____ DATE: _____

Typed or Printed Name of Agent, Broker, or Other Representative: _____

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III. INSURABILITY PROFILE

INSTRUCTIONS: You must answer each applicable question by checking YES or NO.

<p>1. 5 YEARS: In the past 5 years have you received Medical Advice, Consultation, or Treatment for any of the following conditions:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none; vertical-align: top;"> <ul style="list-style-type: none"> • AIDS* * You need not answer "yes" if you have only tested positive for Human Immunodeficiency Virus (HIV). In addition, you need not answer "yes" if you do not have, or have never been tested for HIV or AIDS. You are obligated to answer "yes" if you have actually been diagnosed as having AIDS. • Alzheimer's Disease • Amputation-Due to Disease • Amyotrophic Lateral Sclerosis (ALS) • Anemia - Aplastic or Sideroblastic • Brain Tumor • Cancer - Metastatic • Cerebral Aneurysm, Unoperated • Charcot-Marie Tooth Syndrome • Cirrhosis - Liver • Collagen Vascular Disease • Crest Syndrome • Dementia (including Alzheimer's) • Demyelinating Disease • Diabetes and Peripheral Vascular Disease </td> <td style="width: 33%; border: none; vertical-align: top;"> <ul style="list-style-type: none"> • Ehlers-Danlos Syndrome • Falls - Multiple with Any History of Fracture • Fractures - Multiple • Friedrich's Ataxia • Heart Valve Replacement - Double • Hemochromatosis • Hepatitis - Chronic • Huntington's Chorea • Incontinence - Bowel or Bladder • Lou Gehrig's Disease (ALS) • Lupus (SLE) - Internal • Marfan's Syndrome • Memory Problems • Mental Retardation • Mental Condition Treated with Antipsychotic Meds • Mixed Connective Tissue Disease • Monoclonal Gammopathy • Multiple Myeloma • Multiple Sclerosis • Muscular Dystrophy • Myasthenia Gravis • Neurofibromatosis </td> <td style="width: 33%; border: none; vertical-align: top;"> <ul style="list-style-type: none"> • Neurogenic Bladder • Organ Transplants • Organic Brain Syndrome • Parkinson's Disease/ Parkinsonism • Peripheral Vascular Disease and Smoking • Polycystic Kidney Disease • Post-Polio Syndrome • Psychosis • Pulmonary Hypertension • Renal Disease • Schizophrenia • Scleroderma • Shunt • Skin Ulcers and Diabetes • Strokes - Multiple • Thrombocytosis • Tourette Syndrome • Transient Ischemic Attacks (TIAs) - Multiple • Tumor - Spinal Cord </td> </tr> </table>	<ul style="list-style-type: none"> • AIDS* * You need not answer "yes" if you have only tested positive for Human Immunodeficiency Virus (HIV). In addition, you need not answer "yes" if you do not have, or have never been tested for HIV or AIDS. You are obligated to answer "yes" if you have actually been diagnosed as having AIDS. • Alzheimer's Disease • Amputation-Due to Disease • Amyotrophic Lateral Sclerosis (ALS) • Anemia - Aplastic or Sideroblastic • Brain Tumor • Cancer - Metastatic • Cerebral Aneurysm, Unoperated • Charcot-Marie Tooth Syndrome • Cirrhosis - Liver • Collagen Vascular Disease • Crest Syndrome • Dementia (including Alzheimer's) • Demyelinating Disease • Diabetes and Peripheral Vascular Disease 	<ul style="list-style-type: none"> • Ehlers-Danlos Syndrome • Falls - Multiple with Any History of Fracture • Fractures - Multiple • Friedrich's Ataxia • Heart Valve Replacement - Double • Hemochromatosis • Hepatitis - Chronic • Huntington's Chorea • Incontinence - Bowel or Bladder • Lou Gehrig's Disease (ALS) • Lupus (SLE) - Internal • Marfan's Syndrome • Memory Problems • Mental Retardation • Mental Condition Treated with Antipsychotic Meds • Mixed Connective Tissue Disease • Monoclonal Gammopathy • Multiple Myeloma • Multiple Sclerosis • Muscular Dystrophy • Myasthenia Gravis • Neurofibromatosis 	<ul style="list-style-type: none"> • Neurogenic Bladder • Organ Transplants • Organic Brain Syndrome • Parkinson's Disease/ Parkinsonism • Peripheral Vascular Disease and Smoking • Polycystic Kidney Disease • Post-Polio Syndrome • Psychosis • Pulmonary Hypertension • Renal Disease • Schizophrenia • Scleroderma • Shunt • Skin Ulcers and Diabetes • Strokes - Multiple • Thrombocytosis • Tourette Syndrome • Transient Ischemic Attacks (TIAs) - Multiple • Tumor - Spinal Cord 	<input type="checkbox"/> YES <input type="checkbox"/> NO
<ul style="list-style-type: none"> • AIDS* * You need not answer "yes" if you have only tested positive for Human Immunodeficiency Virus (HIV). In addition, you need not answer "yes" if you do not have, or have never been tested for HIV or AIDS. You are obligated to answer "yes" if you have actually been diagnosed as having AIDS. • Alzheimer's Disease • Amputation-Due to Disease • Amyotrophic Lateral Sclerosis (ALS) • Anemia - Aplastic or Sideroblastic • Brain Tumor • Cancer - Metastatic • Cerebral Aneurysm, Unoperated • Charcot-Marie Tooth Syndrome • Cirrhosis - Liver • Collagen Vascular Disease • Crest Syndrome • Dementia (including Alzheimer's) • Demyelinating Disease • Diabetes and Peripheral Vascular Disease 	<ul style="list-style-type: none"> • Ehlers-Danlos Syndrome • Falls - Multiple with Any History of Fracture • Fractures - Multiple • Friedrich's Ataxia • Heart Valve Replacement - Double • Hemochromatosis • Hepatitis - Chronic • Huntington's Chorea • Incontinence - Bowel or Bladder • Lou Gehrig's Disease (ALS) • Lupus (SLE) - Internal • Marfan's Syndrome • Memory Problems • Mental Retardation • Mental Condition Treated with Antipsychotic Meds • Mixed Connective Tissue Disease • Monoclonal Gammopathy • Multiple Myeloma • Multiple Sclerosis • Muscular Dystrophy • Myasthenia Gravis • Neurofibromatosis 	<ul style="list-style-type: none"> • Neurogenic Bladder • Organ Transplants • Organic Brain Syndrome • Parkinson's Disease/ Parkinsonism • Peripheral Vascular Disease and Smoking • Polycystic Kidney Disease • Post-Polio Syndrome • Psychosis • Pulmonary Hypertension • Renal Disease • Schizophrenia • Scleroderma • Shunt • Skin Ulcers and Diabetes • Strokes - Multiple • Thrombocytosis • Tourette Syndrome • Transient Ischemic Attacks (TIAs) - Multiple • Tumor - Spinal Cord 		

<p>2. 1 YEAR: In the <i>past year</i> have you needed assistance or supervision in performing activities of daily living*, used any Medical Equipment**, or received nursing home care, home health care, or adult day care services?</p> <p><i>*Includes Walking, Dressing, Eating, Taking Medications, Getting In and Out of Bed, Bathing, Toileting, Bowel/Bladder Control</i></p> <p><i>**Wheelchair, Walker, Motorized Scooter, Quad Cane, Dialysis, Catheters, Ventilators, Oxygen, Stairlift, or Home Intravenous Meds</i></p>	<input type="checkbox"/> YES <input type="checkbox"/> NO
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STOP! If questions 1 OR 2 are checked "Yes", we cannot offer coverage at this time. Do not Submit the Application.

<p>3. 1 YEAR: In the <i>past year</i> have you been hospitalized overnight, been advised to have surgery, received rehabilitative services including physical or occupational therapy, OR have you received disability income or worker's compensation?</p>	<input type="checkbox"/> YES <input type="checkbox"/> NO
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4. Height: _____ ' _____ " Weight: _____ lbs.

Applicant's Height and Weight must fall within Company guidelines.

<p>5. In the <i>past 2 years</i> have you used tobacco products?</p> <p>If "YES": Type: _____ Amount/Frequency: _____ / _____ If quit, give date: _____</p>	<input type="checkbox"/> YES <input type="checkbox"/> NO
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III. STANDARD INSURABILITY PROFILE (Continued)

() Stability is in parentheses in months, example (6) means 6 months. All stability assumes single conditions and stable for time period listed.

★ Conditions marked with a ★ are preferred after the stability period.



AGENTS ONLY: This symbol means that disorders of these marked body systems often interact with each other. Please check your Agent Field Underwriting Guide to evaluate insurability or call in to the UW Hotline at (1-877-233-5435) for pre-qualification review. If applicant has multiple conditions, agent should contact Underwriting Hotline for pre-qualification.

DURING THE PAST 5 YEARS HAVE YOU RECEIVED MEDICAL ADVICE, CONSULTATION, OR TREATMENT FOR ANY OF THE FOLLOWING:

Please  **CIRCLE** all that apply and detail in Section IV

6. Bone, Joint or Muscular Problems:

YES

<input type="checkbox"/> NO		
Ankylosing Spondylitis, No Steroids (6) Arthritis, Osteoarthritis, DJD (6) Arthritis, Rheumatoid, No Oral Steroids (6) Arthroscopic Surgery (3) Avascular Necrosis (12) Bunionectomy (3) (After 12★) Bursitis with treatment (3) (After 12★) Chronic Fatigue Syndrome (12) Compression Fracture (24) Dupuytren's Contractures, Single Joint (3★)	Fracture, Arm, No Fall (3) Fracture, All Other Accidental, No Fall (6) Fibromyalgia (6) Gout (6) Herniated Disc, Operated (3) Hernia Repair, Umbilical or Inguinal (3★) Knee/Hip Replacement (3) Kyphosis, No Respiratory Problem (0★) Lyme Disease (12) Osteomyelitis (12)	Osteopenia (0★) Osteoporosis, One Med (6) Paget's Disease (24) Pain In Any Joints (6) Polymyalgia Rheumatica (6) Polymyositis/Dermatomyositis (12) Rotator Cuff Tear (3) (After 12★) Sciatica (6) Scoliosis, No Respiratory Problem (0★) Spinal Stenosis (6)

7. Digestive, Gastrointestinal Problems, Bladder, or Kidney Problems:

YES

<input type="checkbox"/> NO		
Azotemia-Early Renal Insufficiency (12) Celiac Sprue (12) Colitis, Crohn's Disease (12) Colon Polyps (3★) Diverticulitis (6★) Gallbladder Disease (0★)	Gastrointestinal Bleed (GI) (6) Hepatitis (6) Hiatal Hernia (0★) Irritable Bowel Syndrome (6★) Loss of Appetite (6) Nephrectomy-Single Kidney, No Diabetes (12)	Prostate Enlargement, With Med or Surgery (3★) Stress Incontinence (6) Ulcer, Gastric/Peptic/Duodenal, No Bleeding (6★) Unintentional Weight Loss (6)

8. Mental or Alcohol/Drug Problems:

YES

<input type="checkbox"/> NO		
Anxiety (6) Alcoholism with Abstinence (24)	Depression, Chronic (12) Depression, Situational (6★)	Drug Dependency w/ Abstinence (24) Manic Depression (24)

9. Cancer:


YES


<input type="checkbox"/> NO		
Basal Cell Carcinoma of Skin (0★) Breast, No Nodes (12) Colon, No Nodes (12) Hodgkin's Disease (36)	Leukemia, Acute (ALL) (36) Leukemia, Chronic Lymphocytic (CLL) (0-48 only) Melanoma in-situ (6) Positive Nodes (36)	Prostate, No Nodes (12) Squamous Cell Carcinoma of Skin (0★) Uterine, No Nodes (12) All Other Cancers (36)


10. Neurological, Eye, or Ear Problems:


YES

<input type="checkbox"/> NO		
Bell's Palsy (3★) Blindness, Adapted (6) Carpal Tunnel Syndrome or Surgery (3★) Cerebral Palsy (12) Diabetic Retinopathy (12) Dizziness or Syncope, No Falls (12) Encephalitis (12★) Epilepsy (12)	Fall, Accidental, Single (3★) Falls, Accidental 2, No Fracture (6) Glaucoma (6) Guillain Barre' (6) Head Injury (12) Labrynthitis (6★) Macular Degeneration (6) Meniere's Disease (6) Neuropathy, Idiopathic (6)	Ocular Myasthenia Gravis (12) Raynaud's (6) Retinal Detachment, No Diabetes (3★) Retinal Hemorrhage, No Diabetes (3★) Seizure Disorder (24) Tremors, Benign (6) Unsteadiness/Loss of Balance (12)

11. Coronary or Circulatory Problems: 			<input type="checkbox"/> YES
<p>Aneurysm, Abdominal, Thoracic Operated (3★) Aneurysm, Abdominal, Thoracic Unoperated (3) Aneurysm, Cerebral, Operated (12) Angina-Chest Pain (6) Angioplasty (6) Atrial Fibrillation/Flutter (6) Cardiomyopathy, No Heart Failure (24) Carotid Artery Disease, Unoperated (12) Carotid Artery Surgery- Endarterectomy (6) Coronary Artery Disease (6) Coronary Artery Bypass Graft (CABG) (6) Deep Vein Thrombosis, Single Episode (12)</p>			<input type="checkbox"/> NO
<p>Dizziness or Syncope (12) Endocarditis (12) Femoral-Popliteal Bypass Graft – No Diabetes and No Smoking (6) Heart Arrhythmia (3) Heart Attack – Myocardial Infraction (MI) (6) High Blood Pressure-One Med (6★) High Blood Pressure-More than One Med (6) Heart Failure/Congestive Heart Failure (12) Heart Valve Disease, Single Valve (6) Irregular Heart Beat (6) Pacemaker (6)</p>	<p>Pericarditis (6) Peripheral Vascular Disease - No Diabetes, No Smoking (6) Phlebitis, Superficial (0★) Pulmonary Emboli, Single Episode (12) Stroke, Transient Ischemic Episode, Amaurosis Fugax, Single Event, No Smoking, No Diabetes, No Heart Failure (12) Temporal Arteritis or Buerger's Disease (12) Varicose Veins, No Skin Ulcers, No Edema (0★)</p>		

12. Hematology or Blood Problems: 			<input type="checkbox"/> YES
<p>Anemia, Iron Deficiency (6★) Anemia, Pernicious, B12 deficiency (6)</p>	<p>Anemia, Hemolytic, No Surgery (12) Polycythemia Vera, Primary and No Regular Phlebotomies (24)</p>	<p>Thrombocytopenia, Idiopathic, Operated (24) Thrombocytopenia, Idiopathic, Unoperated (24)</p>	<input type="checkbox"/> NO

13. Respiratory Problems: 			<input type="checkbox"/> YES
<p>Asthma (6) Bronchitis, Acute (0★) Bronchiectasis (6)</p>	<p>Chronic Obstructive Pulmonary Disease (COPD)/Emphysema (6) Sarcoidosis (24) Shortness of Breath (12)</p>	<p>Sleep Apnea, Operated (6) Sleep Apnea, Unoperated-CPAP, No Oxygen (12) Tuberculosis (6)</p>	<input type="checkbox"/> NO

14. Endocrine Problems: 			<input type="checkbox"/> YES
<p>Thyroid Problem, No Cancer (0★) Hormone Replacement Therapy (0★)</p>	<p>Diabetes, No Peripheral Vascular Disease (6) Hyperparathyroidism, Operated (6)</p>	<p>Pancreatitis, Acute (6)</p>	<input type="checkbox"/> NO

IV. EXPLANATION OF MEDICAL PROFILE QUESTIONS

Provide details for any YES answers to questions 6 Through 14 in Section III. If more space is needed, use additional sheets of paper. Applicant must sign additional sheets.

QUESTION NUMBER	DESCRIPTION OF ACCIDENT/ILLNESS	ONSET DATE	TYPE OF TREATMENT/ MEDICATION

MEDICATIONS: *Please print.*

List any medications being taken. If more space is needed, use additional sheets of paper. Applicant must sign additional sheets.

Medication (<i>Please Print</i>)	Dosage	Date (mm,yyyy) Medication Started

V. AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF DETERMINING INSURABILITY AND SIGNATURES

PRIMARY PHYSICIAN INFORMATION: *Please print.*

1. Primary Care Physician Name	Street Address, City, State, Zip	Phone #	Date Last Seen
2. Other Physicians (Indicate Specialty			

PRINT APPLICANT NAME _____

Applicant Social Security Number _____


From Me. I agree to permit company representatives to contact me to ascertain my health status to determine if my application is accepted.

From My Health Care Providers. I authorize any physician, medical practitioner, hospital, clinic or other health care provider or health related facility, including but not limited to those listed above, insurance or reinsurance company or employer, having information available as to any diagnosis, treatment and prognosis with respect to any of my physical or mental conditions and/or treatments, to furnish MedAmerica Insurance Company and/or designated business associates acting as insurance support organizations on MedAmerica Insurance Company's behalf any such protected health information, which may include my entire medical record, needed to determine my eligibility for insurance. THIS AUTHORIZATION EXPRESSLY INCLUDES INFORMATION ABOUT DRUGS, ALCOHOLISM, MENTAL ILLNESS AND COMMUNICABLE DISEASES. This authorization does not include psychotherapy notes. Regulations require a separate authorization for psychotherapy notes. We will contact you if we determine that such an authorization is needed.

For 24 Months. I agree that this authorization will be valid for 24 months from the date signed below and that a photocopy shall be as valid as this original. You may revoke this authorization at any time by giving written notice of revocation to the LTC Privacy Officer, PO Box 41930, Rochester, New York 14604 or LTCPrivacy.Officer@MedAmericaLTC.com. Revocation will not affect any action taken in reliance on this authorization before written notice of revocation is received.

Your Rights. Although voluntary, this authorization is required to determine your eligibility for enrollment. If you choose not to complete this authorization, we will be unable to determine your eligibility for insurance. By signing this authorization, you acknowledge that if you authorize a person or organization to receive your protected health information that is not a health plan, covered health care provider or health care clearinghouse subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Dated at: City _____ State _____ Month _____ Day _____ Year _____

 APPLICANT'S SIGNATURE: _____

VI. POLICY BENEFIT SELECTION

1. MAXIMUM MONTHLY BENEFIT: (MMB): Select A., B., or C.

A. LONG TERM CARE INSURANCE
MAXIMUM MONTHLY BENEFIT:

\$ _____ per month
Minimum \$2100 Multiples of \$300

Select One: Community Benefit:

60%

80%

100%

B. FACILITY ONLY RIDER :
MAXIMUM MONTHLY BENEFIT:
Minimum \$2100 Multiples of \$300


\$ _____ per month
Minimum \$2100 Multiples of \$300

C. COMMUNITY ONLY RIDER*:
MAXIMUM MONTHLY BENEFIT:
Minimum \$2100 Multiples of \$300

\$ _____ per month
Minimum \$2100 Multiples of \$300

***No Rider except Shortened Benefit
Nonforfeiture available with selection of
Community Only Rider.**

If you choose other than A. LONG TERM CARE INSURANCE, you must check the box noting the Rider selected, and initial the statement below.

I have elected to purchase the Rider checked above. I understand that by choosing this Rider, I am limiting my coverage to care provided in a specific location. I may not have coverage for all the types of long term care services I might require.  _____

Initial Here

2. **LIFETIME MAXIMUM:** Select one: 24 mos.* 36 mos.* 48 mos. 60 mos. 84 mos.** Unlimited**

* Only 24 mos. or 36 mos. Lifetime Maximum available for Community Only Rider.

** 84 mos. and Unlimited not available to Applicants over age 79.

3. **ELIMINATION PERIOD:** Select one: 30 Days 60 Days 90 Days 180 Days

4. **PREMIUM PAYMENT OPTIONS:** Lifetime 10 Pay Paid Up at Age 65*
 Reduced Premium (choose one): Age 65* Age 70**

***Not available to Applicants over age 55. ** Not available to Applicants over age 60.**

5. **INFLATION/BENEFIT INCREASE RIDER:**

None. I reject Inflation Protection 5% Simple 5% Compound 2X Max 5% Compound: No Max

6. **RIDERS:** All Riders are available only at time of original purchase unless otherwise stated. Unchecked Riders will default to "NO."

SHARED CARE RIDER: Must be purchased by both Care Partners and have the same effective date. Policies must be identical in benefits and premium payment options. Not available with selection of 24 mo. or Unlimited Lifetime Maximum. Not available in conjunction with the Restoration of Benefits Rider.

YES

RESTORATION OF BENEFITS RIDER: Not available with Unlimited Lifetime Maximum. Not available in conjunction with the Shared Care Rider.

YES

SHARED WAIVER OF PREMIUM RIDER: Must be purchased by both Care Partners within 6 months of each other and have the same effective date. Not available if Partners age difference is more than 15 years.

YES

SURVIVOR BENEFIT RIDER: Premiums must be payable for more than 10 years. Must be purchased by both Care Partners and have the same effective date. Not available if Partners age difference is more than 15 years.

YES

NONFORFEITURE RIDERS: Return of Premium available only to Applicants age 75 and under. Full Return of Premium available only to Applicants age 65 and under. You may not select both Return of Premium and Full Return of Premium.

Return of Premium
 Full Return of Premium
 Shortened Benefit Period

VII. PREMIUM PAYMENT INFORMATION: All Applicants must choose one method and complete required information

1. **DIRECT BILL**

Select the frequency of your Direct Billing payment

- Quarterly
 Semi-Annual
 Annual

2. **ELECTRONIC FUNDS TRANSFER (EFT)** or **CREDIT CARD: Only VISA and Master Card Accepted.**

Select the frequency of your EFT or Credit Card payment.

- Monthly Quarterly Semi-Annual Annual

EFT: _____
 Bank Name

Bank Account # (Attach Voided Check). **Not required if submitting Premium Check**
If check not attached, billing defaults to Direct Billing Quarterly.

CREDIT CARD: _____
 Expiration Date: MM/YYYY

 Credit Card Number

I authorize my financial institution or credit card company to automatically make payments to MedAmerica Insurance Company for my insurance. This authorization shall remain in force until I give notification of termination to my financial institution and MedAmerica Insurance Company in writing.

Account Holder Signature

Joint Account Holder Signature

3. **PAYROLL DEDUCTION**
 (Available only if approved by Affiliation)

Is your Affiliation contributing to the payment of your premium?

- YES NO

I authorize my Affiliation to deduct the applicable premium from my salary or remit payment on my behalf. I may revoke this authorization at any time by written notice to my Affiliation and to MedAmerica Insurance Company.

Employee/Member Signature

 Employee Social Security Number

VIII. AGENT'S STATEMENT

1. Has the Applicant purchased any other health insurance policy from you during the **past five (5) years**? *If Yes, provide the following information:*

COMPANY	POLICY NUMBER	IN FORCE:
_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO

2. By my signature on this form I certify that:
- (a) I have reviewed the current health insurance coverage of the Applicant and find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.
 - (b) I have personally interviewed the Applicant and have accurately recorded information supplied to me by the Applicant at the time application was made.
 - (c) I am in compliance with the Long Term Care Insurance requirements in the state of residence of the Applicant as shown on his/her/their Application.
 - (d) I have delivered the Outline of Coverage, Suitability Personal Worksheet and Rate Disclosure Form (where required), and appropriate Shopper's Guide to the Applicant at the first time of solicitation.

Soliciting Agent Name *(Please print)* _____

Writing Number _____

Agency Name _____

Phone Number (Best number to reach soliciting agent.) : (____) - _____

✍ SOLICITING AGENT SIGNATURE: _____ **DATE:** _____

3. More than one Agent?: YES NO: How many? _____ **If YES, please enter all Agent(s) names, Agent Writing Number(s), and % splits. Case splits must total 100%. (Only appointed Agents/Brokers may be paid commissions.)**

Agent Name: _____	Agent Writing#: _____	%: _____
Agent Name: _____	Agent Writing#: _____	%: _____
Agent Name: _____	Agent Writing#: _____	%: _____
TOTAL		100%

4. More than one General Agency? YES NO: How many? _____ **If YES, please enter all General Agency names, General Agency Writing Number(s), and % splits. Case splits must total 100%. (Only appointed Agencies/Brokers may be paid commissions.)**

General Agency Name: _____	General Agency Writing#: _____	%: _____
General Agency Name: _____	General Agency Writing#: _____	%: _____
General Agency Name: _____	General Agency Writing#: _____	%: _____
TOTAL		100%

5. How was case quoted? Preferred Standard Modified

6. Amount of Conditional Premium Check (attached): \$ _____

7. *Special Requests, Remarks, and Instructions:*

IX. SIGNATURES AND AUTHORIZATIONS: To be completed by ALL Applicants.

1. FRAUD NOTICE:

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties.

- 2. PROTECTION AGAINST UNINTENDED LAPSE:** I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this insurance policy for nonpayment of premium. I understand that notice will not be given until **31 days after** a premium is due and unpaid. I understand, also, that I have the right not to appoint a lapse designee. Therefore, **I select one of the following options:** **I elect NOT to designate** any person to receive such notice. **I designate** the person listed below to be notified by MedAmerica Insurance Company if my premium is not paid:

Name: _____ Phone Number: _____

Address: _____
Street City State Zip

- 3. INFLATION PROTECTION OPTION:** I have reviewed the Outline of Coverage and the graph that compare the benefits and premiums of this policy with and without inflation protection, and

- I ACCEPT inflation protection.**
 I REJECT inflation protection.

- 4. SHORTENED BENEFIT PERIOD NONFORFEITURE RIDER:** I have reviewed the Outline of Coverage describing the available nonforfeiture benefit rider, and

- I ACCEPT the Shortened Benefit Period non-forfeiture rider**
 I REJECT the Shortened Benefit Period non-forfeiture rider.

5. DECLARATION AND APPLICATION CONDITIONS

To the best of my knowledge and belief, I have answered all questions completely and truthfully. I understand this application is for consideration and the company will use this application or require, at their expense, that I see a health care professional to determine if my application is accepted. I understand that the premium for the coverage I have applied for is based on medical underwriting. The premium I was quoted includes certain assumptions regarding my health. Therefore, the premium for my policy may be different from the premium I was quoted. My coverage will begin when I am notified of the effective date of coverage. To receive benefits under this policy, I will satisfy the elimination period and the benefit eligibility requirements as set forth in the policy.

I acknowledge receipt of the Outline of Coverage, Suitability Personal Worksheet, Rate and Disclosure Form (if applicable in my state), and appropriate Shopper's Guide. If I am eligible for Medicare, I received *A Guide to Health Insurance for People with Medicare*.

I understand that with this signature I am agreeing with all applicable conditions contained in this Section.

Dated at: City _____ State _____ Month _____ Day _____ Year _____

 **APPLICANT SIGNATURE:** _____

Care Partner Statement

Please Print

Care Partner Name: _____ SS#: _____

Care Partner Name: _____ SS#: _____

The undersigned attest that we satisfy the definition of Care Partner set forth in Section 1 below and agree to the requirements set forth in Section 2 below.

1. A Care Partner is defined as follows:

A Care Partner consists of the applicant and one other person of the same or opposite sex. Such persons must satisfy all of the following requirements:

- a. Each is at least 18 years of age;
- b. Each is mentally competent to consent to contract;
- c. They are not related by blood or a degree of closeness, which would prohibit marriage in the law of the state in which they reside;
- d. They have a single dedicated relationship of at least 12 months duration and intend to remain in the relationship indefinitely;
- e. They share the same permanent residence and have done so for at least 12 months;
- f. Neither is currently married to another person under either statutory or common law;
- g. They are financially interdependent as evidenced by actions or conditions such as joint ownership of real property or a common leasehold interest in real property; common ownership of an automobile; a joint bank account; a will which designates the other as primary beneficiary; or completion of a beneficiary designation form for a retirement plan or life insurance policy signed and completed to the effect that one Care Partner is beneficiary of the other.

2. We affirm the statements made above are true and complete to the best of our knowledge. We understand that false statements may result in a premium charge retroactive to the original effective date of coverage under the terms of the long term care insurance policy this is attached to.

X: _____
Care Partner Signature

X: _____
Care Partner Signature

Date

Date

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CONDITIONAL PREMIUM RECEIPT

MEDAMERICA INSURANCE COMPANY

Administrative Offices: 165 COURT STREET, ROCHESTER, NY 14647

This acknowledges receipt of the initial premium in connection with your application for a MedAmerica Insurance Company long term care insurance policy. All premium checks must be made payable to MedAmerica. Do not make check payable to the agent or leave the payee blank.

PAYMENT OF PREMIUM DOES NOT PROVIDE INSURANCE COVERAGE UNTIL THE CONDITIONS SPECIFIED BELOW ARE SATISFIED.

APPLICANT NAME: _____	APPLICATION DATE: _____
PREMIUM RECEIPT DATE: _____	INITIAL FULL MODAL PREMIUM: \$ _____

SIGNATURE OF LICENSED AND APPOINTED AGENT

Agent Name and Business Address(Please Print)

X _____

The initial and subsequent premiums will differ from the amount submitted if coverage is issued other than as applied for or an anticipated discount does not apply. The premium for coverage applied for is based on medical underwriting guidelines and the premium quoted includes certain assumptions regarding the applicant's health.

If coverage is declined, this amount will be returned.

CONDITIONS THAT MUST BE SATISFIED BEFORE COVERAGE IS EFFECTIVE

1. THIS RECEIPT BEARS THE SAME DATE AND IS SIGNED BY THE SAME AGENT AS THE APPLICATION;
2. AN AMOUNT EQUAL TO THE FIRST MODAL PREMIUM SELECTED HAS BEEN COLLECTED WITH THE APPLICATION; AND
3. MEDAMERICA , UPON INVESTIGATION, IS SATISFIED THAT ON THE EFFECTIVE DATE OF COVERAGE, SUCH PERSON WAS INSURABLE ACCORDING TO THE COMPANY'S RULES AND REGULATIONS.

EFFECTIVE DATE OF COVERAGE

IF THE APPLICANT IS INSURABLE, THE POLICY WILL BECOME EFFECTIVE ON THE LATEST OF THE FOLLOWING DATES:

1. DATE OF COMPLETION OF ALL PARTS OF THE APPLICATION AND SUPPLEMENTS THERETO ON ALL PERSONS PROPOSED FOR INSURANCE; OR
2. DATE OF COMPLETION OF ALL REPORTS, MEDICAL EXAMINATIONS OR TESTS, INCLUDING A SECOND MEDICAL EXAMINATION, AS REQUESTED FOR ANY PERSON TO BE INSURED BECAUSE OF AGE, MEDICAL HISTORY, THE PLAN, OR THE AMOUNT OF INSURANCE APPLIED FOR; OR
3. THE DATE AS REQUESTED ON THE APPLICATION, WHICH MAY BE NO GREATER THAN SIXTY DAYS BEYOND THE COMPANY ASSIGNED EFFECTIVE DATE AND NOT EARLIER THAN THE APPLICATION SIGNATURE DATE.

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CareDirections
Simplicity

LONG TERM CARE INSURANCE - OUTLINE OF COVERAGE
Policy Number SPL-336
for Individual Sales

Caution: The issuance of this Long Term Care Policy is based upon your responses to the questions on your application. A copy of your application is enclosed. If your answers are incorrect or untrue, the Company may have the right to deny Benefits or rescind your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the Company at the address above.

Notice to Buyer: This Policy may not cover all of the costs associated with LONG TERM CARE incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

1. **POLICY:** This Policy is an individual Policy of insurance.
2. **PURPOSE OF OUTLINE OF COVERAGE:** This Outline of Coverage provides a very brief description of the important features of the Policy. You should compare this Outline of Coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY CAREFULLY!**
3. **FEDERAL TAX CONSEQUENCES:** This Policy is intended to be a Qualified Long Term Care insurance contract under section 7702B(b) of the Internal Revenue Code.
4. **TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED:**
 - (a) **RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE.** This means that you have the right, subject to the terms of your Policy, to continue your Policy as long as you pay your premiums on time. MedAmerica Insurance Company cannot change any of the terms of your Policy on its own, except that, in the future, IT MAY CHANGE THE PREMIUM YOU PAY. Where applicable, premium increases must be approved by the State Department of Insurance.
 - (b) **WAIVER OF PREMIUM:** Your premium payments will be waived on a monthly basis starting the day after the date your Elimination Period is satisfied. The Waiver of Premium will end on the date you are no longer Benefit Eligible
5. **TERMS UNDER WHICH PREMIUMS MAY BE CHANGED:** We reserve the right to increase your premium as of the premium due date; however, any changes in the premium rates must apply to all similar policies issued in your state on this Policy form. This means we cannot single you out for an increase because of any change in your age or health. However, your rates may go up based on the experience of all policyholders with a Policy similar to yours.

6. **TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED:** If you feel this Policy does not meet your insurance needs, return it to us or your agent within 30 days. If you do so, We will return any premium you may have paid. We also will void your Policy from its effective date.
7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE:** If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from the insurance company. Neither MedAmerica Insurance Company nor its agents represent Medicare, the federal government, or any state government.
8. **LONG TERM CARE COVERAGE:** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services. These services must be provided in a setting other than an acute care unit of a hospital, such as a nursing facility, in the community, or in the home.

This Policy provides coverage up to the Maximum Monthly Benefit as listed on the Schedule of Policy Benefits page of your Policy. Coverage is subject to Policy limitations and an Elimination Period.

9. **BENEFITS AND CONDITIONS FOR ELIGIBILITY:**

Benefits Provided By This Policy: This Policy pays you a monthly cash amount if you are Benefit Eligible. The actual amount depends on the Maximum Monthly Benefit you have chosen and where you are receiving care. Contingent Nonforfeiture Benefits are also included if you do not purchase an optional Nonforfeiture Benefit. All Benefits count toward fulfillment of your Lifetime Maximum.

Benefit Eligible: This means You will receive Benefits. To be Benefit Eligible or achieve Benefit Eligibility under this Policy all of the following conditions must be met.

1. We have verified You are Chronically Ill and have a Plan of Care;
2. You are not Chronically Ill due to war or any act of war, declared or undeclared;
3. Your Elimination Period has been met. (Does not apply to Benefits that do not require meeting the Elimination Period.)

We will work with You, Your family and Your physician when We need information about Your condition This information will be gathered by Us or one of Our representatives. You may contact Us with any questions regarding Our decision.

We will also need a Plan of Care. The Plan of Care is updated as Your needs change. You may use the services of Our Personal Care Advisors. These services are provided at not cost to You.

To continue Benefit Eligibility, We must verify You are Chronically Ill and have an updated Plan of Care at least every 12 months.

Activities of Daily Living

Bathing: This means washing yourself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence: This means the ability to maintain control of bowel or bladder functions; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing: This means the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating: This means the ability to feed oneself by getting food into your body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.

Toileting: This means the ability to go to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring: This means the ability to move into or out of a bed, chair or wheelchair.

Elimination Period: There is a one time Elimination Period. The Elimination Period (Waiting Period) is the number of calendar days You must wait before You will receive Benefits. Your Elimination Period begins the earliest of the date We have verified You are Chronically Ill and have a Plan of Care or the date You contact Us to establish Benefit Eligibility. The Elimination Period will end after the number of days chosen by You and shown in Your Schedule of Policy Benefits has ended. Benefits are not payable during the Elimination Period except where the Policy so states.

Days in an Elimination Period are combined, and do not need to be consecutive. You need to meet Your Policy's Elimination Period only once.

OPTIONAL RIDERS UNDER THIS POLICY*

You may elect any of the optional Riders listed. Depending on the Rider you select, you may pay an additional premium.

** Availability of Riders may vary by State.*

Shortened Benefit Period Rider – Form # SBPR

We will provide continued coverage equal to premiums you have paid if your Policy has been in force for three years and lapses.

Return of Premium Rider (ROPR) and Full Return of Premium Rider (FROPR) – Forms # ROPR and # FROPR

ROPR: If you die while the Policy is in force, We will refund all premiums paid for your Policy and any Riders less any Benefits paid or payable.

FROPR: If you die while the Policy is in force, We will refund all premiums paid for your Policy and any Riders disregarding any Benefits paid or payable.

Survivor Benefit Rider – Form # SVR

You and your Care Partner must both purchase this Rider. If after 10 years your Care Partner dies, no further payment of premium is due on your Policy.

Restoration of Benefits Rider - # ROBR

We will restore your Lifetime Maximum to what it would have been had no Benefits been paid under this Policy whenever a period of 180 consecutive days elapses in which:

1. You were not Chronically Ill
2. Your Policy did not lapse and all premiums were paid; and
3. You did not reach your Lifetime Maximum; and
4. Your Policy remained in force.

Shared Care Rider – Form # SCR

When purchased by both Care Partners, the Rider permits Care Partner to share the Benefits under their Policies by first using their own Lifetime Maximum and then, at the option of the other Care Partner, using the other Care Partner's Lifetime Maximum. In no case can the use of a portion of a Care Partner's Benefits reduce his or her Lifetime Maximum below a level that would provide that Care Partner a minimum of 24 months of Benefits.

Shared Waiver Rider – Form # SWR

When purchased by both Care Partners, the Rider provides that when one Care Partner's premiums are waived, premiums will be waived for the other.

Facility Only Rider – Form # FACR-337

This Rider changes the Benefits under your Policy by providing coverage only when you are Benefit Eligible and either reside in a Qualified Facility or receive care under a Hospice Care Program.

Community Only Rider – Form # COMMR-338

This rider changes the Benefits under your Policy by providing coverage only when you are Benefit Eligible and either reside in other than a Qualified Facility or receive care under a Hospice Care Program.

Compound Inflation - No Maximum Rider – Form # CMP

This Rider provides for an annual increase in your Maximum Monthly Benefit equal to 5% of your prior year's Maximum Monthly Benefit. This increase will continue for as long as your Policy is in force.

Compound Inflation - 2X Maximum Rider – Form # CMP2X

This Rider provides for an annual increase in your Maximum Monthly Benefit equal to 5% of your prior year's Maximum Monthly Benefit. This increase will continue until your Maximum Monthly Benefit is twice its original amount.

Simple Benefit Increase Rider – Form # SBIR

This Rider provides for an annual increase in your Maximum Monthly Benefit equal to 5% of your original Maximum Monthly Benefit. This increase will continue for as long as your Policy is in force.

10. **LIMITATIONS AND EXCLUSIONS:**

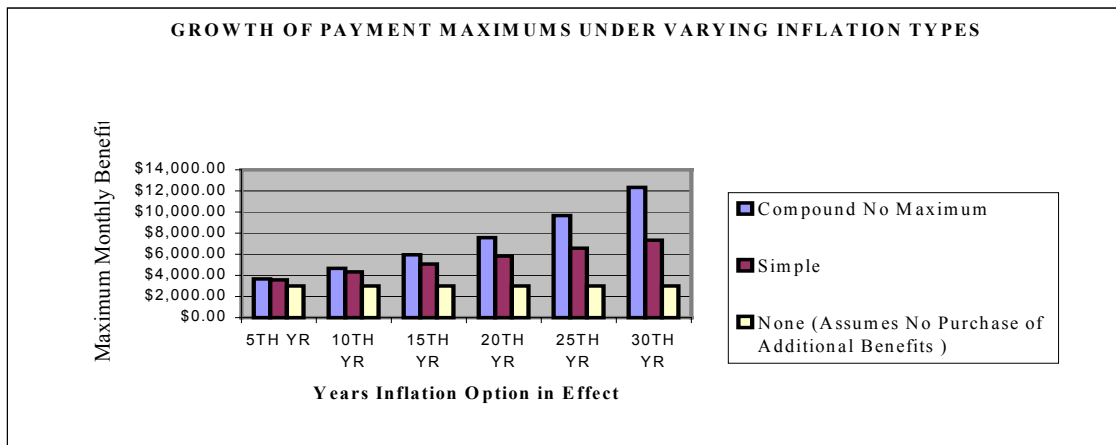
- (a) **Pre-existing conditions:** There are no pre-existing condition limitations in this Policy.
- (b) **Exclusions:** There are no exclusions under this Policy.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

11. **RELATIONSHIP OF COST OF CARE AND BENEFITS:**

Because the cost of long term care services will likely increase over time, you should consider whether and how the Maximum Monthly Benefits of this plan might be adjusted. Maximum Monthly Benefits will not increase over time if you do not purchase inflation protection.

The following is a hypothetical comparison of the levels of a Policy that increases Maximum Monthly Benefits over a period of coverage with a Policy that does not increase Maximum Monthly Benefits. The comparison shows the effect on Benefits at five (5) year intervals over thirty years for a client purchasing a \$3000 Maximum Monthly Benefit.



Compound – No Maximum: If you purchase Compound – No Maximum indexing, your Maximum Monthly Benefit will increase on every anniversary of the effective date of the Policy. Annual increases will apply to Benefits payable on or after the date of the increase. This first increase will be equal to 5% of your original Maximum Monthly Benefit. Each increase thereafter will equal 5% of the Maximum Monthly Benefit in effect on the date of the increase. Benefits increase without regard to health status or age.

Compound – 2X Maximum: If you purchase Compound – 2X Maximum indexing, your Maximum Monthly Benefit will increase on the anniversary of the effective date of the Policy. Annual increases will apply to Benefits payable on or after the date of the increase. This first increase will be equal to 5% of your original Maximum Monthly Benefit. Each increase thereafter will equal 5% of the Maximum Monthly Benefit in effect on the date of the increase. Benefits increase without regard to health status or age until your Maximum Monthly Benefit is twice the original Maximum Monthly Benefit.

Simple: If you purchase simple indexing, your Maximum Monthly Benefit will increase on every anniversary of the effective date of the Policy. Annual increases will apply to Benefits payable on or after the date of the increase. This increase will be always equal 5% of your original Maximum Monthly Benefit. Benefits increase without regard to health status or age.

None: If you purchase no indexing, your Maximum Monthly Benefit will not increase over time.

12. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS:** This Policy provides coverage if you are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses that result in a cognitive impairment.
13. **PREMIUM:**
- (a) The total annual premium quoted for your Policy is shown below. The total premium amount of your issued Policy is listed on the Premium Information page of your Schedule of Policy Benefits and may vary from the amount that is identified below due to medical underwriting.
(Agent: Please use the space below to indicate the premium quoted.)

Basic Benefits Annual Premium (Check one)

- a) Long Term Care Insurance
- b) Facility Only
- c) Community Only

\$ _____

Optional Riders Modal Premium

- Inflation Rider \$ _____
- Restoration of Benefits Rider \$ _____
- Survivor Benefit Rider \$ _____
- Shared Waiver Rider \$ _____
- Shared Care Rider \$ _____
- Return of Premium \$ _____
- Full Return of Premium \$ _____
- Shortened Benefit Period \$ _____

Total Modal Premium for Optional Riders \$ _____
 Less any /Affiliation/ Employer Program/ Discounts

Your Total Modal Premium will be: \$ _____ on a _____ basis*.
 The Annualized Modal Premium for this policy is: _____

* You may elect to pay your premium on other than an annual basis. Please note that payment schedules of less than annual will result in a higher premium amount paid per year.

14. ADDITIONAL FEATURES:

- (a) Medical underwriting of your application is used to determine your eligibility for long term care insurance and to determine your correct Rate Group classification.
- (b) Benefits may be available after termination if you are receiving Benefits covered under the Policy. See the "Extension of Benefits" section of your Policy for specific requirements.
- (c) If your Policy terminates because of non-payment, you may apply for reinstatement of the Policy.
- (d) No prior hospitalization is required before you can receive coverage under this Policy.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE.

CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY.

16. **SENIOR COUNSELING PROGRAMS:** Please refer to *A Shopper's Guide To Long Term Care Insurance* contained in your enrollment material for the telephone number of the Senior Counseling Program in your state.

17. LONG TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM

- 1. **Premium Rate:** Your premium rate that is applicable to you and that will be in effect until a request is made and filed with your State Department of Insurance for an increase is shown on your schedule page in your policy.

2. The premium for this Policy will be shown on the schedule page of your policy.
3. **Rate Schedule Adjustments:** If your rates are changed, the new rates will become effective on the next billing date. The new rates will remain in effect until another request is made and filed with your State Department of Insurance. You have the right to receive a revised schedule page if the premium rate is changed.

We have sold long term care insurance since 1987 and have sold this policy since 2004. We have never raised rates for any long term care policy sold in this state or any other state.

4. **Potential Rate Revision: This policy is Guaranteed Renewable.** This means that the rates for this coverage may be increased in the future. Your rates CANNOT be increased due to your age or declining health, but your rates may go up based on the experience of all insureds with a policy similar to yours. If you receive a premium rate increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:
 - (a) Pay the increased premium and continue your coverage in force as is.
 - (b) Reduce your coverage benefits to a level such that your premiums will not increase.
 - (c) Exercise your long term care nonforfeiture option, if purchased. This option is available for purchase for an additional premium.
 - (d) Exercise your contingent nonforfeiture rights - See No. 3. This option is available if you do not purchase a long term care nonforfeiture option mentioned in (c) above.

5. **Contingent Nonforfeiture Rights**

(a) If the premium rate for your policy goes up in the future and you do not buy a long term care nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long term care insurance coverage, if:

- (1) Your premium after the increase exceeds your original premium by the percentage shown, or more, in the table (provided on the next page/below); and
- (2) You do not pay your premium within 120 days of the increase causing your policy to lapse.

(b) The amount of coverage, new Lifetime Maximum Benefit amount, etc., you will keep will equal the total amount of premiums you have paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining Lifetime Maximum Benefit amount is less than the total amount of premiums you have paid, the amount of coverage will be that remaining amount.

(c) Except for this reduced Lifetime Maximum Benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

(d) Should you choose this Contingent Nonforfeiture option, your policy, with this reduced Lifetime Maximum Benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for ten years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to not pay any more premiums causing your policy to lapse.
- Your "paid-up" policy benefits are \$10,000, provided you have at least \$10,000 of benefits remaining under your policy.

**Contingent Nonforfeiture Cumulative Premium Increase over
Initial Premium That Qualifies for Contingent Nonforfeiture Table**

Percentage increase is cumulative from date of original issue.

It does NOT represent a one-time increase.

Issue Age	Substantial Percent Over Initial Premium	Issue Age	Substantial Percent Over Initial Premium
29 and under	200%	72	36%
30-34	190%	73	34%
35-39	170%	74	32%
40-44	150%	75	30%
45-49	130%	76	28%
50-54	110%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

