Flex Care
Long Term Care Insurance

Featuring Flex Cash Long Term Care Insurance

APPLICATION

for Brokerage, Associations, and Employer Groups

Complete this section ONLY FOR pre-approved Association or Employer Group accounts.

Name of Association or Employer Group *(Print)*

Service Group Number

UNDERWRITING:

Complete the following Part(s), based on the type of underwriting available to applicant. To be eligible for MGI or SI underwriting, the applicant must be age 18 – 71 and working a minimum of 30 hours per week.

Modified Guaranteed Issue (MGI):
Eligible employee of approved Employer Pay All.....Part A

Simplified Issue (SI):
Eligible employee/employee spouse of approved voluntary Employer Group.....Part A and B

Modified Application:
Eligible family member of approved Employer Group .....Part A, B, and C
Eligible member, employee, or family member of approved Association .....Part A, B, and C

Full Underwriting:
All others.....Parts A, B, C, and D

Pre-Screen Comments _____

Underwriting Call ID# _____

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

NEW JERSEY

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

Administrative Office: 165 Court Street Rochester, NY 14647
Home Office: Pittsburgh, PA | **1-800-544-0327**

Flex Care
Long Term Care Insurance

Producer's Name _____ Producer's Writing Number _____

Application is for: ☐ New Coverage ☐ Upgrade of Policy Number _____

SECTION 1: PERSONAL INFORMATION

Applicant's Name (Please Print) First	MI	Last	Sex	Date of Birth Month	Day	Year	Age	Height	Weight

Street Address *(No PO Box)* _____

City _____ State _____ Zip _____

Mailing/Delivery Street Address *(If different)* _____

City _____ State _____ Zip _____

Social Security Number _____ Email _____

Daytime Phone _____ Evening Phone _____ Best Time to Call ☐ AM ☐ PM

SECTION 2: BENEFICIARY

(Optional) A Beneficiary is a person(s) named by You to receive any premiums that may be due in the event of Your death.

Name _____ Relationship to Applicant _____

Phone _____ Street Address _____

City _____ State _____ Zip _____

SECTION 3: CURRENT EMPLOYMENT STATUS

(Answer this section if applying through an approved Employer Program.)

	YES	NO
3a. Do you work outside your home for at least 30 hours per week?	☐	☐
3b. Have you been absent due to illness or injury for more than 5 consecutive days over the last 180 days?	☐	☐
3c. Employer Name _____ Phone Number _____ *(If not the employer offering the program.)*		
3d. Are you Self Employed?	☐	☐
3e. New Hire? Date of Hire _____	☐	☐

I authorize my Employer to verify my employment status for MedAmerica Insurance Company (the Company) by phone or by census. If I am self employed, I understand that a representative of the Company will contact me to confirm my Actively at Work status.

3f. I am the ☐ Employer/Member ☐ Retiree ☐ Board Member ☐ Spouse/Domestic Partner ☐ Family Member: Relationship _____

OFFICE USE ONLY

App. Rec _____ App Status _____ UW Date _____ Init _____

☐ Preferred ☐ Standard Effective Date _____

SECTION 4: MARITAL STATUS *(Select one of the following):*

☐ **Married/Civil Union Partner***

☐ **Domestic Partner**** You have a Spouse/Domestic Partner who is: ☐ Applying for coverage at the same time, or ☐ Already has a MedAmerica long term care policy.

Spouse/Domestic Partner's First Name _____ Spouse/Domestic Partner's Last Name _____ Spouse/Domestic Partner's SSN _____

☐ **One Spouse*** ☐ **Domestic Partner**** .....You have a Spouse/Domestic Partner, but who is not applying for coverage.

☐ **Individual**.....You do not have a Spouse/Domestic Partner. Single or Widowed

* Under New Jersey law, Spouse includes New Jersey Civil Union Partners as well as partners in same-sex relationships formed in other jurisdictions that provide substantially all the rights and benefits of marriage.

** Domestic Partners are partners in a relationship formed in New Jersey. This includes partners in a relationship formed in other jurisdictions that provides some but not all of the rights and obligations of marriage. If you are applying as a Domestic Partner, the Domestic Partner Statement must be signed.

SECTION 5: BENEFIT SELECTION *(Complete all of the following):*

5a. **Plan Type** *(Select one):* ☐ Comprehensive *(FC-336-NJ)* ☐ Facilities Only *(FC-337-NJ)*

The Maximum Assisted Living Facility Benefit is 75% of the Maximum Nursing Home Benefit.

5b. **Daily Benefit:**

Maximum Nursing Home Benefit (NH) .....$ _____ per day (Minimum $50 – Maximum $500; Multiples of $10)

Maximum Assisted Living Facility (ALF), Home Health Care (HHC) and Adult Day Care Benefit (ADC) *(Select one):*

☐ 50%[1] ☐ 75% ☐ 100% ☐ 125%[1]

[1] Not Available with the Monthly Cash Benefit Rider

5c. **Benefit Duration** *(Select One):*

☐ 365 Days ☐ 730 Days ☐ 1095 Days ☐ 1460 Days ☐ 1825 Days
☐ 2190 Days ☐ 2555 Days ☐ 2920 Days ☐ 3650 Days

5d. **Elimination Period** *(Select One):*

☐ 30 Days ☐ 60 Days ☐ 100 Days ☐ 180 Days ☐ 365 Days

5e. **Benefit Increase Option:** *(Select One):*

☐ 3% Simple – No Maximum ☐ 5% Simple – No Maximum ☐ Guaranteed Purchase Option
☐ Combination Benefit Increase ☐ 3% Compound – No Maximum ☐ 5% Compound – No Maximum
☐ Daily Benefit Increase ☐ 5% Compound – 2x Maximum ☐ None

5f. **Optional Benefits:**

☐ **20 Calendar Day Elimination Period for ALF, HHC, ADC Rider**
☐ **Monthly ALF, HHC, ADC Benefit Rider**
☐ **Monthly Cash Benefit Rider**
☐ **Restoration of Benefits Rider**
☐ **Extended Benefit Rider** *(If Yes, Select One):*
☐ 730 Days ☐ 1095 Days

☐ **Limited Premium Payment Period** *(Select One):*
☐ 10 Years ☐ 20 Years
☐ **Return of Premium Rider** *(Select One):*
☐ Return of Premium Upon Death Rider
☐ Graded Return of Premium Upon Death Rider
☐ **Non-forfeiture Shortened Benefit Period Rider**

5g. **Optional Benefits for Spouse/Domestic Partner:**

☐ **Survivor Benefit Rider**
☐ **Shared Waiver Rider**

☐ **Shared Extended Benefit Rider** *(If Yes, Select One):*
☐ 730 Days (2 Years) ☐ 1460 Days (4 Years)
☐ 1095 Days (3 Years) ☐ 1825 Days (5 Years)

SECTION 6: INSURANCE HISTORY

YES NO

6a. Are you covered by a state assistance program (Medicaid)? ☐ ☐
If YES, as a Medicaid recipient you probably should not apply for this coverage.
We recommend ending the application at this point.

6b. Do you currently or have you had in the last 12 months another nursing home (NH), home health care, long term care insurance policy, rider or certificate in force? **If Lapsed, Provide Term Date** _____ ☐ ☐
If YES, please provide the following information. (Please use extra paper if needed)

Company_____ **Still In Force** ☐ ☐

Street _____ City _____ State _____ Zip _____

Policy Type: ☐ NH & Home Care ☐ NH Only ☐ Home Care Only

Policy Number_____ Daily Benefit Amount _____ Years Coverage_____ Effective Date_____ Term Date_____

6c. Are you allowing any other nursing home (NH), 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 Lapsed, Provide Term Date** _____ ☐ **YES** ☐ **NO**

If YES, You must sign both Notices Regarding Replacement of Accident and Sickness or Long term Care Insurance Forms. Submit Company Copy with this Application and retain the Applicant Copy.

Company_____ **Still In Force**_____ ☐ **YES** ☐ **NO**

Street _____ City _____ State _____ Zip _____

Policy Type: ☐ NH & Home Care ☐ NH Only ☐ Home Care Only

Policy Number_____ Daily Benefit Amount _____ Years Coverage_____ Effective Date_____ Term Date_____

SECTION 7: UNDERWRITING

PART A *You must answer each question by checking YES or NO.* YES NO

7a. ***Have you ever*** received Medical Advice, Consultation, or Treatment for any of the following conditions? ☐ ☐

- Diabetes Treated with Insulin
- Any Diabetes with Skin Ulcers
- Multiple Joint Replacements OR Any Joint Deformities
- Kidney Disease
- Liver Cirrhosis
- Hepatitis B, C, D, or E
- Stroke or Transient Ischemic Attack (TIA)
- Memory Loss, Alzheimer's Disease, or Dementia
- Bipolar Disorder, Schizophrenia, Psychosis, Mental Retardation
- Amyotrophic Lateral Sclerosis (ALS), Myasthenia Gravis
- Multiple Sclerosis
- Parkinson's Disease/Parkinsonism
- Muscular or Neurological Conditions causing Limits
- Post-Polio Syndrome
- Lupus (SLE)
- Scleroderma
- Amputation-Due to Disease
- Organ or Bone Marrow Transplants
- Brain or Spinal Tumors-benign or malignant
- Metastatic Cancer, Multiple Myeloma
- Pulmonary Embolism
- Carotid Artery Disease
- Peripheral Vascular Disease
- AIDS – Answer "yes" if you have actually been diagnosed as having AIDS. You need not answer "yes" if you have only tested positive for Human Immunodeficiency Virus (HIV).

7b. ***In the PAST YEAR:*** Have you needed assistance or supervision in taking medication, or performing activities of daily living: Bathing, Continence, Dressing, Eating, Toileting, Transferring? ☐ ☐

7c. ***In the PAST YEAR:*** Have used any Medical Equipment: Wheelchair, Walker, Motorized Scooter, Quad Cane, Canadian Crutches, Catheters, Ventilators, Oxygen, Stair lift, or Home Intravenous Medications? ☐ ☐

7d. ***In the PAST YEAR:*** Have you been admitted to a nursing home, assisted living facility, psychiatric hospital, OR alcohol/drug rehabilitation? ☐ ☐

STOP ***STOP! If any questions in PART A is answered "YES" we cannot offer coverage at this time. DO NOT SUBMIT APPLICATION.***

PART B *You must answer each question by checking YES or NO.* **YES NO**

7e. ***In the PAST YEAR:*** Have you been hospitalized overnight *(except for uncomplicated childbirth)* OR been advised to have surgery, OR been diagnosed with cancer AND received OR been advised to receive Radiation or Intravenous Chemotherapy? ..... ☐ ☐

7f. ***In the PAST YEAR:*** Have you been referred to or received medical advice, consultation or treatment from any physician specializing in any of the following: Neurology *(Nerves),* Nephrology *(Kidney/Renal),* Pulmonary *(Respiratory),* OR Hematology *(Blood)*?... ☐ ☐

7g. ***In the PAST YEAR:*** Have you been declined, postponed, or had your benefits modified for a long term care application? ..... ☐ ☐

PART C *You must answer each question.*

7h. *Complete the following information regarding your nonprescription or prescription medications.* ☐ No Medications

Medication	Dosage *(x/day)*	Reason Taking	# Months on Med

7i. **Physicians:** List all physicians seen in the last 5 years.

Physician(s) Name	Street Address	City, State, Zip	Phone Number	Date Last Seen
Primary:				
Other (specialty):				

PART D *You must answer each question by checking YES or NO.* **YES NO**

During the past **5 Years** have you consulted with a medical professional, had surgery for, been hospitalized for, had therapy or rehabilitation services from a medical professional for, **or taken any medication for any condition(s) or symptom(s) of the following (j-r)?**

7j. **Any Heart, Circulatory, Vascular, or Blood problems?** ..... ☐ ☐
Examples *(List not all inclusive):* Aneurysms, Strokes, TIA, Heart Attack, Angina, Dizziness, Pacemaker, Chest Pain, Irregular Heartbeat, Vascular Headaches, Peripheral Vascular Disease, Carotid Disease, Thrombocytopenia, Anemia and Hypertension

7k. **Any Bone, Joint, Muscular or Connective Tissue problems?** ..... ☐ ☐
Examples *(List not all inclusive):* Arthritis, Osteoporosis, Osteopenia, Back Problems, Paget's Disease, Polymyalgia, Rotator Cuff Tear, Bunion Surgery, Spinal Stenosis, Connective Tissue Disease

7l. **Any Respiratory Problems?** ..... ☐ ☐
Examples *(List not all inclusive):* Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Emphysema, Bronchitis, Sarcoidosis

7m. **Any Endocrine Problems?** ..... ☐ ☐
Examples (List not all inclusive): Diabetes, Thyroid problem, Hormone Replacement, Pancreatitis, Hyperparathyroidism

7n. **Any Neurological, Eye or Ear Problems?** ..... ☐ ☐
Examples *(List not all inclusive):* Bell's Palsy, Blindness, Carpal Tunnel, Cerebral Palsy, Epilepsy, Parkinson's Restless Leg, Seizure Disorder, Tremors, Unsteadiness, Loss of Balance, Falls, Glaucoma, Macular Degeneration

7o. **Any Mental, Alcohol or Drug Problems?** ..... ☐ ☐
Examples *(List not all inclusive):* Anxiety, Depression, Alcoholism, Manic Depression, Memory Loss

7p. **Any Digestive, Bladder, or Kidney Problems?** ..... ☐ ☐
Examples *(List not all inclusive):* Colitis, Colon Polyps, Gallbladder Disease, GI Bleed, Hiatal Hernia, Loss of Appetite, Nephrectomy, Renal Disease, Prostate Enlargement, Stress Incontinence, Weight Gain, Weight Loss, Dyspepsia

7q. **Any Cancer?** ..... ☐ ☐
Examples *(List not all inclusive):* Breast Cancer, Prostate Cancer, Uterine Cancer, Thyroid Cancer, Leukemia, Skin Cancer

7r. **In the past 2 years have you used tobacco products?** ..... ☐ ☐

If "YES," Type _____ Amount/Frequency: _____ If quit, give date _____

Details of Diagnoses: includes Date of Onset, Tests/Treatments/Follow-up over the last 5 Years for all conditions. Use extra sheet of paper if needed.

Description of Conditional/Problem	Date of Onset MM/YYYY	Type of Tests/Treatment/Follow-up/Medication Changes in the last 5 years	# Months Stable (No Change in Treatment)

SECTION 8: SIGNATURES AND AUTHORIZATIONS *To be completed by ALL applicants.*

8a. **FRAUD NOTICE:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

8b. **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 _____

Street Address _____

City _____ State _____ Zip _____

8c. **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.

8d. **NON-FORFEITURE SHORTENED BENEFIT PERIOD RIDER:** I have reviewed the Outline of Coverage describing the available nonforfeiture benefit rider, and

☐ **I ACCEPT** the Non-forfeiture Shortened Benefit Period Rider.

☐ **I REJECT** the Non-forfeiture Shortened Benefit Period Rider.

8e. **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, or if selected, my alternate effective date. To receive benefits under this policy, I understand I must 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 *(if applicable in my state)*, Rate and Disclosure Form *(if applicable in my state),* and appropriate Shopper's Guide.

I understand the Producer or Broker of Record for my Policy, and any managing entities *(which may include an affiliate of the Company)*, may receive compensation, monetary and/or non-monetary, as a result of my purchasing this insurance.

CAUTION: If your answers on this application are incorrect or untrue, or you fail to include all material medical information requested, MedAmerica Insurance Company has the right to deny benefits or rescind your policy.

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's Signature **X** _____

SECTION 9: EFFECTIVE DATE REQUEST *(Select one of the following):*

☐ Date of Application ☐ Date of Approval ☐ List Bill *(The Effective Date will be determined by MedAmerica Insurance Company)*

☐ Same as Spouse/Domestic Partner: _____ ☐ Other Requested Date: _____

(No more than 90 days from date of Application)

SECTION 10: PREMIUM PAYMENT METHOD *(Select one of the following):*

☐ **Direct Bill**

Premium Mode: ☐ Quarterly ☐ Annual ☐ Semi-Annual

☐ **List Bill** *(Check this box if):*

100% Employer/Association Paid:
The Employer/Association is paying **the entire** premium for the benefits chosen at the time of enrollment.

Alternate Billing Address: Address that applicant is requesting billing be mailed to **IF** different than the Applicant Address.

Name _____ Phone Number _____

Street _____ City _____ State _____ Zip _____

☐ **Electronic Funds Transfer (EFT)*** *(Sign authorization below)*

Premium Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

_____ _____ _____

Bank Name | Bank Account Number | Routing Number

Requires Minimum of 2 months Conditional Premium. Attached Voided Check if Requesting EFT from Different Bank than Conditional Premium Check.

☐ **Credit Card*** *(Sign authorization below)*

Premium Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

☐ VISA ☐ MASTERCARD _____ _____

Credit Card Number | Expiration Date MM/YY

***Authorization for EFT and Credit Card: Required IF Choosing EFT OR Credit Card Payment Method**

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

☐ **Payroll Deduction** *(Available only if approved by Employer/Association)*

I authorize the party responsible for my payroll to deduct the applicable premium from my salary for the insurance coverage. I may revoke this authorization at any time by written notice to my Employer/Association OR to MedAmerica Insurance Company.

_____ **X** _____

Print Name of Employees/Association Member (First, Last Name) | Employee/Association Member Signature

_____

Eligible Census ID: SSN, Employer ID or DOB (Required if Employee/Association Member is NOT the Applicant)

SECTION 11: PRODUCER STATEMENT

	YES	NO
11a. **Has the Applicant purchased any other health insurance policy from you during the past five (5) years?**	☐	☐

If Yes, provide the following information:

COMPANY	TYPE OF POLICY	POLICY NUMBER	In Force YES	In Force NO
			☐	☐
			☐	☐

11b. **By my signature on this form I certify that:**

- 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.
- I have consulted with the Applicant and have accurately recorded information supplied to me by the Applicant at the time application was made.
- 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.
- I have delivered the Outline of Coverage, Suitability Personal Worksheet (where required), and Rate Disclosure Form (where required), and appropriate Shopper's Guide to the Applicant at the first time of solicitation.

Soliciting Producer's Name (Please Print) _____ Writing # _____

Agency Name _____ Phone _____

Soliciting Producer's Signature **X** _____ Date _____

	YES	NO
11c. **Are you SPLITTING the Commission Payment?**	☐	☐

If YES, List all producers receiving compensation, their Writing Number(s), and % splits.
The first producer listed **MUST** be the soliciting producer and the producer of record. Case splits must total 100%.
(Only Licensed and Appointed Producers/Brokers may receive compensation.)

Soliciting Producer's Name _____ Writing # _____ %
First Name, Last Name (Please Print)

Co-Producer's Name _____ Writing # _____ %
First Name, Last Name (Please Print)

Co-Producer's Name _____ Writing # _____ %
First Name, Last Name (Please Print)

Co-Producer's Name _____ Writing # _____ %
First Name, Last Name (Please Print)

SECTION 12: RATE CLASS APPLIED FOR: *(Attached proposal):*

☐ Preferred ☐ Standard

SECTION 13: ADDITIONAL PREMIUM INFORMATION

Modal Premium Quoted $ _____ Conditional Premium with Application $ _____

SECTION 14: HIPAA MEDICAL AUTHORIZATION *(Uses and Disclosures of Medical Information) Must be signed by ALL applicants.*

This is a HIPAA Compliant Authorization. "HIPAA" is the Health Insurance Portability and Accountability Act of 1996, as amended.

I hereby authorize the following uses and disclosures of medical information about me.

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, or subject to the prohibitions of a Business Associate Agreement, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Applicant's Name *(Print)*

Applicant's Date of Birth

Applicant's Social Security Number

X

Applicant's Signature Date

A signed copy of this form will be provided with the policy if issued and any other time upon request.

MEDAmerica
An Excellus Company
MedAmerica Insurance Company Home Office: Pittsburgh, PA
MedAmerica Insurance Company of Florida Home Office: Orlando, FL
MedAmerica Insurance Company of New York Home Office: Rochester, NY
("MedAmerica")

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

SUPPLEMENTAL HIPAA MEDICAL AUTHORIZATION (Uses and Disclosures of Medical Information)
Must be signed by all applicants.

This is a HIPAA compliant authorization. "HIPAA" is the Health Insurance Portability and Accountability Act of 1996, as amended.

I hereby authorize the following uses and disclosures of medical information about me.

From My Health Care Providers. I authorize any physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager or other health care provider or health related facility, including but not limited to those identified above, insurance or reinsurance company or employer, including the Medical Information Bureau, having information available as to any diagnosis, treatment and prognosis with respect to any of my physical or mental conditions and/or treatments (including prescriptions and medications), to furnish MedAmerica and/or designated business associates acting as insurance support organizations on MedAmerica'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. I understand that I or my authorized representative am entitled to receive a copy of the authorization form if so requested.

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.

PRINT APPLICANT NAME: _____

APPLICANT DATE OF BIRTH: _____ / _____ / _____
MM *DD* *YYYY*

APPLICANT SOCIAL SECURITY NUMBER: _____ - _____ - _____

☞☞ **APPLICANT'S SIGNATURE:** _____ **DATE:** _____

COMPLETE & RETURN

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

Administrative Office: 165 Court Street Rochester, NY 14647
Home Office: Pittsburgh, PA | **1-800-544-0327**

DOMESTIC PARTNER STATEMENT

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

1. A Domestic Partner is defined as follows:

   A Domestic 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 that was formed in New Jersey and intend to remain in the relationship indefinitely. This also includes partners in a relationship formed in other jurisdictions that provide some but not all the rights and obligations of marriage;
   e. They share the same permanent residence;
   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 Domestic Partner is beneficiary of the other.

2. We affirm the statement 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.

_____ _____
Domestic Partner's Name (Print) Domestic Partner's Social Security Number

_____ _____
Domestic Partner's Name (Print) Domestic Partner's Social Security Number

X _____ _____
Domestic Partner's Signature Date

X _____ _____
Domestic Partner's Signature Date

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

Administrative Office: 165 Court Street Rochester, NY 14647
Home Office: Pittsburgh, PA | **1-800-544-0327**

LONG TERM CARE INSURANCE PERSONAL WORKSHEET

People buy long term care insurance for many reasons. Some don't want to use their own assets to pay for long term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive, and may not be right for everyone. By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form # _____

The premium for the coverage you are considering will be:

$_____ per month

$_____ per quarter

$_____ per year

This Policy is guarantee renewable.

The Company's Right to Increase Premiums

MedAmerica Insurance Company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History

We have sold Long Term Care insurance since 1987 and have sold this Policy since 2011. MedAmerica Insurance Company has not raised rates for this Policy form in this state or any other state. However, in the past ten years, we have raised rates on the following Policy series that are no longer available for sale, as summarized below.

Policy Series	Year Available for Sale	Year of Increase/ Percentage of Increase
LBP; CD5; CD7; LBP7; CD8; LBP8; CD9; LBP9; LTQ11-998; NTQ11-998; HTQ11-998; FLQ11-998; PRT11-998; PNQ11-998; GRP11-200; LTQ11-1100; NTQ11-1100; HTQ11-1100, GRP11-1100; GRP11-101; LTQ11-401; NTQ11-401; HTQ11-401; GRP11-401; GRP11-501; LTQ11-601; NTQ11-601; HTQ11-601; FLQ11-601; GRP11-601; PRT11-601; PNQ11-601; PGR11-601; TGR11-601; TLQ11-701; TNQ11-701; THQ11-701; TGR11-701; LTC-177-NAR	1992-2008	2010: 39% maximum increase (actual may vary by state)

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Questions Related to Your Income

How will you pay each year's premium? *(Check one)*

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What is your annual income? *(Check one)*

☐ Under $10,000 ☐ $10,000-$20,000 ☐ $20,000-$30,000
☐ $30,000-$40,000 ☐ $40,000-$50,000 ☐ Over $50,000

How do you expect your income to change over the next 10 years? *(Check one)*

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? *(Check one)* ☐ **YES** ☐ **NO**

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The National average annual cost of care in a Nursing Home in 2009 was $76,000, but this figure varies across the country. In 10 years the National average annual cost would be about $123,800 if costs increase 5% annually.

What elimination period are you considering?

# of days _____ Approximate cost for that period of care $ _____.

How are you planning to pay for your care during the elimination period? *(Check one)*

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? *(Check one)*

☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$40,000
☐ $40,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? *(Check one)*

☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

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Disclosure Statement

(Check one)

☐ *The answers to the questions above describe my financial situation.*
or
☐ *I choose not to complete this information.*

(This box must be checked) ☐ I acknowledge that the Company and/or its agent (below), if applicable, has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**

Applicant's Signature X _____ **Date** _____

I explained to the applicant the importance of completing this information.

Agent's Signature _____ Date _____

Agent's Printed Name _____

In order for us to process your application, please return this signed statement to the Company, along with your application.

My agent has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.

Applicant's Signature _____ Date _____

The company may contact you to verify your answers. Please see the Personal Worksheet Instruction Sheet for additional information.

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AUTHORIZATION FORM FOR FINANCIAL NON-DISCLOSURE ON THE LONG TERM CARE INSURANCE PERSONAL WORKSHEET

For your protection, state law requires us to consider the information on your Long Term Care Insurance Personal Worksheet when we review your application, to avoid selling a policy to you, if you do not need this coverage.

If you have chosen not to disclose your financial information on the Personal Worksheet, please verify below how you would like us to proceed.

☐ **Yes,** I wish to purchase this coverage. I still choose not to complete the financial information required in the Long Term Care Insurance Personal Worksheet. Please review my application.

☐ **No,** I have decided not to buy a policy at this time.

Applicant's Name X _____ **Date** _____

Please return this form with your application or enrollment form.

We thank you for your cooperation.

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NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

INSURER COPY

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 an individual long term care insurance policy to be 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.

STATEMENT TO APPLICANT BY PRODUCER:

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

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. The 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 producer 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, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____ _____

Producer's Signature Date

_____

Type or Print Name of Producer, Broker, or Other Representative

The above "Notice to Applicant" was delivered to me on:

_____

Date

X _____ _____

Applicant's Signature Date

Complete and Return

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MEDAmerica