



The **Federal** Long Term Care Insurance Program™



The Federal Long Term Care Insurance Program is sponsored by the U.S. Office of Personnel Management, offered by John Hancock Life & Health Insurance Company, Boston, MA 02117, and administered by Long Term Care Partners, LLC



Supplemental Answers for Abbreviated Application

Valid beginning October 1, 2009

Complete this form only if you need additional space to answer any of the following questions on your application. For assistance, call **1-800-LTC-FEDS** (1-800-582-3337) (TTY 1-800-843-3557).

Name

 First M.I. Last
Home phone _____ **Social Security number** _____ **Date of birth** _____
 _____ / _____ / _____
 Month Day Year

This form is part of the application I signed on _____ / _____ / _____
 Month Day Year

Signature _____ **Date** _____ / _____ / _____
 Month Day Year

Part C, Questions 2–5: If the answer to any of questions 2–5 is “**YES**,” explain below.

Name, address, and phone number of treating health professional	Question number	Diagnosis or disorder	Date of onset (mm/yy)	Date of last treatment (mm/yy)
Name _____ Address _____ Phone _____				
Name _____ Address _____ Phone _____				
Name _____ Address _____ Phone _____				

Part C, Question 6: Medications: List all prescription medications taken over the past 6 months.

Name, address, and phone number of treating health professional	Name of medication Check box if taking currently	Dosage (e.g., 10 mg)	Frequency (e.g., 2 x a day)	Reason prescribed
Name _____ Address _____ Phone _____	<input type="checkbox"/>			
Name _____ Address _____ Phone _____	<input type="checkbox"/>			
Name _____ Address _____ Phone _____	<input type="checkbox"/>			
Name _____ Address _____ Phone _____	<input type="checkbox"/>			

You may use as many additional forms as you need to provide your complete information. Attach completed forms to your application.