

FLTCIP 2.0 Full Underwriting Application

Valid beginning June 1, 2010



Important information to consider before you apply for coverage under the Federal Long Term Care Insurance Program

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 receive. Others don't want their family to have to pay for care and don't want to rely on Medicaid. But long term care insurance can be expensive and is not right for everyone.

Please read below for important information and questions that will help you decide if you should apply for this coverage. You should also read the Outline of Coverage and *A Shopper's Guide to Long-Term Care Insurance*, both of which are found in the Information Kit and online at www.LTCFEDS.com. If you have questions about whether long term care insurance is appropriate for you, please call us at **1-800-582-3337** (TTY 1-800-843-3557).

1. Can you afford to pay the premiums for the coverage you're considering?

If you will be paying premiums solely from your own income, a rule of thumb is that you may not be able to afford this coverage if the premiums will be more than 7% of your income. Your premium will be based on the benefit options you select and your age at the time we receive your application. If you need help calculating your premium, please visit www.LTCFEDS.com or call us at 1-800-582-3337 (TTY 1-800-843-3557).

2. Can you afford future changes to your premiums?

Your premiums may increase if:

- ▶ you increase your coverage, either by accepting increases to your benefits under the Future Purchase Option, or by requesting and being approved for an increase in your benefits, and/or
- ▶ you are among a class of enrollees whose premium is determined to be inadequate.

Effective January 2010, John Hancock raised FLTCIP 1.0 rates for enrollees with the Automatic Compound Inflation Option who purchased coverage at age 69 or younger. While there are no current plans to increase premium rates in the future, premiums are not guaranteed to remain at today's rates.

3. If you are considering the Future Purchase Option, have you considered if you can afford increased premiums for future increases to your benefits?

If you do not plan to accept future increases, have you considered how you will pay for any long term care that exceeds the amount your insurance will cover?

4. Do you qualify for Medicaid, or are you likely to qualify in the near future?

Medicaid may be available for persons with low income (for example, less than \$20,000/individual or \$40,000/couple) and few assets (for example, less than \$30,000/individual or \$50,000/couple, not counting the value of your home). Medicaid covers some long term care services. If you have low income and few assets now, or expect to in the next 10 years, you may want to consider whether long term care insurance is right for you. It is important to remember that Medicaid eligibility requirements vary by state. To learn more about Medicaid, contact your local or state Medicaid agency.



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

John Hancock

Part B

Answer these questions first

1. YES NO **Do you currently reside in, or has a health professional advised you to enter, a nursing home or any type of assisted living facility?**
2. YES NO **Are you currently receiving home health care services or attending adult day care?**
3. YES NO **Do you currently require or receive human help or supervision with any of these activities?**
- ▶ Bathing
 - ▶ Dressing
 - ▶ Eating
 - ▶ Transferring yourself from bed to chair
 - ▶ Toileting (getting to and using the toilet, completing hygiene-related functions after use)
 - ▶ Continence (changing protective undergarment, managing ostomy bag and catheter, completing hygiene-related functions)
4. YES NO **Do you currently have, or have you ever been diagnosed with, or ever been treated for, any of the following conditions?**
- ▶ AIDS, AIDS-related complex, HIV
 - ▶ Alzheimer's disease, organic brain syndrome, dementia
 - ▶ Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
 - ▶ Cirrhosis (excluding primary biliary)
 - ▶ Huntington's chorea
 - ▶ Multiple sclerosis
 - ▶ Muscular dystrophy
 - ▶ Organ transplant (excluding kidney, bone marrow, cornea transplants)
 - ▶ Parkinson's disease
 - ▶ Paraplegia or quadriplegia
 - ▶ Schizophrenia
 - ▶ Stroke (cerebrovascular accident): multiple
 - ▶ Stroke (cerebrovascular accident): with residual impairment (such as paralysis, weakness, gait disturbance, vision disturbance, mental impairment)
 - ▶ Transient ischemic attack (TIA): multiple
5. YES NO **Do you currently use any of the following medical devices, aids, or treatments (for any reason)?**
- ▶ Dialysis
 - ▶ Hospital bed
 - ▶ Motorized scooter
 - ▶ Multi-pronged cane
 - ▶ Oxygen (excluding CPAP)
 - ▶ Stair lift
 - ▶ Walker
 - ▶ Wheelchair
6. YES NO **Do you currently require or receive human help or supervision with any of these activities because of mental retardation?**
- ▶ Living independently
 - ▶ Making decisions about your money
 - ▶ Taking medications
 - ▶ Preparing meals
 - ▶ Shopping
 - ▶ Using transportation
 - ▶ Walking



If the answer to any of questions 1–6 in Part B is “YES,” you are NOT eligible for any of the insurance options under this program. You are eligible for a non-insurance service package providing access to care coordination and a discounted network of long term care providers and services. If you would like to receive information about this package, make sure that Parts A and B are complete and mail this application. Do not complete the rest of this application.

If the answer to each of questions 1–6 in Part B is “NO,” please continue with this application. We will review your answers to determine if we can offer coverage. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage.

Depending on the answers to the questions in this application, you may receive a call from a registered nurse to conduct a telephone interview or to schedule an in-home interview. We may also request medical information from your health care provider(s).

Part C**Answer these questions next**

1. YES* NO **Do you currently have, or have you ever been diagnosed with, or treated for, any of the following conditions?**
- ▶ Kidney transplant
 - ▶ Mental retardation
 - ▶ Paralysis of the extremities
 - ▶ Kidney failure
2. YES NO **Do you currently require or receive human help or supervision with any of these activities?**
- ▶ Preparing meals
 - ▶ Using transportation
 - ▶ Walking
 - ▶ Taking medications
 - ▶ Shopping
 - ▶ Making decisions about your money
3. YES NO **Do you currently use crutches, a cane, prosthetics, braces or a catheter?**
4. YES NO **Are you currently receiving disability income such as disability retirement annuity payments, VA disability compensation, workers' compensation, any federal or state disability payments, or any other type of disability payment?**

*If the answer to question 1 in Part C is "YES," you are not eligible for the unlimited benefit period in Part G of this application.

5. **Within the last 10 years, have you had, been diagnosed with, or been treated for any of the following conditions?**
- A. YES NO Stroke or cerebrovascular accident (CVA), transient ischemic attack (TIA), carotid artery disease
 - B. YES NO Peripheral vascular disease
 - C. YES NO Coronary artery disease (such as heart attack, angina), heart arrhythmia, cardiomyopathy, congestive heart failure, aneurysm, valvular disease
 - D. YES NO Diabetes (excluding gestational diabetes)
 - E. YES NO Cancer (excluding basal cell cancer or squamous cell cancer of the skin)
 - F. YES NO Chronic kidney disease (such as nephritis), incontinence, prostate disorder
 - G. YES NO Liver disorder (such as hepatitis), ulcerative colitis, Crohn's disease
 - H. YES NO Any psychiatric disorder (such as depression, bipolar disorder)
 - I. YES NO Disorder of the brain (such as tremor, seizure disorder, head injury, tumor, infection), neuropathy, syncope, paralysis, any chronic or progressive neurological disorder
 - J. YES NO Chronic lung disease (such as COPD, emphysema, sarcoidosis, chronic bronchitis, asbestosis, asthma [excluding seasonal asthma], bronchiectasis, sleep apnea)
 - K. YES NO Memory loss
 - L. YES NO Rheumatoid arthritis, any other type of arthritis, osteoporosis, back disorder, scoliosis, spinal stenosis, disc disease
 - M. YES NO Connective tissue disorder (such as scleroderma, systemic lupus, CREST syndrome)
 - N. YES NO Muscle disorder (such as fibromyalgia, polymyalgia rheumatica, chronic fatigue syndrome)
 - O. YES NO Fracture, amputation
 - P. YES NO High blood pressure
 - Q. YES NO Macular degeneration, glaucoma, retinitis pigmentosa, Meniere's disease
 - R. YES NO Anemia, polycythemia vera, thrombocytopenia, hemochromatosis
 - S. YES NO Alcoholism, drug dependency

Part C**Answer these questions next (continued)**

If the answer to any of questions 1–5 is “YES,” explain below. If you need additional space, you can attach a separate piece of paper, download a form at www.LTCFEDS.com/supplement, or call 1-800-LTC-FEDS (1-800-582-3337).

| 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 | | | | |
| _____ Name _____ Address _____ _____ Phone | | | | |
| _____ Name _____ Address _____ _____ Phone | | | | |
| _____ Name _____ Address _____ _____ Phone | | | | |

Part C

Answer these questions next (continued)

6. YES NO Have you taken any prescription medications over the past 6 months? If yes, please complete the chart below.

If you need additional space, you can attach a separate piece of paper, download a form at www.LTCFEDS.com/supplement, or call 1-800-LTC-FEDS (1-800-582-3337).

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

Part D

Answer these additional questions

1. **Height:** _____ feet _____ inches **Weight:** _____ pounds
2. YES NO **Are you employed or engaged in any hobbies, social activities, or volunteer work?**
3. YES NO **Do you exercise?**
4. YES NO **Have you used tobacco products (cigarette, pipe, cigar, or chewing tobacco) in the past 12 months?**
If yes, type: _____ frequency: _____
5. YES NO **Within the past 2 years, have you had a complete physical exam?**
If yes, month: _____ year: _____
Physician's name: _____
6. YES NO **Do you currently drink alcoholic beverages *every day*?**
If yes, please indicate number of drinks *per day*: 1 2 3 4 or more
7. YES NO **Have you ever had an application for life, health, disability, or long term care insurance declined, postponed, modified, or rated (offered insurance at a higher premium rate than the standard premium rate)?**
If yes, name of insurance company: _____
Type of insurance: _____
Reason: _____
8. YES NO **Within the past 5 years, has a health professional recommended that you should have any surgeries, tests, or procedures that have *not* been performed?**
9. YES NO **Have you ever resided in a nursing home or any type of assisted living facility?**
10. YES NO **Have you ever attended adult day care or received home health care services?**
11. YES NO **Within the past 5 years, have you ever been hospitalized or have you ever consulted with, or received treatment from, a health professional for any disease or condition not previously identified in any section of this application (excluding childbirth without complications, the common cold, or flu)?**

If the answer to any of questions 8–11 is “YES,” explain below. Attach a separate piece of paper if necessary.

| 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 | | | | |

Part E

Authorization to use and disclose health information

For the purposes of the Federal Long Term Care Insurance Program (including underwriting, claims, and customer service), I authorize any licensed health care practitioner, medical facility, employer, insurance company, or any other entity or person that has any health information about me to give that health information to Long Term Care Partners, LLC, John Hancock Life & Health Insurance Company, their reinsurers, and/or their subcontractors that need to know health information to provide contracted services.

The health information I am permitting to be disclosed and used for the Federal Long Term Care Insurance Program includes any information on my medical history, and the diagnosis, prognosis, and treatment of any physical or mental condition. It includes the disclosure of any medical care or surgery, psychiatric or psychological care or examinations, and information about alcohol or drug use (including any information otherwise protected by Federal Regulations 42 CFR Part 2 or other applicable laws). I understand that this authorization includes my consent to use and disclose medical information that relates to mental illness, HIV, AIDS, HIV-related illness, sexually transmitted diseases, or other serious communicable diseases, but only in accordance with any law or regulation that applies to any such disclosure of this information about me.

I understand that:

- ▶ If I do not sign this authorization, my application for long term care insurance may not be processed and any claim for long term care insurance benefits may be denied.
- ▶ I may revoke this authorization at any time, except to the extent that:
 - ▶ action has already been taken in reliance on it before my revocation, or
 - ▶ Long Term Care Partners or my insurer has a right to contest my long term care insurance claim or coverage.
- ▶ To revoke this authorization I must notify Long Term Care Partners, LLC, P.O. Box 797, Greenland, NH 03840-0797, in writing.
- ▶ If I do revoke this authorization, I understand that my application for long term care insurance may not be processed and any claim for long term care insurance benefits may be denied.
- ▶ If I do not revoke this authorization, it will be valid for 24 months from the date I sign it.
- ▶ My health information may be redisclosed and no longer protected by applicable law, including federal health information privacy regulations. This can occur only if such redisclosure is required or allowed by law (for example, in response to a subpoena).
- ▶ A copy of this authorization is as valid as the original.

Applicant's signature **X** _____ Date signed _____ / _____ / _____
(Required) (Required: mm/dd/yy)



Have you signed and dated the authorization in Part E? We cannot process this application without your signature and the date.

Part F

Your primary physician information

Primary physician or health care practitioner's first name _____ Last name _____

Address _____

City _____ State/Territory _____

Country _____ Zip/Foreign postal code _____

Phone _____ - _____ - _____

Check here if you do not have a primary physician or health care practitioner or if you have *not* seen the person listed above during the last two years.

NOTE: Your signature below also confirms the elections you made in Part G (choose a prepackaged plan or customized plan), Part I (billing options), and Part J (protection against an unintended lapse).

- ▶ If you rejected an Automatic Compound Inflation Option in Part G by choosing the Future Purchase Option, you are confirming that you reviewed the descriptions and graphs of the inflation protection options in the Outline of Coverage. You also understand that if you elect an Automatic Compound Inflation Option, you may switch to the Future Purchase Option at any time, and if you elect the Future Purchase Option, you may switch to an Automatic Compound Inflation Option under certain circumstances.
- ▶ If you elected automatic bank withdrawal in Part I, you are authorizing your bank to charge your account for such withdrawals, payable to Long Term Care Partners. This authorization will remain in effect until you, your bank, or Long Term Care Partners terminates it by a thirty (30) day written notice to the others. You will not receive any bills or other notices of the withdrawals from Long Term Care Partners. You agree that if the automatic bank withdrawal is not honored by your bank, for whatever reason, Long Term Care Partners will have no liability for the payments.
- ▶ If you elected payroll or annuity/pension deduction from your own pay or annuity/pension in Part I, you are authorizing Long Term Care Partners to deduct from your pay or annuity/pension the amount necessary to pay the premiums for the Federal Long Term Care Insurance Program coverage issued to you. If you elect payroll deduction, then we reserve the right to deduct from your annuity/pension or direct bill you the amount necessary to pay the premiums upon your retirement. You can cancel your payroll or annuity/pension deduction by contacting Long Term Care Partners to choose a different billing option.
- ▶ If you did not name someone in Part J to receive a notice if your coverage is about to lapse, you are confirming that you understand that such notices do not obligate such person in any way and are not sent until 45 days after your premium was due but unpaid. You also understand that you may identify a person (and/or name a different person) to receive notice of pending lapse at any time in the future.



The company's right to increase premiums: Premiums are not guaranteed. I understand that my premium will not change because I get older or my health changes or for any other reason related solely to me. Premiums may only increase if I am among a group of enrollees whose premium is determined to be inadequate. I understand that while the group policy is in effect, OPM must approve the change.

Note: You must check the above box to confirm that you have read and understand the paragraph above titled "The company's right to increase premiums." We cannot process your application if you do not check the box.

Applicant's signature **X** _____ Date signed _____/_____/_____
 (Required) (Required: mm/dd/yy)



Have you signed and dated the agreement and acknowledgment above? Have you read the statement about the company's right to increase premiums, and did you check the box? You must complete these items before we can process this application.

Mail to: Long Term Care Partners, P.O. Box 797, Greenland, NH 03840-0797

or

Fax to: 1-866-921-4510