# Supplemental Answers for the FLTCIP 2.0 Abbreviated Underwriting Application

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.

First Name | M.I. | Last Name

**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/yyyy) | Date of last treatment (mm/yyyy) |
|---|---|---|---|---|
| Name<br>Address<br>Phone | | | | |
| Name<br>Address<br>Phone | | | | |
| Name<br>Address<br>Phone | | | | |

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

| Name, address, and phone number of treating health professional | Name of medication<br>Check box if taking currently | Dosage (e.g., 10 mg) | Frequency (e.g., 2 x a day) | Reason prescribed |
|---|---|---|---|---|
| Name<br>Address<br>Phone | ☐ | | | |
| | ☐ | | | |
| Name<br>Address<br>Phone | ☐ | | | |
| | ☐ | | | |
| Name<br>Address<br>Phone | ☐ | | | |
| | ☐ | | | |

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



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, and administered by Long Term Care Partners, LLC.