# FLTCIP 2.0 Full Underwriting Application

Valid beginning August 1, 2015

## 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 buy insurance to make sure they can choose the type of care they receive. Others do not want to use their own assets or have their family pay for long term care. But long term care insurance can be expensive and is not right for everyone.

Please read below for important information and questions that may help you decide if you should apply for this coverage. You should also read the FLTCIP 2.0 Outline of Coverage and *A Shopper's Guide to Long-Term Care Insurance*, both of which are found online at **www.LTCFEDS.com** and in the information kit. If you have questions about whether long term care insurance is appropriate for you, please call us at **1-800-LTC-FEDS** (1-800-582-3337) **TTY** 1-800-843-3557.

1. **Can you afford to pay the premiums for the coverage you are considering?**

   If you plan to pay premiums solely from your own income, a rule of thumb is that you may not be able to afford this coverage if the premium is more than 7% of your income.* Your premium is based on the benefit options you select, your age, and the premium rates in effect at the time we receive your application. If you need help calculating your premium or creating a plan that suits your needs, please visit **www.LTCFEDS.com** or call us at **1-800-LTC-FEDS** (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 group of enrollees (for example, those with the same plan design or set of benefits) whose premium is determined to be inadequate.

   Note: Premiums are not guaranteed. While the group policy is in effect, the U.S. Office of Personnel Management (OPM) must approve an increase in premium rates.

3. **If you are considering the future purchase option, have you looked at whether 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 per individual or $40,000 per couple) and few assets (for example, less than $30,000 per individual or $50,000 per 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.

* National Association of Insurance Commissioners. "A Shopper's Guide to Long-Term Care Insurance," 2013.

# FLTCIP 2.0 Full Underwriting Application

Valid beginning August 1, 2015

**Do not use this application if you are:**

1. in one of the following groups:
   - new or newly eligible employee
   - spouse of a new or newly eligible employee
   - newly married spouse of an eligible employee

2. **and** applying **within** 60 days of becoming eligible to apply.

If you are eligible for any of the above, you may use the FLTCIP 2.0 Abbreviated Underwriting Application. Call us at **1-800-LTC-FEDS** (1-800-582-3337) **TTY** 1-800-843-3557 or visit **www.LTCFEDS.com/apply** for the application.

**Each eligible individual wishing to apply for coverage must complete a separate application.**

## Part A Personal information

**IMPORTANT:** If you received a rate quote and you are the individual named on the address label, remove the label and place it below. If not, please fill out the information below.

☐ Mr. ☐ Mrs. ☐ Ms.

First name | M.I. | Last name

Address line 1

Address line 2

City | State/Territory

Country | Zip/Foreign postal code

**Gender**

☐ Male ☐ Female

**Date of birth**

Month / Day / Year

**Home phone**

– –

**Work phone**

– – Extension

**Email**

**Social Security number***

– –

Please call us at the number below if you do **not** have a Social Security number (SSN).

* We use SSNs to obtain health information for underwriting purposes and during the claims process, verify eligibility, and process payroll deductions.

## Part A Personal information (continued)

**This application is only for the three groups shown below. Select what group makes you eligible, and then answer the questions for that group.** To determine if you are eligible for the program, visit **www.LTCFEDS.com/eligibility** for a detailed description of each option below or call us at **1-800-LTC-FEDS** (1-800-582-3337) **TTY** 1-800-843-3557.

### Employees

**If you are an employee, please select your affiliation:**

- ☐ Federal government
- ☐ U.S. Postal Service
- ☐ Uniformed services
- ☐ Other

**Please provide your agency or branch of service.**

_____

Visit **www.LTCFEDS.com/agency** or call us at the number below if you need help determining your agency name.

### Annuitants

**I am a(n):**

- ☐ Annuitant
- ☐ Survivor of a deceased workforce member receiving an annuity

**Please select your affiliation.**

- ☐ Federal government or U.S. Postal Service
- ☐ Tennessee Valley Authority
- ☐ U.S. Department of State
- ☐ Uniformed services
  **Please provide your branch of service.**

  _____
- ☐ Other
  **Please provide your retirement system.**

  _____

### Qualified relatives

**If you are a qualified relative of an employee, please select one.**

- ☐ Current spouse of an eligible employee
- ☐ Domestic partner* of an eligible employee
- ☐ Adult child of a living eligible employee
- ☐ Parent, parent-in-law, or stepparent of a living eligible employee

**Please select the employee's affiliation.**

- ☐ Federal government
- ☐ U.S. Postal Service
- ☐ Uniformed services
- ☐ Other

**Please provide the employee's agency or branch of service.**

_____

**If you are a qualified relative of an annuitant, please select one.**

- ☐ Current spouse of an eligible annuitant
- ☐ Domestic partner* of an eligible annuitant
- ☐ Adult child of a living eligible annuitant

**Please select the annuitant's affiliation.**

- ☐ Federal government or U.S. Postal Service
- ☐ Tennessee Valley Authority
- ☐ U.S. Department of State
- ☐ Uniformed services
  **Please provide the annuitant's branch of service.**

  _____
- ☐ Other
  **Please provide the annuitant's retirement system.**

  _____

**Please provide the following information about the employee or annuitant who makes you an eligible individual.**

**Employee's or annuitant's name**

First name | M.I. | Last name

**Employee's or annuitant's date of birth**

Month / Day / Year

**Employee's or annuitant's SSN**

___ – ___ – ____

* A Declaration of Domestic Partnership form must be submitted to the employee's agency or annuitant's retirement system before you apply. Visit **www.LTCFEDS.com/dp** for details.

## Part B Health questions (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, cognitive impairment, 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 intellectual disability (formerly referred to as 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 the FLTCIP. 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 practitioner(s).

## Part C Health questions (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
   - ▶ Kidney failure
   - ▶ Intellectual disability (formerly referred to as mental retardation)
   - ▶ Paralysis of the extremities

* **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.

2. ☐ Yes ☐ No **Do you currently require or receive human help or supervision with any of these activities?**
   - ▶ Preparing meals
   - ▶ Taking medications
   - ▶ Using transportation
   - ▶ Shopping
   - ▶ Walking
   - ▶ 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?**

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, 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 Health questions (continued)

**If the answer to any of questions 1–5 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 | | | | |
| Name<br>Address<br>Phone | | | | |
| Name<br>Address<br>Phone | | | | |
| Name<br>Address<br>Phone | | | | |

If you need additional space, you can attach a separate piece of paper, download a form at **www.LTCFEDS.com/supplement**, or call the number below.

## Part C Health questions (continued)

6. ☐ Yes ☐ No **Have you taken any prescription medications over the past six months? If yes, please complete the chart below.**

| 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<br>Address<br>Phone | | | | |
| Name<br>Address<br>Phone | | | | |
| Name<br>Address<br>Phone | | | | |
| Name<br>Address<br>Phone | | | | |
| Name<br>Address<br>Phone | | | | |
| Name<br>Address<br>Phone | | | | |
| Name<br>Address<br>Phone | | | | |

If you need additional space, you can attach a separate piece of paper, download a form at **www.LTCFEDS.com/supplement**, or call the number below.

## Part D Additional health 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 two 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 five 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 five 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.**

| 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 | | | | |

If you need additional space, you can attach a separate piece of paper, download a form at **www.LTCFEDS.com/supplement**, or call the number below.

## Part D Additional health questions (continued)

**Questions 8–11 (continued).**

| 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 | | | | |
| Name<br>Address<br>Phone | | | | |
| Name<br>Address<br>Phone | | | | |

If you need additional space, you can attach a separate piece of paper, download a form at **www.LTCFEDS.com/supplement**, or call the number below.

## 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 FLTCIP 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** _____ (Required) **Date signed** ____/____/____ (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 Primary care physician's or health care practitioner's information

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

Last name

Address

City

State/Territory

Country

Zip/Foreign postal code

Phone

## Part G Plan options

You can **either** choose a prepackaged plan **or** customize your own plan. Do **not** choose both. **If the answer to question 1 in Part C is "Yes," you are not eligible for the unlimited benefit period.** If you have any questions about options or premiums, please refer to *Book One: Program Details and Rates,* visit us online at **www.LTCFEDS.com/apply**, or call us at **1-800-LTC-FEDS** (1-800-582-3337) **TTY** 1-800-843-3557.

### Prepackaged plan

**1. Choose a plan**

| | | |
|---|---|---|
| ☐ **Plan A** | Daily benefit amount<br>Benefit period | **$150**<br>2 years |
| ☐ **Plan B** | Daily benefit amount<br>Benefit period | **$150**<br>3 years |
| ☐ **Plan C** | Daily benefit amount<br>Benefit period | **$200**<br>3 years |
| ☐ **Plan D** | Daily benefit amount<br>Benefit period | **$200**<br>5 years |

**2. Choose an inflation protection option**

- ☐ 4% Automatic compound inflation option
- ☐ 5% Automatic compound inflation option
- ☐ Future purchase option

***or***

### Customized plan

**1. Choose a daily benefit amount**

☐ $100 ☐ $150 ☐ $200 ☐ $250
☐ $300 ☐ $350 ☐ $400 ☐ $450

**2. Choose a benefit period**

☐ 2 years ☐ 3 years ☐ 5 years ☐ Unlimited

**3. Choose an inflation protection option**

- ☐ 4% Automatic compound inflation option
- ☐ 5% Automatic compound inflation option
- ☐ Future purchase option


Have you chosen a prepackaged plan **or** a customized plan? If you have chosen a prepackaged plan, check only one box for your plan and one box for your inflation protection option. If you have chosen a customized plan, be sure to check one box each for the daily benefit amount, benefit period, and the inflation protection option. **We cannot process this application if you leave any of these choices blank.**

## Part H Replacement coverage questions

Please answer the following questions about replacement of existing coverage. Federal law requires that we ask you these questions. Your answers to these questions will **not** affect your eligibility for insurance under the FLTCIP. This insurance is also not intended to replace any existing medical or health insurance coverage. These are different types of insurance that cover different types of care.

1. Medicaid (or other state-administered Medicaid program) is the state/Federal program that helps pay medical costs for some people with low incomes and limited resources. Please note that Medicaid is **not** the same as Medicare.

☐ **Yes** ☐ **No** **Are you covered under Medicaid? If you answer "Yes," you may wish to carefully consider whether you really need long term care insurance.**

2. If you currently have a long term care insurance policy or certificate, you should compare its benefits and costs with the benefits and costs of the FLTCIP. It may or may not make sense for you to replace that policy or certificate with coverage under this program. You should be certain that you are making an informed decision, and you should not cancel any long term care insurance you currently have unless or until your coverage under the FLTCIP is effective.

☐ **Yes** ☐ **No** **Are you replacing another long term care insurance policy or certificate currently in force with coverage under the FLTCIP? If you answer "Yes," we are required to notify your current insurance carrier that you have applied for coverage under this program. If you answer "Yes," please provide the following information:**

Policy number

Insurance company name

Insurance company street address

City

State/Territory

Zip/Foreign postal code

## Part I

## Billing options (choose one)

### Direct bill

If you are approved for coverage and you do not choose a billing option or fill out this part completely, you will be billed directly. For assistance with completing this page, please call us at **1-800-LTC-FEDS** (1-800-582-3337) **TTY** 1-800-843-3557.

☐ **Please send me a direct bill monthly to the address I provided in Part A of this application.**

*or*

### Payroll or annuity/ pension deduction

Due to timing issues, please be aware that there is usually a short delay before your payroll or annuity/pension deductions begin. You may receive a direct bill for any outstanding premiums resulting from a delay. Visit our website at **www.LTCFEDS.com/payroll** to find a payroll or annuity office identifier.

☐ **My pay or annuity/pension**

I authorize Long Term Care Partners to deduct premiums from my pay or annuity/pension. I have provided my Social Security number in Part A of this application.

**Choose one:**

(Insert **A, F, or I** below and fill in the remaining seven or eight characters)

☐ **CSRS/FERS annuity deductions** CS

☐ **All payroll or other annuity/pension deductions**

Office identifier

*or*

☐ **Someone else's pay or annuity/pension**

If you are requesting that deductions be taken from someone else's pay or annuity/pension, that employee or annuitant must complete this section and sign the authorization below.

**Choose one:**

(Insert **A, F, or I** below and fill in the remaining seven or eight characters)

☐ **CSRS/FERS annuity deductions** CS

☐ **All payroll or other annuity/pension deductions**

Office identifier

☐ Mr. ☐ Mrs. ☐ Ms.

Payor's first name M.I. Last name

_ _

Payor's Social Security number

I authorize Long Term Care Partners to deduct from my pay or annuity/pension that amount necessary to pay the premiums for the FLTCIP coverage for this applicant.

Payor's signature X _____ (Required)

Date signed _____/_____/_____ (Required: mm/dd/yy)

*or*

### Automatic bank withdrawal

☐ I authorize Long Term Care Partners to initiate automatic bank withdrawals from the account number provided on my voided check or savings deposit slip. Withdrawals will begin the month after I am approved and will continue on the third business day of every month. I understand that any past due premium will be collected by withdrawing up to two months of premium from my account until current.

Depositor's signature X _____ (Required)

Date signed _____/_____/_____ (Required: mm/dd/yy)

**Choose one:**

☐ **Checking:** You must attach a **voided check** (do not attach a checking deposit slip). We do not accept money market accounts.

☐ **Savings:** You must attach a **voided savings deposit slip** that lists a nine-digit routing number.

## Part J Protection against unintended lapse

It is a good idea to designate at least one person living outside of your household to receive notice if your insurance coverage is about to lapse because Long Term Care Partners did not receive your premiums.

Note: This person will **not** be responsible for paying your premiums. The person you designate can help find out why you stopped paying premiums. We will not contact this person until 45 days after a premium was due and is unpaid.

**Would you like to name a person in addition to yourself to receive notice if your insurance coverage is about to lapse because we did not receive your premiums? You must indicate "Yes" or "No."**

☐ **Yes, please contact the individual listed below.** ☐ **No, I reject this offer.**

**If "Yes," please provide all information requested.**

☐ Mr. ☐ Mrs. ☐ Ms.

First name | M.I. | Last name

Address

City | State/Territory

Country | Zip/Foreign postal code

Home phone | Work phone | Extension

## Part K Agreement and acknowledgment

To complete your application, you must confirm the following before submitting your application:

1. That you understand the company's right to increase premiums by checking the box on page 15.
2. That you agree to and acknowledge the terms stated in this application by signing and dating page 15.

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I am applying for insurance coverage under the FLTCIP. All of the answers and explanations I have given on this application, including my status as an eligible individual in Part A, are true and complete. I understand that the decision to approve my application will be based on my answers and explanations on this application. If required, my medical records or answers to interview questions will also be considered.

I agree to immediately inform Long Term Care Partners in writing if between the date I sign this application and the date my insurance coverage is effective (1) my health changes in a way that would cause any answer I have given on this application to no longer be correct, or (2) I receive any medical advice or treatment from a physician or other health care practitioner for a condition that would affect an answer to any question on this application. I understand that Long Term Care Partners may use information about such health changes or medical advice or treatment, whether provided by me or otherwise obtained, to reevaluate my application for coverage. I further understand that my coverage will not go into effect as scheduled or will be voided if the information, if known previously, would have caused the carrier not to issue my coverage.

I understand I have the right to request a copy of this application at any time, but I also understand I will receive one automatically.

*continued*

## Part K Agreement and acknowledgment (continued)

**Caution: If you are approved for coverage, but you should not have been because one or more of your answers or explanations are incorrect or untrue, or fails to include all material information requested, we may have the right to deny benefits or void your insurance. This is true even if you did not knowingly misrepresent the facts as shown in your medical records. We may also void your insurance at any time if we find that at the time of application, you misrepresented your status as a member of an eligible group.**

**Note: Your signature below also confirms the elections you made in Part G: Plan Options, Part I: Billing Options, and Part J: Protection Against 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 FLTCIP 2.0 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 request to change from the future purchase option to the automatic compound inflation option, and should you make such a request:
  - you will be required to provide, at your expense, evidence of your good health that is satisfactory to us; and
  - the effective date of all future automatic compound benefit increases will be the anniversary of the first day of the month that next follows the date of our approval of your request.
- 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 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 FLTCIP 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 on 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.


## Please check the box and sign below.

☐ **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.**

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

***or***

**Fax to: 1-866-921-4510**

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

Note: We may request medical records from your primary care physician or health care practitioner. We will advise you by letter if this request is necessary. If we have any questions regarding the answers on your application, an associate with Long Term Care Partners or one of our affiliated entities may reach out to you for additional information either in writing or by phone.

Some of our affiliated entities may request that you provide them with a separate authorization for physician information in addition to the one in this application.

If any of our associates or affiliated entities need to reach out to you regarding any aspect of your application, they will identify themselves as contacting you on behalf of Long Term Care Partners.