Long Term Care Insurance

Consumer Application Booklet with SPEEDApp℠

Simplicity ii℠

Offered by
MedAmerica Insurance Company
Home Office: Pittsburgh, PA

EMPLOYER PROGRAM

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

SE2-244-TN

TENNESSEE

PRIVACY NOTICE

Thank you for selecting MedAmerica as your long term care insurance company. Although your application is our initial source of information, we may also need to obtain information about you from doctors, hospitals, health care providers who have information about you or your mental or physical health or from a medical examination we may ask you to take; an in-person health interview; or the Medical Information Bureau (MIB). We will treat any information we obtain as confidential. We will not disclose information to anyone unless we are permitted to do so by law without your express written permission. It may be necessary to share information we obtain with an individual or organization performing a function for us.

We will provide you with any information contained in our files upon your request. If you wish to correct, amend or delete any of the information in the file you dispute, please contact us and we will advise you of the required procedures.

Please refer to the Authorization to Disclose Protected Health Information form for further details.

LTC Privacy Officer
PO Box 41930
Rochester, NY 14604
LTCPrivacy.Officer@MedAmericaltc.com
1-800-544-0327 Ext. 3413

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

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

Simplicity℠ ii
Long Term Care Insurance
TAX QUALIFIED COVERAGE

EMPLOYER PROGRAM APPLICATION
SPL2-336-TN

❒ NEW POLICY
❒ COVERAGE INCREASE
Indicate your current policy number here: ____________________

EP Name: ____________________
Case Number: ____________________

I. APPLICANT INFORMATION: 6 Questions to Complete

1. IDENTIFYING INFORMATION

Applicant Name (First, MI, Last)	Social Security Number

Legal Residence Street Address (no PO Box - Must Provide Street Address)	Mailing/Delivery Street Address (if different)
City State Zip	City State Zip

Home Phone (   ) | Work Phone (   ) | Best Time to Call: ☐ AM ☐ PM | Email:

Date of Birth: ___/___/_____ MM / DD / YYYY | Age (On Date Signed) | Sex: ☐ Male ☐ Female | Height: Ft. In. | Weight: Lbs.

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Single with Care Partner * ☐ Widowed with Care Partner *

* ***If you are Widowed or Single and applying for the Care Partner Premium, the Care Partner Statement must be signed.***

2. ELIGIBILITY STATUS FOR EMPLOYER PROGRAM: (Complete A. OR B.)

A. I am the Eligible of the Employer Program (Check One)

☐ Actively At Work Employee [1] During Open-Enrollment
☐ Actively At Work New Hire Date of Hire: ____________
☐ Actively At Work Employee [1] After Initial Open-Enrollment
☐ Eligible Employee but NOT an Actively at Work Employee [1], as defined below
☐ Retiree ☐ Board Member
Employee Census ID ____________

B. I am related to the Eligible of the Employer Program (Check One)

☐ Care Partner (Spouse /Domestic Partner) ☐ Parent ☐ Child (adopted & step) ☐ Parent-in-law
☐ Care Partner of a Child ☐ Brother/Sister (adopted, step, & in-law) ☐ Grandparent ☐ Grandparent-in-law

____________________ First, Last Name of Eligible of the Employer Program
____________________ Eligible Census ID -SSN, Employee ID or DOB

[1]Actively At Work Employee shall mean an employee or Care Partner of an employee, **aged 18 to 71**, currently paid by the above employer, employed outside the home by another employer, or self-employed outside the home, and not on Leave Without Pay or an authorized absence due to illness or injury for more than 5 consecutive days over the last 180 days. **The Actively At Work must be regularly scheduled to work not less than 30 hours per week** and be present at their Employer's place of business or an alternate work site as designated by the Employer and be performing the material and substantial duties of their jobs. If the employee works from home, they are considered Actively At Work if they are not hospital confined and not disabled to a degree that they could not have reported for work at the Employer's usual place of business and performed all the material and substantial duties of their occupations not less than 30 hours per week.

APPLICANT that is ACTIVELY AT WORK EMPLOYEE of the Employer Program: I hereby acknowledge that I am an Actively At Work Employee of the Employer offering this program **as defined above**.

SIGNATURE of APPLICANT that is ACTIVELY AT WORK EMPLOYEE☛ ____________________

APPLICANT that is ACTIVELY AT WORK CARE PARTNER of an Eligible of the Employer Program: I hereby acknowledge that I am an Actively At Work Employee, as defined above, AND that I am the Care Partner of an Eligible Member of the Employer Program. I understand that I may be required to provide proof of my actively at work status. By my signature below, I authorize my Employer to verify my employment status for MedAmerica Insurance Company (the Company) on request. If I am self-employed, I understand additional documentation may be required at the Company's discretion. **Name of Employer/Phone#** ____________________

SIGNATURE of APPLICANT -ACTIVELY AT WORK CARE PARTNER☛ ____________________

OFFICE USE ONLY: App. Rec:________ App Status:________ Eff. Date:________ UW Date: ________ Init:______

I. APPLICANT INFORMATION (Continued)

3. CARE PARTNER (Spouse/Domestic Partner) INFORMATION

a) Is your Care Partner (Spouse/Domestic Partner) applying for coverage at this time? ☐ YES* ☐ NO **If YES, answer (c)**

b) Does your Care Partner (Spouse /Domestic Partner) have a MedAmerica policy? ☐ YES* ☐ NO **If YES, answer (c)**

c) Care Partner (Spouse /Domestic Partner) name and SS# : ______________________ ______________________

Name (First, MI, Last) Social Security Number

* ***Single or Widowed Care Partners must complete the Care Partner Statement.***

4. ALTERNATE EFFECTIVE DATE

☐ **Same as Care Partner (Spouse/Domestic Partner)** ☐ **Other:** ____________ **Refer to Conditional Receipt**

5. ALTERNATE BILLING ADDRESS: Address that applicant is requesting billing be mailed to IF different than the Applicant Address.

Name (First, MI, Last)			Phone Number
			( )
Street Address	**City**	**State**	**Zip**

6. 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.

Beneficiary Name (First, MI, Last)	Relationship		Phone Number
			( )
Street Address	**City**	**State**	**Zip**

II. INSURANCE HISTORY

1. Are you covered by a state assistance program (Medicaid)? ☐ **YES** ☐ **NO**
   If YES, as a Medicaid recipient you probably should not apply for this coverage. <u>We recommend ending the application at this point.</u>

2. 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? **<u>If Lapsed, Provide Term Date</u>** ☐ **YES** ☐ **NO**
   <u>If YES,</u> please provide the following information. (Please use extra paper if needed)

2a). Company Name	Address (Street, City, State, Zip)		Policy Type: ☐ NH & Home Care ☐ NH Only ☐ Home Care Only		
Still In Force ☐ Yes ☐ No	**Policy Number**	**Daily Benefit Amount**	**Years Coverage**	**Effective Date**	**Term Date**

2b). Company Name	Address (Street, City, State, Zip)		Policy Type: ☐ NH & Home Care ☐ NH Only ☐ Home Care Only		
Still In Force ☐ Yes ☐ No	**Policy Number**	**Daily Benefit Amount**	**Years Coverage**	**Effective Date**	**Term Date**

3. 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? **<u>If Lapsed, Provide Term Date</u>** ☐ **YES** ☐ **NO**
   <u>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.</u>

Company Name	Address (Street, City, State, Zip)		Policy Type: ☐ NH & Home Care ☐ NH Only ☐ Home Care Only		
Still In Force ☐ Yes ☐ No	**Policy Number**	**Daily Benefit Amount**	**Years Coverage**	**Effective Date**	**Term Date**

III. POLICY BENEFIT SELECTION: COMPREHENSIVE COVERAGE 6 Steps to Complete

STEP 1: CASH BENEFIT ACCOUNT (Choose One)	STEP 2: MONTHLY CASH BENEFIT (Choose One From the SAME Row as Your Cash Benefit Account)			
	MONTHLY CASH BENEFIT	EFB: [2] Increase Facility Benefit to:	MONTHLY CASH BENEFIT	EFB: [2] Increase Facility Benefit to:
☐ $100,000 2 Options: a or b	a. ☐ $1,500	☐ EFB $2,000		
	b. ☐ $3,000 [3]	☐ EFB $4,000		
☐ $200,000 4 Options: a, b, c, or d	a. ☐ $1,500	☐ EFB $2,000	c. ☐ $4,500	☐ EFB $6,000
	b. ☐ $3,000	☐ EFB $4,000	d. ☐ $6,000 [3]	☐ EFB $8,000
☐ $300,000 3 Options: a, b, or c	a. ☐ $3,000	☐ EFB $4,000		
	b. ☐ $4,500	☐ EFB $6,000		
	c. ☐ $6,000	☐ EFB $8,000		
☐ $500,000 2 Options: a or b	a. ☐ $4,500	☐ EFB $6,000		
	b. ☐ $6,000	☐ EFB $8,000		

[2] EFB- ENHANCED FACILITY BENEFIT (Optional): If Selected Increases Facility Coverage to EFB Amount Indicated
[3] Shared Care Rider is Not Available with these Combinations

STEP 3: ELIMINATION PERIOD Choose One	STEP 4: INFLATION Choose One	STEP 5: PREMIUM PAYMENT OPTIONS Choose One
☐ 30 Days	☐ None	☐ Lifetime
☐ 60 Days	☐ 5% Simple	☐ 10 Pay
☐ 90 Days	☐ 3% Compound: No Max	☐ Paid Up at Age 65 [4]
☐ 180 Days	☐ 5% Compound: No Max	
	☐ 5% Compound 2x Max	[4] Not available after age 55

STEP 6: Riders: Riders are available only at the time of Original Purchase unless otherwise stated.		Check Riders You Are Applying For
Shared Care Rider [5]	*Policies must be identical in benefits and premium payment options.* *Also **not** available with:* • *Restoration of Benefits Rider;* • *Comprehensive Coverage $100,000 Cash Benefit Account and $3,000 Monthly Cash Benefit;* • *Comprehensive Coverage $200,000 Cash Benefit Account and $6,000 Monthly Cash Benefit;*	☐
Shared Waiver Rider [5]	• ***Not** available if Care Partners' age difference is more than 15 years.*	☐
Survivor Benefit Rider [5]	• ***Not** available if Care Partners' age difference is more than 15 years.* • ***Not** available with 10 Pay Premium Payment Option.*	☐

[5] For all of the above Shared Riders:
- *Both Care Partners Must Purchase the Riders and the Riders must have the Same Effective Date.*
- *If one Care Partner is Not Eligible or Does Not Apply, they must apply within 6 months of the Original Care Partner and the Original Care Partner can not be Eligible for Benefits at the time the Rider is requested.*

Restoration of Benefits Rider.	• ***Not** Available with Shared Care Rider.*	☐
Non-forfeiture Riders	**Return of Premium Rider:** *Available to Applicants **Age 75 and Under**.* • ***Not** available with Full Return of Premium Rider*	☐
	Full Return of Premium Rider: *Available to Applicants **Age 65 and Under**.* • ***Not** available with Return of Premium Rider*	☐
	Shortened Benefit Period Rider	☐

IV. PREMIUM PAYMENT INFORMATION: All Applicants must SELECT ONE method and complete required information.

1. ☐ DIRECT BILL

Select the frequency of your Direct Billing payment

☐ Quarterly

☐ Semi-Annual

☐ Annual

2. ☐ ELECTRONIC FUNDS TRANSFER (EFT)

Select the frequency of your EFT payment.

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

____
Bank Name

______________________ ______________________
Bank Account Number **Routing Number (9 numbers)**

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

***Sign Authorization Below**

3. ☐ CREDIT CARD

Select the frequency of your Credit Card payment

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

☐ **VISA** ☐ **MASTERCARD**

____
Credit Card Number

____
Expiration Date MM/YY

***Sign Authorization Below**

***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

4. ☐ 100% Employer Paid

(Your Employer is Paying all the Premium for the Benefits Chosen)

5. ☐ PAYROLL DEDUCTION (Available only if approved by Affiliation/Employer)

I authorize my Affiliation/Employer to deduct the applicable premium from my salary. I may revoke this authorization at any time by written notice to my Affiliation/Employer and to MedAmerica Insurance Company.

____
Print Name of Employee/Member (First, Last Name)

☛ ______________________________
Employee/Member Signature

____
Eligible Census ID -SSN, Employee ID or DOB
Required if Employee/Member is NOT the Applicant

V. INSURABILITY PROFILE-MUST BE COMPLETED BY ALL APPLICANTS:
Continue Completing the Insurability Profile Unless You are Directed to STOP- Please read the Stop Instructions Carefully.

INSTRUCTIONS: You must answer each question by **checking YES or NO.**

1. **Have you ever received Medical Advice, Consultation, or Treatment for any of the following conditions:** ☐ YES ☐ NO
- Alzheimer's Disease, Lewy Body Disease, Dementia, Any Memory Problems, Psychosis, Schizophrenia, Mental Retardation
- Amytrophic Lateral Sclerosis (ALS), Myasthenia Gravis, Multiple Sclerosis, Parkinson's Disease/Parkinsonism
- Post-Polio Syndrome, Demyelinating Disease, Other Neurological Conditions affecting the brain or spinal cord
- Lupus (SLE), Mixed Connective Tissue Disease, Scleroderma, Muscular Dystrophy, Other Muscular Conditions Causing Limits
- Kidney Disease, Polycystic Kidney Disease, Liver Cirrhosis, Hepatitis, Hemachromatosis
- Amputation-Due to Disease, Double Heart Valve Replacement , Organ or Bone Marrow Transplants
- Brain or Spinal Tumors-benign or malignant, Multiple Myeloma
- Peripheral Vascular Disease **and** Smoking, Peripheral Vascular Disease **and** Diabetes, Skin Ulcers **and** Diabetes
- 2 or more Strokes or Transient Ischemic Attacks(TIAs), Single Stroke OR TIA **and** Diabetes
- AIDS- You need not answer "yes" if you have only tested positive for Human Immunodeficiency Virus (HIV). In addition, you need not answer "yes" if you do not have, or have never been tested for HIV or AIDS. You are obligated to answer "yes" if you have actually been diagnosed as having AIDS.

2. **In the past year** have you needed assistance or supervision in performing activities of daily living*, used any Medical Equipment**, or received nursing home care, home health care, assisted living care, or adult day care services? ☐ YES ☐ NO

***Activities of Daily Living Include Walking, Dressing, Eating, Toileting, Taking Medications, Getting In and Out of Bed, Bowel and Bladder Control**
****Medical Equipment Includes Wheelchair, Walker, Motorized Scooter, Quad Cane, Canadian Crutches, Catheters, Ventilators, Oxygen, Stairlift, or Home Intravenous Medications.**

STOP! IF questions 1 OR 2 are "Yes," we cannot offer coverage at this time. Do not Submit the Application.

3. **In the *past 2 years* have you consulted with a medical professional, had surgery for, been hospitalized for, had therapy or rehabilitation services for, or taken any medication for any of the following?** ☐ YES ☐ NO
- Arthritis with Multiple Joint Replacements or Causing Limitations
- Cancer
- Cardiomyopathy or Congestive Heart Failure
- Chronic Blood Disorders
- Chronic Muscular or Neurological Conditions
- Vascular Disease or other Circulatory Disease
- Diabetes
- Drug/Substance Abuse
- Bowel or Bladder Problems
- Falls, Fractures, or Compression Fractures
- Joint Deformities
- Lung Disorders such as COPD or Emphysema
- Manic–Depression
- Stroke/TIA/Amaurosis Fugax- Single Episode

4. **In the *past year*** have you been hospitalized overnight, been advised to have surgery, received rehabilitative services including physical or occupational therapy, OR have you received disability income or worker's compensation? ☐ YES ☐ NO

STOP! IF You are Applying During Open Enrollment AND You are An Actively at Work Employee of the Group

☛GO TO SECTION VI: Authorization to Obtain Protected Health Information☛

V. Insurability Profile (Continued) List ALL Current Medications ☐ No Medications

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

STOP!
IF You are applying During Open Enrollment AND You are an Actively at Work Care Partner of an Employee
OR You are Age 71 or Younger Purchasing a $100,000 or $200,000 Cash Benefit Account

☛GO TO SECTION VI: Authorization to Obtain Protected Health Information☛

V. INSURABILITY PROFILE (Continued) If any question in this section is answered Yes, give full details below.

Producers: Call the Underwriting Hotline for Pre-qualification Review: 1-877-233-5435

During the past 5 Years have you consulted with a medical professional, had surgery for, been hospitalized for, had therapy or rehabilitation services for, or taken any medication for any condition(s) or symptom(s) of the following (1-8)?

1. **Any Heart, Circulatory, Vascular, or Blood problems?** ☐YES ☐ NO
   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
2. **Any Bone, Joint, Muscular or Connective Tissue problems?** ☐YES ☐ NO
   Examples (List not all inclusive): Arthritis, Osteoporosis, Osteopenia, Back Problems, Paget's Disease, Polymyalgia, Rotator Cuff Tear, Bunion Surgery, Spinal Stenosis, Connective Tissue Disease
3. **Any Respiratory Problems?** ☐YES ☐ NO
   Examples (List not all inclusive): Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Emphysema, Bronchitis, Sarcoidosis
4. **Any Endocrine Problems?** ☐YES ☐ NO
   Examples (List not all inclusive): Diabetes, Thyroid problem, Hormone Replacement, Pancreatitis, Hyperparathyroidism
5. **Any Neurological, Eye or Ear Problems?** ☐YES ☐ NO
   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
6. **Any Mental, Alcohol or Drug Problems?** ☐YES ☐ NO
   Examples (List not all inclusive): Anxiety, Depression, Alcoholism, Manic Depression, Memory Loss
7. **Any Digestive, Bladder, or Kidney Problems?** ☐YES ☐ NO
   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
8. **Any Cancer?** ☐YES ☐ NO
   Examples (List not all inclusive): Breast Cancer, Prostate Cancer, Uterine Cancer, Thyroid Cancer, Leukemia, Skin Cancer
9. Have you ***ever*** been turned down for nursing home, home health care, or disability insurance? If "Yes:" ☐YES ☐ NO
   Company/Reason:______________________________ **Date:** _______________
10. **In the *past 2* years** have you used tobacco products? ☐YES ☐ NO

If "YES," Type: __________________Amount/Frequency: __________/_______ *If quit, give date:* ______________

Provide Details of Diagnoses including Date of Onset, Tests/Treatments/Follow-up over the last 5 Years for All Conditions.
Please use extra sheet of paper if needed.

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

VI. AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF DETERMINING INSURABILITY AND SIGNATURES

Physician(s) Name	Physician(s) Street Address, City, State, Zip	Phone #	Date Last Seen
1. Primary Care Physician			
2. Other Physicians (Indicate Specialty)			

PRINT APPLICANT NAME: ____

Applicant Social Security Number: ____

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, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Dated at: City____ **State** ____________ **Month**__________ **Day**______**Year**_____

APPLICANT'S SIGNATURE: ____

COMPLETE AND RETURN

VII. SIGNATURES AND AUTHORIZATIONS: To be completed by ALL Applicants.

1. **FRAUD NOTICE:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

2. **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 Number:______________________________

Address:____
Street City State Zip

3. **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.**

4. **SHORTENED BENEFIT PERIOD NONFORFEITURE RIDER:** I have reviewed the Outline of Coverage describing the available nonforfeiture benefit rider, and

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

5. **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 SIGNATURE:** ____

VIII. PRODUCER STATEMENT

1. **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 ☐ NO
____________	____________	____________	☐ YES ☐ NO:

2. **By my signature on this form I certify that:**
   - (a) 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.
   - (b) I have consulted with the Applicant and have accurately recorded information supplied to me by the Applicant at the time application was made.
   - (c) 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.
   - (d) 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 Name (*Please print*) Writing Number

____

Agency Name

Phone Number (Best number to reach soliciting producer) : (_____) - ____________________

SOLICITING PRODUCER SIGNATURE: ________________________ DATE: ____________

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

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 Name:______________________ Writing#: ________________ : ______ %
Please Print First Name, Last Name

Co-Producer Name:______________________ Writing#: ________________ : ______%
Please Print First Name, Last Name

Co-Producer Name:______________________ Writing#________________ :______%
Please Print First Name, Last Name **TOTAL: 100 %**

4. **Amount of Conditional Premium Check (attached): $______________________**

If Conditional Premium is collected, Modal Premium is Required*

***If EFT, 2 months premium is required if Payroll Deduction or Employer Paid, no premium is required.**

Special Requests, Remarks, and Instructions:

THIS PAGE IS INTENTIONALLY LEFT BLANK

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

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

MedAmerica Insurance Company
Administrative Offices: 165 Court Street, Rochester, NY 14647

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 SIGNATURE: ______________________ **DATE:** __________

Typed or Printed Name of Producer, Broker, or Other Representative: ______________________

The above “Notice to Applicant” was delivered to me on (Date):__________

☛ APPLICANT SIGNATURE: ______________________ **DATE:** __________

COMPLETE AND RETURN

THIS PAGE IS INTENTIONALLY LEFT BLANK

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

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

MedAmerica Insurance Company
Administrative Offices: 165 Court Street, Rochester, NY 14647

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 SIGNATURE: ______________________ DATE: ____________

Typed or Printed Name of Producer, Broker, or Other Representative: ______________________

The above “Notice to Applicant” was delivered to me on (Date):____________

APPLICANT SIGNATURE: ______________________ DATE: ____________

APPLICANT COPY

THIS PAGE IS INTENTIONALLY LEFT BLANK

Care Partner Statement

Please Print

Care Partner Name: ______________________________ **SS#:** ______________________

Care Partner Name: ______________________________ **SS#:** ______________________

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

1. A Care Partner is defined as follows:

   A Care 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 of at least 12 months duration and intend to remain in the relationship indefinitely;
   e. They share the same permanent residence and have done so for at least 12 months;
   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 Care Partner is beneficiary of the other.

2. We affirm the statements 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.

X:______________________________ **X:**______________________________

Care Partner Signature Care Partner Signature

______________________________ ______________________________

Date Date

THIS PAGE IS INTENTIONALLY LEFT BLANK

Information to Help You With the Long Term Care Insurance Personal Worksheet

In addition to your application for long term care insurance, state law requires us to consider the information you provide on the **Long Term Care Insurance Personal Worksheet** when we review your application. The purpose is to avoid selling a policy to individuals who for financial reasons, may not need coverage. For your protection, we must retain records indicating that we have asked you to provide documentation that demonstrates the purchase of this insurance is appropriate with your financial resources.

The financial information in the "**Personal Worksheet**," is voluntary. You may or may not choose to provide the income and asset information on this form. Whether you choose to complete this form or not, does not affect your rights to choose to purchase this long-term care insurance.

Completing the "**Personal Worksheet"** will help you determine whether the purchase of this insurance will affect your standard of living. The final choice to complete the form and purchase this insurance is completely yours. However any information you provide on the **"Personal Worksheet**" and your application for insurance is for company use only and is kept in the strictest of confidence.

We would be pleased to be your long term care insurance provider now and in the future. It is in your best interest to consider if you are buying this policy to protect your assets but your assets are less than $30,000, you may wish to consider other options for financing your long term care. In as much as the purchase of long term care insurance can help you maintain your independence, give you more freedom in choosing care providers and help preserve your assets, you should consider if the premium payments would create a financial hardship for you. We consider this purchase of long term care insurance as a commitment for many years. Your ability as an insured to pay the premiums should be taken into account in your decision to buy this insurance.

Our long term care insurance specialists in our Customer Service area or your personal agent, are qualified to discuss the **Long Term Care Insurance Personal Worksheet** with you and help you to determine if this purchase is appropriate for you and to design a financially sound insurance plan for all of your long term care needs.

Thank you for choosing us to be your long term care insurance company.

THIS PAGE IS INTENTIONALLY LEFT BLANK

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

Administrative Offices:
165 Court Street
Rochester, NY 14647
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. **IF YOU ARE ENROLLING IN A GROUP LONG TERM CARE INSURANCE PLAN, YOU MAY USE THIS SHEET FOR YOUR OWN INFORMATION. GROUP EMPLOYEES AND THEIR SPOUSES/CARE PARTNERS DO NOT NEED TO RETURN THIS FORM TO THE COMPANY.**

Premium Information

Policy/Certificate Form #____________________________

The premium for the coverage you are considering will be:
$__________ per month
$__________ per quarter
$__________ per year

This Policy/Certificate is guaranteed 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 2007. MedAmerica Insurance Company has never raised its rates for any long term care policy it has sold in this state or any other state.

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 2002 was $46,000, but this figure varies across the country. In 10 years the National average annual cost would be about $75,000 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.

Disclosure Statement
(Not applicable to employees and spouses under group policies.)

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

☐ 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/certificate may increase in the future. (This box must be checked)

Signed: ____________________________ ____________________
(Applicant) (Date)

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

Signed: ____________________________ ____________________
(Agent) (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.

Signed: ________________________________ ____________________
(Applicant) (Date)

- -

The company may contact you to verify your answers.

Please see the Personal Worksheet Instruction Sheet for additional information.

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.

Signed ____

Applicant's Signature Date

Please return this form with your application or enrollment form.

We thank you for your cooperation.

THIS PAGE IS INTENTIONALLY LEFT BLANK

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

CONDITIONAL PREMIUM RECEIPT
MEDAMERICA INSURANCE COMPANY
Administrative Offices: 165 COURT STREET, ROCHESTER, NY 14647

This acknowledges receipt of the initial premium in connection with your application for a MedAmerica Insurance Company long term care insurance policy. All premium checks must be made payable to MedAmerica. Do not make check payable to the producer or leave the payee blank.

PAYMENT OF PREMIUM DOES NOT PROVIDE INSURANCE COVERAGE UNTIL THE CONDITIONS SPECIFIED BELOW ARE SATISFIED.

APPLICANT NAME: ________________________ **APPLICATION DATE:** ____________

PREMIUM RECEIPT DATE: ________________________ **INITIAL PREMIUM*:** $____________

*** For Monthly EFT: A minimum of 2 months conditional premium is required.**
*** For Credit Card: We will debit your card upon underwriting accepting you for coverage.**

SIGNATURE OF LICENSED AND APPOINTED PRODUCER	Producer Name and Business Address(Please Print)
X________________________	________________________ ________________________ ________________________

The initial and subsequent premiums will differ from the amount submitted if coverage is issued other than as applied for or an anticipated discount does not apply. The premium for coverage applied for is based on medical underwriting guidelines and the premium quoted includes certain assumptions regarding the applicant's health.

If coverage is declined, this amount will be returned.

CONDITIONS THAT MUST BE SATISFIED BEFORE COVERAGE IS EFFECTIVE

1. THIS RECEIPT IS SIGNED BY THE SAME PRODUCER AS THE APPLICATION;
2. AN AMOUNT EQUAL TO THE PREMIUM NOTED ABOVE HAS BEEN COLLECTED WITH THE APPLICATION; AND
3. MEDAMERICA, UPON INVESTIGATION, IS SATISFIED THAT ON THE EFFECTIVE DATE OF COVERAGE, SUCH PERSON WAS INSURABLE ACCORDING TO THE COMPANY'S RULES AND REGULATIONS.

EFFECTIVE DATE OF COVERAGE

IF THE APPLICANT IS INSURABLE, THE POLICY WILL BECOME EFFECTIVE ON THE LATEST OF THE FOLLOWING DATES:

1. DATE OF COMPLETION OF ALL PARTS OF THE APPLICATION AND SUPPLEMENTS THERETO ON ALL PERSONS PROPOSED FOR INSURANCE; OR
2. DATE OF COMPLETION OF ALL REPORTS, MEDICAL EXAMINATIONS OR TESTS, INCLUDING A SECOND MEDICAL EXAMINATION, AS REQUESTED FOR ANY PERSON TO BE INSURED BECAUSE OF AGE, MEDICAL HISTORY, THE PLAN, OR THE AMOUNT OF INSURANCE APPLIED FOR; OR
3. THE DATE AS REQUESTED ON THE APPLICATION, WHICH MAY BE NO GREATER THAN SIXTY DAYS BEYOND THE COMPANY ASSIGNED EFFECTIVE DATE AND NOT EARLIER THAN THE APPLICATION SIGNATURE DATE. IF YOU HAVE SELECTED THIS OPTION, YOU AGREE TO THE FACT THAT YOU MAY BE WAIVING CERTAIN RIGHTS AND GUARANTEES UNDER THE CONDITIONAL RECEIPT.

CONDITIONAL PREMIUM RECEIPT COMPLETE AND LEAVE WITH APPLICANT

THIS PAGE IS INTENTIONALLY LEFT BLANK

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

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

Simplicity[ii]

LONG TERM CARE INSURANCE - OUTLINE OF COVERAGE
Policy Number SPL2-336-TN
for Individual Sales

Caution: The issuance of this Long Term Care Policy is based upon Your responses to the questions on Your application. A copy of Your application is enclosed. If Your answers are incorrect or untrue, the Company has the right to deny Benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact the Company at the address above.

Notice to Buyer: This Policy may not cover all of the costs associated with LONG TERM CARE incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

1. **POLICY:** This Policy is an individual Policy of insurance.

2. **PURPOSE OF OUTLINE OF COVERAGE:** This Outline of Coverage provides a very brief description of the important features of the Policy. You should compare this Outline of Coverage to outlines of coverage for other policies available to You. This is not an insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and the insurance company. Therefore, if You purchase this coverage, or any other coverage, it is important that You **READ YOUR POLICY CAREFULLY!**

3. **FEDERAL TAX CONSEQUENCES:** This Policy is intended to be a Qualified Long Term Care insurance contract under section 7702B(b) of the Internal Revenue Code.

4. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED:**

   (a) **RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE.** This means that You have the right, subject to the terms of Your Policy, to continue Your Policy as long as You pay Your premiums on time. MedAmerica Insurance Company cannot change any of the terms of Your Policy on its own, except that, in the future, IT MAY CHANGE THE PREMIUM YOU PAY. Where applicable, premium increases must be approved by the State Department of Insurance.

   (b) **WAIVER OF PREMIUM:** Your premium payments will be waived on a monthly basis starting the day after the date Your Elimination Period is satisfied. The Waiver of Premium will end on the date You are no longer Benefit Eligible.

5. **TERMS UNDER WHICH PREMIUMS MAY BE CHANGED: We reserve the right to increase Your premium as of the premium due date; however, any changes in the premium rates must apply to all similar policies issued in Your state on this Policy form. This means We cannot single You out for an increase because of any change in Your age or health. However, Your rates may go up based on the experience of all policyholders with a Policy similar to Yours.**

6. **TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED:** If You feel this Policy does not meet Your insurance needs, return it to us or Your producer within 30 days. If You do so, We will return any premium You may have paid. We also will void Your Policy from its effective date.

7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE:** If You are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from the insurance company. Neither MedAmerica Insurance Company nor its producers represent Medicare, the federal government, or any state government.

   DISCLAIMER: THIS POLICY IS NOT DISABILITY INSURANCE OR ANY OTHER TYPE OF INCOME REPLACEMENT COVERAGE. Benefits under this Policy do not replace income or provide payment in the event of illness or accident resulting in disabilities not meeting the definition of Benefit Eligibility as contained herein.

8. **LONG TERM CARE COVERAGE:** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services. These services must be provided in a setting other than an acute care unit of a hospital, such as a nursing facility, in the community, or in the home; this includes skilled, intermediate and custodial care.

   This Policy provides coverage up to the Monthly Cash Benefit as listed on the Schedule of Policy Benefits page of Your Policy. Coverage is subject to Policy limitations and an Elimination Period.

9. **BENEFITS AND CONDITIONS FOR ELIGIBILITY:**

   Benefits Provided By This Policy: This Policy pays You a monthly cash amount if You are Benefit Eligible. The actual amount depends on the Monthly Cash Benefit You have chosen and where You are receiving care. Contingent Nonforfeiture Benefits are also included if You do not purchase an optional Nonforfeiture Benefit. All Benefits count toward fulfillment of Your Cash Benefit Account.

   Benefit Eligible: This means You will receive Benefits. To be Benefit Eligible or achieve Benefit Eligibility under this Policy all of the following conditions must be met.

   1. We have verified You are Chronically Ill;
   2. You have a Plan of Care; and
   3. Your Elimination Period has been met. (Does not apply to Benefits that do not require meeting the Elimination Period.)

   Chronically Ill means that as the result of an Assessment You have been certified by a Licensed Health Care Practitioner as having a chronic illness or disability that causes You to:

   a) Require Substantial Assistance with at least two Activities of Daily Living expected to last at least 90 days; or
   b) Have a Severe Cognitive Impairment that requires Substantial Supervision.

   We will work with You, Your family and Your physician when We need information about Your condition. This information will be gathered by Us or one of Our representatives. You may contact Us with any questions regarding Our decision.

   We will also need a Plan of Care. The Plan of Care is updated as Your needs change. You may use the services of Our Personal Care Advisors. These services are provided at not cost to You.

   To continue Benefit Eligibility, We must verify You are Chronically Ill and have an updated Plan of Care at least every 12 months.

Activities of Daily Living

<u>Bathing:</u> This means washing Yourself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

<u>Continence:</u> This means the ability to maintain control of bowel or bladder functions; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

<u>Dressing:</u> This means the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.

<u>Eating:</u> This means the ability to feed oneself by getting food into Your body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.

<u>Toileting:</u> This means the ability to go to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

<u>Transferring:</u> This means the ability to move into or out of a bed, chair or wheelchair.

Elimination Period: There is a one time Elimination Period. The Elimination Period (Waiting Period) is the number of calendar days You must wait before You will receive Benefits. Your Elimination Period begins the earliest of the date We have verified You are Chronically Ill and have a Plan of Care or the date You contact Us to establish Benefit Eligibility. The Elimination Period will end after the number of days chosen by You and shown in Your Schedule of Policy Benefits has ended. Benefits are not payable during the Elimination Period except where the Policy so states.

Days in an Elimination Period are combined, and do not need to be consecutive. You need to meet Your Policy's Elimination Period only once.

OPTIONAL RIDERS UNDER THIS POLICY

You may elect any of the optional Riders listed. Depending on the Rider You select, You may pay an additional premium.

Shortened Benefit Period Rider – Form # S2-SBPR-TN

We will provide continued coverage equal to premiums You have paid if Your Policy has been in force for three years and lapses.

Return of Premium Rider (ROPR) and Full Return of Premium Rider (FROPR) – Form # S2-ROPR-TN and Form # S2-FROPR-TN

ROPR: If You die while the Policy is in force, We will refund all premiums paid for Your Policy and any Riders less any Benefits paid or payable.

FROPR: If You die while the Policy is in force, We will refund all premiums paid for Your Policy and any Riders disregarding any Benefits paid or payable.

Restoration of Benefits Rider – Form # S2-ROBR-TN

This Rider will restore this Policy's Cash Benefit Account to the total that would have applied if no Benefits had been paid under this Policy. This Restoration of Benefits applies whenever a period of 180 consecutive days elapses in which:

1. You are not eligible for or being paid Benefits because You are no longer deemed Chronically Ill; and
2. Your Policy did not lapse and all premiums were paid; and
3. You did not exhaust Your Cash Benefit Account; and
4. Your Policy remained in force.

Survivor Benefit Rider – Form # S2-SVR-TN

You and Your Care Partner must both purchase this Rider. If after 10 years Your Care Partner dies, no further payment of premium is due on Your Policy.

Shared Care Rider – Form # S2-SCR-TN

You and Your Care Partner must both purchase this Rider. This Rider permits Care Partners to share the Benefits under their Policies by first using their own Cash Benefit Account and then, at the option of the other Care Partner, drawing Monthly Cash Benefits from your Care Partner's Cash Benefit Account.

If one Care Partner dies, the surviving Care Partner can assume the deceased Care Partner's remaining Cash Benefit Account at no extra premium. In no case can the use of a portion of a Care Partner's Benefits reduce his or her Cash Benefit Account below a level that would provide that Care Partner less than 24 times his/her Facility Monthly Cash Benefit.

Shared Waiver Rider – Form # S2-SWR-TN

You and Your Care Partner must both purchase this Rider. This Rider provides that when one Care Partner's premiums are waived, premiums will be waived for the other.

Facility Only Rider – Form # S2-FACR-TN

This Rider changes the Benefits under Your Policy by providing coverage only when You are Benefit Eligible and either reside in a Qualified Facility or receive care under a Hospice Care Program.

NOTE: BY PURCHASING THE FACILITY ONLY RIDER YOU CHANGE THE BENEFITS OF YOUR COVERAGE FROM A COMPREHENSIVE LONG TERM CARE POLICY TO A LIMITED BENEFIT POLICY.

Community Only Rider – Form # S2-COMMR-TN

This Rider changes the Benefits under Your Policy by providing coverage only when You are Benefit Eligible and either reside in other than a Qualified Facility or receive care under a Hospice Care Program.

NOTE: BY PURCHASING THE COMMUNITY ONLY RIDER YOU CHANGE THE BENEFITS OF YOUR COVERAGE FROM A COMPREHENSIVE LONG TERM CARE POLICY TO A LIMITED BENEFIT POLICY.

Compound Inflation - No Maximum Rider – Form # S2-CMP-TN

This Rider provides for an annual increase in Your Cash Benefit Account and Monthly Cash Benefit. On Your policy anniversary date Your Monthly Cash Benefit will be increased by the percentage shown on Your Schedule of Policy Benefits. Your Cash Benefit Account will increase by the same proportion as the increase in the Monthly Cash Benefit. This increase will continue for as long as Your Policy is in force.

Compound Inflation - 2X Maximum Rider – Form # S2-CMP2X-TN

This Rider provides for an annual increase in both Your Cash Benefit Account and Monthly Cash Benefit. On Your Policy Anniversary Date Your Monthly Cash Benefit will be increased by 5%. Your Cash Benefit Account will increase by the same proportion as the increase in the Monthly Cash Benefit. This increase will continue until Your Monthly Cash Benefit is twice its original amount.

Simple Benefit Increase Rider – Form # S2-SBIR-TN

This Rider provides for an annual increase in both Your Cash Benefit Account and Monthly Cash Benefit. On Your Policy Anniversary Date Your Monthly Cash Benefit will be increased by 5% of its original amount.

Your Cash Benefit Account will increase by the same proportion as the increase in the Monthly Cash Benefit. This increase will continue for as long as Your Policy is in force.

10. LIMITATIONS AND EXCLUSIONS:

(a) **Pre-existing conditions:** There are no pre-existing condition limitations in this Policy.

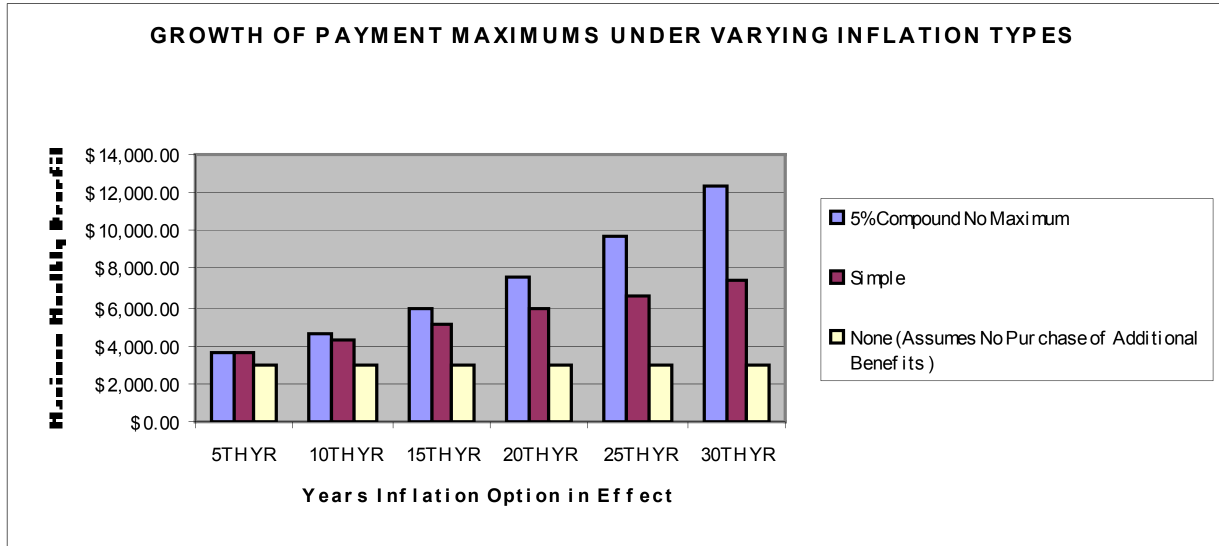
(b) **Exclusions:** Benefits are not payable if Your Chronic Illness is due to War or any act of war, declared or undeclared.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

11. **RELATIONSHIP OF COST OF CARE AND BENEFITS:**

Because the cost of long term care services will likely increase over time, You should consider whether and how the benefits of this plan might be adjusted. Neither the Cash Benefit Account nor the Monthly Cash Benefit will increase over time if You do not purchase inflation protection.

The following is a hypothetical comparison of the levels of a Policy that increases Monthly Cash Benefits over a period of coverage with a Policy that does not increase Monthly Cash Benefits. The comparison shows the effect on Benefits at five (5) year intervals over thirty years for a client purchasing a $3000 Monthly Cash Benefit with a 5% index percentage.



Compound – No Maximum: If You purchase Compound – No Maximum indexing, both Your Cash Benefit Account and Monthly Cash Benefit will increase on the anniversary of the effective date of the Policy. Your Monthly Cash Benefit will be increased by the percentage shown on Your Schedule of Policy Benefits. Your Cash Benefit Account will increase by the same proportion as the increase in the Monthly Cash Benefit. This increase will continue for as long as Your Policy is in force. Inflation increases will continue without regard to health status or age.

Compound – 2X Maximum: If You purchase Compound – 2X Maximum indexing, both Your Cash Benefit Account and Monthly Cash Benefit will increase on the anniversary of the effective date of the Policy. Your Monthly Cash Benefit will be increased by 5%. Your Cash Benefit Account will increase by the same proportion as the increase in the Monthly Cash Benefit. This increase will continue until Your Monthly Cash Benefit is twice its original amount. Inflation increases will continue up to the two times maximum without regard to health status or age.

Simple: If You purchase simple indexing, Your Cash Benefit Account and Monthly Cash Benefit will increase on every anniversary of the effective date of the Policy. Your Monthly Cash Benefit will be increased by 5% of its original amount. Your Cash Benefit Account will increase by the same proportion as the increase in the Monthly Cash Benefit. Inflation increases will continue without regard to health status or age.

None: If You purchase no indexing, Your Cash Benefit Account and Monthly Cash Benefit will not increase over time.

12. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS:** This Policy provides coverage if You are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses that result in a cognitive impairment.

13. **PREMIUM:**

The total annual premium quoted for Your Policy is shown below. The total premium amount of Your issued Policy is listed on the Premium Information page of Your Schedule of Policy Benefits and may vary from the amount that is identified below due to medical underwriting.

(Producer: Please use the space below to indicate the premium quoted.)

Basic Benefits Annual Premium (Check one)

a) ☐ Comprehensive Coverage
b) ☐ Facility Only
c) ☐ Community Only

$ ____________________

Optional Riders Modal Premium

Inflation Rider	**$** ______________
Survivor Benefit Rider	**$** ______________
Shared Waiver Rider	**$** ______________
Shared Care Rider	**$** ______________
Return of Premium Rider	**$** ______________
Full Return of Premium Rider	**$** ______________
Restoration of Benefits Rider	**$** ______________
Shortened Benefit Period Rider	**$** ______________
	$ ______________

Total Modal Premium for Optional Riders $ ________________________
Less any /Affiliation/ Employer Program/ Discounts

Your Total Modal Premium will be: $ ______________ on a ____________________basis*.
The Annualized Modal Premium for this policy is: ____________________________

* You may elect to pay Your premium on other than an annual basis. Please note that payment schedules of less than annual will result in a higher premium amount paid per year.

14. **ADDITIONAL FEATURES:**

(a) Medical underwriting of Your application is used to determine Your eligibility for long term care insurance. It may also be used to determine Your correct Rate Group classification, if applicable.

(b) Benefits may be available after termination if You are receiving Benefits covered under the Policy. See the "Extension of Benefits" section of Your Policy for specific requirements.

(c) If Your Policy terminates because of non-payment, You may apply for reinstatement of the Policy.

(d) No prior hospitalization is required before You can receive coverage under this Policy.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE.

CONTACT MEDAMERICA IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY.

16. **SENIOR COUNSELING PROGRAMS:** Please refer to *A Shopper's Guide To Long Term Care Insurance* contained in Your enrollment material for the telephone number of the Senior Counseling Program in Your state.

17. **LONG TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM**

1. **Premium Rate:** Your premium rate that is applicable to You and that will be in effect until a request is made and filed with Your State Department of Insurance for an increase is shown on Your schedule page in Your policy.

2. The premium for this Policy will be shown on the schedule page of Your policy.

3. **Rate Schedule Adjustments:** If Your rates are changed, the new rates will become effective on the next billing date. The new rates will remain in effect until another request is made and filed with Your State Department of Insurance. You have the right to receive a revised schedule page if the premium rate is changed.

   We have sold long term care insurance since 1987 and have sold this policy since 2007. We have never raised rates for any long term care policy sold in this state or any other state.

4. **Potential Rate Revision: This policy is Guaranteed Renewable.** This means that the rates for this coverage may be increased in the future. Your rates CANNOT be increased due to Your age or declining health, but Your rates may go up based on the experience of all insureds with a policy similar to Yours. If You receive a premium rate increase in the future, You will be notified of the new premium amount and You will be able to exercise at least one of the following options:

   (a) Pay the increased premium and continue Your coverage in force as is.
   (b) Reduce Your coverage benefits to a level such that Your premiums will not increase.
   (c) Exercise Your long term care nonforfeiture option (Shortened Benefit Period Rider), if purchased. This option is available for purchase for an additional premium.
   (d) Exercise Your contingent nonforfeiture rights - See No. 3. This option is available if You do not purchase a long term care nonforfeiture option mentioned in (c) above.

5. **Contingent Nonforfeiture Rights**

   (a) If the premium rate for Your policy goes up in the future and You do not buy a long term care nonforfeiture option, You may be eligible for contingent nonforfeiture. Here's how to tell if You are eligible:

   You will keep some long term care insurance coverage, if:

   (1) Your premium after the increase exceeds Your original premium by the percentage shown, or more, in the table (provided on the next page/below); and
   (2) You do not pay Your premium within 120 days of the increase causing Your policy to lapse.

   (b) Your Cash Benefit Account under this Rider will be the greater of:

   (1) The sum of all premiums paid for Your coverage and any attached Riders under this Policy less benefits paid; or
   (2) The Facility Monthly Cash Benefit (Community Monthly Cash Benefit if You have purchased the Community Only Rider) in effect on the date Your coverage under this Policy lapses.

   (c) Your Monthly Cash Benefit is payable up to Your Cash Benefit Account under this Rider.

   (d) The Cash Benefit Account under this Rider can never be greater than the Cash Benefit Account under Your Policy at the time You elected to use Your contingent nonforfeiture rights.

   (e) Except for this reduced Cash Benefit Account, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

(f) Should You choose this Contingent Nonforfeiture option, Your policy, with this reduced Cash Benefit Account, will be considered "paid-up" with no further premiums due. Monthly Cash Benefits from Your Cash Benefit Account will be paid at the level current when the policy was lapsed.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for ten years, so You have paid a total of $10,000 in premium.
- In the eleventh year, You receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and You decide to not pay any more premiums causing Your policy to lapse.
- Your “paid-up” policy benefits are $10,000, provided You have at least $10,000 of benefits remaining under Your policy.

Contingent Nonforfeiture Cumulative Premium Increase over Initial Premium That Qualifies for Contingent Nonforfeiture Table

Percentage increase is cumulative from date of original issue.

It does NOT represent a one-time increase.

Issue Age	Substantial Percent Over Initial Premium	Issue Age	Substantial Percent Over Initial Premium
29 and under	200%	72	36%
30-34	190%	73	34%
35-39	170%	74	32%
40-44	150%	75	30%
45-49	130%	76	28%
50-54	110%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

THIS PAGE IS INTENTIONALLY LEFT BLANK

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

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

Things You Should Know Before You Buy Long Term Care Insurance

Long-Term Care Insurance

- A long term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long term care.

Medicaid

- Medicaid will generally pay for long term care if you have very little income and few assets. You should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local County Department of Social Services.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of the appropriate Shopper's Guide regarding Long Term Care Insurance approved by Your States Commissioner of Insurance. Read it carefully. If you have decided to apply for long term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

THIS PAGE IS INTENTIONALLY LEFT BLANK

The Medical Underwriting *Process*

As part of your application for long term care coverage, you will be asked to participate in a phone history assessment and/or a face-to-face assessment interview.

What is medical underwriting?

It is a review of your medical history and current activity level to determine your eligibility for MedAmerica long term care coverage. This information is obtained by MedAmerica staff and contracted vendors.

How is information gathered?

The following assessment tools determine your insurability:

1. Application
2. Phone History Interview (PHI)
3. Face-To-Face Interview (FTF)
4. Medical Records (APS—Attending Physicians Statement) from any and all physicians seen in the last 5 years.

Any applicant may be requested to participate in any or all of these assessment tools.

Important: All questions should be taken seriously and responded to honestly as the results will determine your insurability. All information obtained during this process is confidential and for coverage purposes only. Each party involved is required to protect the privacy of your personal health information and is in compliance with HIPAA.

What is a phone history assessment?

A MedAmerica representative will contact you by phone to ask you a series of questions about your application, medical history, medications and current activities. There will be questions designed to screen for cognitive impairment. **This interview can only be completed with you, the applicant.**

When will the representative call?

About 1-2 weeks after you sign the application with your agent, the representative will contact you during routine business hours:
Monday through Friday
8:30 a.m. - 6:00 p.m. EST

Promptly scheduling your interview will help to expedite our decision for acceptance and complete the application process.

LTC-170-805

(continued on back)

How long will the assessment interview take?
The interview takes about 20 to 30 minutes.

Please have the following items on hand:
- The names, addresses and phone numbers of all physicians you have seen.
- The names and dosages of all medications.

What is a face-to-face assessment?
- This is an assessment of your medical history and current activity level, conducted in your home or at a quiet location convenient to you. The assessment is administered by a trained clinician, either a registered nurse or a social worker. The clinician will call to schedule a convenient time for the interview and will provide appropriate identification upon their arrival.
- The clinician will ask you questions about your application, medical history, medications and current activities. There will be questions designed to screen for cognitive impairment.

How long will the face-to-face assessment take?
The interview will take approximately 30 to 60 minutes.

What you need to know:
- No disrobing is required.
- No blood or other specimens are taken.
- Your blood pressure will be taken and height and weight recorded.
- Have available the names and dosages of all medications you are currently taking.
- In order to gather the most accurate information and ensure no distractions, the company requests the interview take place with only you and the assessor in the room.

How are medical records obtained?
We may request your medical records from your primary doctor and/or any specialists you see. We handle the request to your doctor and pay any associated fee. We may ask you for help if we have difficulty obtaining your records.

How long does the underwriting process take before I know the final decision on my application?
Generally the process takes about 4-6 weeks. We thank you in advance for your patience and cooperation.

Reminders:
- Any applicant may be requested to participate in any or all of these assessment methods.
- The interviewers gather information only and take no part in the decision on your application.

Any questions can be directed to our Customer Service Department at: 1-800-544-0327.