

The Clarksville-Montgomery Employees' Insurance Trust

Enrollment Booklet

Inside this booklet:

Spousal Benefit Transfer Rider

Rates

Enrollment Instructions

Enrollment Form A

Enrollment Form B

Long-Form Health Statement

Outline of Coverage

Personal Worksheet

Things You Should Know

Rate Disclosure



Take care of each other with a
**Spousal Benefit
Transfer Rider.**

***For couples—an opportunity to
share and inherit benefits!***

When both you and your spouse purchase policies with identical benefits (of more than two years, but less than lifetime coverage), each of you may also purchase a rider which allows you to share a portion of your benefits with one another. A 5-year policy with our Spousal Benefit Transfer Rider may provide up to 5 years of protection.

What if one of you needs more?

Our Spousal Benefit Transfer Rider allows for the transfer of benefits from one policy to the other, so long as the required minimum coverage is held in reserve for the donating spouse.

***What if one of you should
pass away?***

The surviving spouse will inherit the total remaining combined pool of Lifetime Benefit Amounts, yet be responsible for continuing only his or her own premium!

***And When Both Qualify...
a 10% Premium Discount for Each!***

MEDAmerica
INSURANCE COMPANY

An Excellus Company
Home Office: Pittsburgh, PA

Telephone: 1-800-544-0327

Mailing Address:
c/o MedAmerica Administrators
165 Court Street • Rochester, NY 14647

The Clarksville-Montgomery Employees' Ins. Trust

Monthly* Group Long Term Care Rates

Daily Benefit Amount: \$100
Elimination Period: 90 Days
Payment Period: Lifetime Payment

	Initial Lifetime Benefit: \$73,000 \$100/day x 730 (2 Years)			Initial Lifetime Benefit: \$109,500 \$100/day x 1095 (3 Years)			Initial Lifetime Benefit: \$182,500 \$100/day x 1825 (5 Years)		
Benefit Duration	2 Years			3 Years			5 Years		
Inflation	None	Simple/20	Compounded Benefits	None	Simple/20	Compounded Benefits	None	Simple/20	Compounded Benefits
Issue Age									
18-21	\$3.10	\$4.65	\$14.72	\$3.87	\$6.20	\$18.60	\$4.65	\$7.75	\$25.57
22	3.87	5.42	14.72	3.87	6.20	19.37	5.42	8.52	26.35
23	3.87	5.42	15.50	3.87	6.20	20.15	5.42	8.52	27.90
24	3.87	5.42	16.27	4.65	6.97	20.92	5.42	9.30	28.67
25	3.87	6.20	17.05	4.65	6.97	21.70	6.20	9.30	29.45
26	3.87	6.20	17.82	4.65	7.75	22.47	6.20	10.07	31.00
27	4.65	6.20	17.82	5.42	7.75	23.25	6.97	10.85	32.55
28	4.65	6.97	18.60	5.42	8.52	24.02	6.97	11.62	33.32
29	4.65	6.97	19.37	5.42	8.52	24.80	7.75	12.40	34.87
30	4.65	7.75	20.15	6.20	9.30	26.35	7.75	13.17	36.42
31	5.42	7.75	20.92	6.20	10.07	27.12	8.52	13.95	37.97
32	5.42	8.52	21.70	6.97	10.85	27.90	8.52	14.72	39.52
33	5.42	9.30	23.25	6.97	11.62	29.45	9.30	15.50	41.07
34	6.20	9.30	24.02	7.75	12.40	30.22	10.07	16.27	42.62
35	6.20	10.07	24.80	7.75	13.17	31.77	10.85	17.82	44.17
36	6.97	10.85	25.57	8.52	13.95	33.32	10.85	18.60	46.49
37	6.97	11.62	27.12	8.52	14.72	34.10	11.62	20.15	48.04
38	7.75	12.40	27.90	9.30	15.50	35.65	12.40	21.70	50.37
39	7.75	13.17	29.45	10.07	16.27	37.20	13.95	23.25	52.69
40	8.52	13.95	30.22	10.85	17.82	38.75	14.72	24.80	55.02
41	9.30	14.72	31.77	11.62	19.37	41.07	15.50	26.35	57.34
42	10.07	16.27	33.32	12.40	20.15	42.62	16.27	28.67	59.67
43	10.07	17.05	34.87	13.17	21.70	44.17	17.82	30.22	62.77
44	10.85	18.60	36.42	13.95	23.25	46.49	19.37	32.55	65.09
45	11.62	19.37	37.97	14.72	24.80	48.82	20.15	34.87	68.19
46	12.40	20.92	39.52	15.50	27.12	50.37	21.70	37.97	71.29
47	13.17	22.47	41.07	17.05	28.67	52.69	23.25	40.29	74.39
48	14.72	24.02	43.39	17.82	31.00	55.79	24.80	43.39	78.26
49	15.50	26.35	44.94	19.37	33.32	58.12	27.12	47.27	81.36
50	16.27	27.90	47.27	20.92	35.65	61.22	29.45	50.37	86.01
51	17.82	30.22	49.59	22.47	38.75	63.54	31.77	54.24	89.89
52	19.37	32.55	51.92	24.02	41.84	66.64	34.10	58.89	94.54
53	20.92	34.87	54.24	26.35	44.94	70.52	36.42	63.54	99.19
54	22.47	37.97	57.34	28.67	48.82	73.62	39.52	68.19	103.84
Spousal Discount	x 0.9								
Spousal Benefit Transfer Rider	x 1.24			x 1.15			x 1.05		
Monthly Home Health Care	x 1.09	x 1.07	x 1.05	x 1.09	x 1.07	x 1.05	x 1.09	x 1.07	x 1.05

* To obtain annual rates, multiply the rates in this exhibit by 11.11 (an approximate savings of 8%)

The Clarksville-Montgomery Employees' Ins. Trust

Monthly* Group Long Term Care Rates

Daily Benefit Amount: \$100
Elimination Period: 90 Days
Payment Period: Lifetime Payment

	Initial Lifetime Benefit: \$73,000 \$100/day x 730 (2 Years)			Initial Lifetime Benefit: \$109,500 \$100/day x 1095 (3 Years)			Initial Lifetime Benefit: \$182,500 \$100/day x 1825 (5 Years)		
Benefit Duration	2 Years			3 Years			5 Years		
Inflation	None	Simple/20	Compounded Benefits	None	Simple/20	Compounded Benefits	None	Simple/20	Compounded Benefits
Issue Age									
55	24.02	41.07	60.44	31.00	52.69	77.49	43.39	74.39	109.26
56	26.35	44.17	63.54	33.32	56.57	82.14	46.49	79.81	115.46
57	28.67	47.27	66.64	36.42	61.22	86.01	50.37	86.79	121.66
58	31.00	51.14	70.52	39.52	65.87	90.66	55.02	93.76	127.86
59	33.32	55.79	73.62	42.62	71.29	96.09	59.67	100.74	134.83
60	36.42	60.44	78.26	46.49	77.49	101.51	65.09	110.04	143.36
61	39.52	65.09	82.91	50.37	83.69	106.94	71.29	118.56	151.11
62	42.62	69.74	87.56	55.02	90.66	113.14	77.49	127.86	159.63
63	46.49	75.17	92.21	59.67	97.64	119.33	84.46	137.93	168.93
64	50.37	81.36	97.64	65.09	105.39	126.31	91.44	148.78	179.00
65	55.02	87.56	103.84	71.29	113.91	134.83	99.96	161.18	189.85
66	59.67	94.54	109.26	77.49	122.43	142.58	108.49	173.58	201.47
67	65.09	101.51	115.46	83.69	131.73	150.33	118.56	186.75	213.10
68	70.52	108.49	122.43	91.44	141.81	159.63	128.63	200.70	225.50
69	75.94	116.24	129.41	99.19	151.88	168.15	140.26	215.42	238.67
70	78.97	118.82	130.63	102.58	154.98	170.48	145.39	220.66	241.33
71	85.61	127.67	138.01	111.44	166.05	180.07	157.93	236.16	255.35
72	92.25	135.79	145.39	120.29	177.86	190.40	171.22	253.13	270.11
73	99.63	144.65	153.50	130.63	189.67	200.74	185.24	270.11	285.61
74	107.75	154.24	161.62	140.96	202.21	211.81	200.74	287.82	301.10
75	118.08	166.05	172.69	154.24	217.71	225.83	219.19	309.96	321.03
76	128.41	177.86	183.02	168.26	233.21	239.85	239.11	332.10	340.96
77	139.48	189.67	194.09	182.29	249.44	253.87	260.51	355.72	362.36
78	151.29	202.95	205.16	198.52	266.42	269.37	283.39	380.81	384.50
79	163.84	207.38	217.71	215.50	273.06	285.61	307.75	391.14	408.11
80	178.60	222.88	232.47	234.68	293.72	305.53	337.27	422.14	437.63
81	193.36	238.37	246.49	254.61	313.65	323.98	366.05	450.92	464.20
82	208.85	253.87	260.51	276.01	334.31	343.17	397.04	481.18	492.98
83	225.83	270.11	276.01	297.41	355.72	363.83	428.78	512.91	522.50
84	243.54	287.08	292.25	321.03	379.33	385.24	463.46	546.12	553.50
85	262.73	305.53	309.96	346.12	402.95	408.11	500.36	581.54	586.71
Spousal Discount	x 0.9								
Spousal Benefit Transfer Rider	x 1.24			x 1.15			x 1.05		
Monthly Home Health Care	x 1.09	x 1.07	x 1.05	x 1.09	x 1.07	x 1.05	x 1.09	x 1.07	x 1.05

* To obtain annual rates, multiply the rates in this exhibit by 11.11 (an approximate savings of 8%)

The Clarksville-Montgomery Employees' Ins. Trust

Monthly* Group Long Term Care Rates

Daily Benefit Amount: \$130
Elimination Period: 90 Days
Payment Period: Lifetime Payment

	Initial Lifetime Benefit: \$94,900 \$130/day x 730 (2 Years)			Initial Lifetime Benefit: \$142,350 \$130/day x 1095 (3 Years)			Initial Lifetime Benefit: \$237,250 \$130/day x 1825 (5 Years)		
Benefit Duration	2 Years			3 Years			5 Years		
Inflation	None	Simple/20	Compounded Benefits	None	Simple/20	Compounded Benefits	None	Simple/20	Compounded Benefits
Issue Age									
18-21	\$4.03	\$6.04	\$19.14	\$5.04	\$8.06	\$24.18	\$6.04	\$10.07	\$33.24
22	5.04	7.05	19.14	5.04	8.06	25.18	7.05	11.08	34.25
23	5.04	7.05	20.15	5.04	8.06	26.19	7.05	11.08	36.27
24	5.04	7.05	21.15	6.04	9.07	27.20	7.05	12.09	37.27
25	5.04	8.06	22.16	6.04	9.07	28.21	8.06	12.09	38.28
26	5.04	8.06	23.17	6.04	10.07	29.21	8.06	13.10	40.29
27	6.04	8.06	23.17	7.05	10.07	30.22	9.07	14.10	42.31
28	6.04	9.07	24.18	7.05	11.08	31.23	9.07	15.11	43.32
29	6.04	9.07	25.18	7.05	11.08	32.24	10.07	16.12	45.33
30	6.04	10.07	26.19	8.06	12.09	34.25	10.07	17.13	47.35
31	7.05	10.07	27.20	8.06	13.10	35.26	11.08	18.13	49.36
32	7.05	11.08	28.21	9.07	14.10	36.27	11.08	19.14	51.38
33	7.05	12.09	30.22	9.07	15.11	38.28	12.09	20.15	53.39
34	8.06	12.09	31.23	10.07	16.12	39.29	13.10	21.15	55.41
35	8.06	13.10	32.24	10.07	17.13	41.30	14.10	23.17	57.42
36	9.07	14.10	33.24	11.08	18.13	43.32	14.10	24.18	60.44
37	9.07	15.11	35.26	11.08	19.14	44.32	15.11	26.19	62.46
38	10.07	16.12	36.27	12.09	20.15	46.34	16.12	28.21	65.48
39	10.07	17.13	38.28	13.10	21.15	48.35	18.13	30.22	68.50
40	11.08	18.13	39.29	14.10	23.17	50.37	19.14	32.24	71.52
41	12.09	19.14	41.30	15.11	25.18	53.39	20.15	34.25	74.55
42	13.10	21.15	43.32	16.12	26.19	55.41	21.15	37.27	77.57
43	13.10	22.16	45.33	17.13	28.21	57.42	23.17	39.29	81.60
44	14.10	24.18	47.35	18.13	30.22	60.44	25.18	42.31	84.62
45	15.11	25.18	49.36	19.14	32.24	63.46	26.19	45.33	88.65
46	16.12	27.20	51.38	20.15	35.26	65.48	28.21	49.36	92.68
47	17.13	29.21	53.39	22.16	37.27	68.50	30.22	52.38	96.71
48	19.14	31.23	56.41	23.17	40.29	72.53	32.24	56.41	101.74
49	20.15	34.25	58.43	25.18	43.32	75.55	35.26	61.45	105.77
50	21.15	36.27	61.45	27.20	46.34	79.58	38.28	65.48	111.82
51	23.17	39.29	64.47	29.21	50.37	82.60	41.30	70.52	116.85
52	25.18	42.31	67.49	31.23	54.40	86.63	44.32	76.56	122.90
53	27.20	45.33	70.52	34.25	58.43	91.67	47.35	82.60	128.94
54	29.21	49.36	74.55	37.27	63.46	95.70	51.38	88.65	134.99
Spousal Discount	x 0.9								
Spousal Benefit Transfer Rider	x 1.24			x 1.15			x 1.05		
Monthly Home Health Care	x 1.09	x 1.07	x 1.05	x 1.09	x 1.07	x 1.05	x 1.09	x 1.07	x 1.05

* To obtain annual rates, multiply the rates in this exhibit by 11.11 (an approximate savings of 8%)

The Clarksville-Montgomery Employees' Ins. Trust
Monthly* Group Long Term Care Rates

Daily Benefit Amount: \$130
Elimination Period: 90 Days
Payment Period: Lifetime Payment

	Initial Lifetime Benefit: \$94,900 \$130/day x 730 (2 Years)			Initial Lifetime Benefit: \$142,350 \$130/day x 1095 (3 Years)			Initial Lifetime Benefit: \$237,250 \$130/day x 1825 (5 Years)		
Benefit Duration	2 Years			3 Years			5 Years		
Inflation	None	Simple/20	Compounded Benefits	None	Simple/20	Compounded Benefits	None	Simple/20	Compounded Benefits
Issue Age									
55	31.23	53.39	78.57	40.29	68.50	100.74	56.41	96.71	142.04
56	34.25	57.42	82.60	43.32	73.54	106.78	60.44	103.76	150.10
57	37.27	61.45	86.63	47.35	79.58	111.82	65.48	112.83	158.16
58	40.29	66.49	91.67	51.38	85.63	117.86	71.52	121.89	166.22
59	43.32	72.53	95.70	55.41	92.68	124.91	77.57	130.96	175.28
60	47.35	78.57	101.74	60.44	100.74	131.97	84.62	143.05	186.36
61	51.38	84.62	107.79	65.48	108.80	139.02	92.68	154.13	196.44
62	55.41	90.66	113.83	71.52	117.86	147.08	100.74	166.22	207.52
63	60.44	97.71	119.88	77.57	126.93	155.13	109.80	179.31	219.61
64	65.48	105.77	126.93	84.62	137.00	164.20	118.87	193.42	232.70
65	71.52	113.83	134.99	92.68	148.08	175.28	129.95	209.53	246.81
66	77.57	122.90	142.04	100.74	159.16	185.36	141.03	225.65	261.92
67	84.62	131.97	150.10	108.80	171.25	195.43	154.13	242.78	277.03
68	91.67	141.03	159.16	118.87	184.35	207.52	167.22	260.91	293.14
69	98.72	151.11	168.23	128.94	197.44	218.60	182.33	280.05	310.27
70	102.66	154.46	169.81	133.36	201.47	221.62	189.00	286.86	313.72
71	111.29	165.98	179.41	144.87	215.87	234.09	205.31	307.01	331.95
72	119.93	176.53	189.00	156.38	231.22	247.53	222.58	329.07	351.14
73	129.52	188.04	199.56	169.81	246.57	260.96	240.81	351.14	371.29
74	140.07	200.51	210.11	183.25	262.88	275.35	260.96	374.17	391.44
75	153.50	215.87	224.50	200.51	283.02	293.58	284.94	402.95	417.34
76	166.94	231.22	237.93	218.74	303.17	311.81	310.85	431.73	443.24
77	181.33	246.57	252.32	236.97	324.28	330.03	338.67	462.43	471.07
78	196.68	263.84	266.71	258.08	346.34	350.18	368.41	495.05	499.85
79	212.99	269.59	283.02	280.14	354.98	371.29	400.07	508.48	530.55
80	232.17	289.74	302.21	305.09	381.84	397.19	438.45	548.78	568.92
81	251.36	309.89	320.44	330.99	407.75	421.18	475.86	586.19	603.46
82	271.51	330.03	338.67	358.82	434.61	446.12	516.16	625.53	640.88
83	293.58	351.14	358.82	386.64	462.43	472.98	557.41	666.78	679.26
84	316.60	373.21	379.92	417.34	493.13	500.81	602.50	709.96	719.55
85	341.55	397.19	402.95	449.96	523.83	530.55	650.47	756.01	762.72
Spousal Discount	x 0.9								
Spousal Benefit Transfer Rider	x 1.24			x 1.15			x 1.05		
Monthly Home Health Care	x 1.09	x 1.07	x 1.05	x 1.09	x 1.07	x 1.05	x 1.09	x 1.07	x 1.05

* To obtain annual rates, multiply the rates in this exhibit by 11.11 (an approximate savings of 8%)

The Clarksville-Montgomery Employees' Insurance Trust

Instructions



How to Enroll

This information is designed to help you complete your enrollment form.

Note: Each person applying must complete an Enrollment Form. Additional Enrollment Forms are available by contacting Customer Service at **1-800-544-0327** toll free.

Step 1: Review the information in your kit and fill out the appropriate Enrollment Form from this booklet. There are two Enrollment Forms (*Enrollment Form A & Enrollment Form B*).

- ◆ **Enrollment Form A** is only for active employees enrolling at the initial open enrollment and **new** employees who enroll within 30 days of date of hire. To meet Active-at-Work Requirements, you must work 25 or more hours per week on a regular basis at your usual place of business or at a location to which your job requires you to travel.
- ◆ All other eligibles / family members should complete **Enrollment Form B** & the **Standard Issue Health Statement**.

Step 2: Complete **Section A** with the **General Information** for the person who is the member of the group.

Step 3: Complete **Section B** with the **Enrollee Information**.

Step 4: Complete **Section B-1** with the **Enrollee Information** for the person who is applying for this insurance

Note: The answers to **Sections B** through **H** should be for the Enrollee (*the person applying for insurance*).

Use the information that follows to help you enroll in your long-term care insurance plan.

Go to **Section C** of the Enrollment Form.

Decision 1: Daily Benefit Amount (C2) What Daily Benefit Amount is right for you?

Choose from the options in **Section C2**.

On to Decision 2.

Decision 2: Benefit Period (C1) Determine your "Pool of Money"

The Benefit Period is used to calculate your Lifetime Benefit Amount, known as your "Pool of Money" – the dollars you will have available for your covered long-term care expenses. To determine the "Pool of Money", multiply your Daily Benefit Amount by the Benefit Period.

Example: \$100 per day x 1095 days (or 3 years) = \$109,500

Choose from the options in **Section C1**.

On to Decision 3.

QUESTIONS?

CALL OUR CUSTOMER SERVICE CENTER toll-free: 1-800-544-0327

Decision 3: Inflation Protection (D1) Inflation Protection increases your Lifetime Benefit Amount and Daily Benefit each year to offset future increases in the cost of long-term care services.

Choose from the options in **Section D1**.

On to Decision 4.

Decision 4: Optional Riders

Spousal Benefit Transfer Rider (D2) An optional benefit allowing benefits to be shared and inherited by you and your spouse. This is only for couples who select identical plans.

Monthly Home Care Benefit Rider (D3) This rider provides for a monthly maximum benefit amount for Home Care and Adult Day Care services and enhances the Premium Waiver to begin after we have paid an amount equal to 30 times the Daily Benefit Amount for services covered under this rider.

Choose **Yes** or **No** for all options in **Section D**.

On to Sections E – H.

Sections E to H:

Section E – Payment Term: Your payment term is **Lifetime**.

Section F – Payment Method: Choose a payment method and payment frequency.

Section G – Insurance Information: Please provide the insurance information requested in this section.

Section G1-A – Enrollment Form A only: Health Statement. Please answer **Yes** or **No**.

Section G1-B – Enrollment Form B only: Physician Information. Please provide information for each of your physicians.

Section H – Options and Signatures: Complete this section. Be sure to **SIGN** and **DATE** the Enrollment Form.

If you are completing **Enrollment Form B:** You must also complete the **Standard Issue Health Statement**.

Be sure to **SIGN** and **DATE** the Health Statement.



Mailing Address: c/o MedAmerica Administrators, 165 Court Street, Rochester, NY 14647

QUESTIONS?
CALL OUR CUSTOMER SERVICE CENTER toll-free: 1-800-544-0327



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

Enrollment Form A

For Actives and New Hires at Initial Open Enrollment Only.



The Clarksville-Montgomery Employees' Insurance Trust — Group #8204

Long-Term Care Insurance Certificate # GRP11-342-MA-TN-200 (Rev. 601)

A Separate Enrollment Form Must be Completed for Each Enrollee.

Please check the appropriate box:

- Clarksville-Montgomery County School System Employee
- Montgomery County Government and Highway Employee

A. GENERAL INFORMATION

ELIGIBLE EMPLOYEE: (Last) (First) (M.I.)			Social Security Number
Address			
City	County	State	Zip
Home Phone: ()	Work Phone: ()	Best Time to be Reached: <input type="checkbox"/> AM <input type="checkbox"/> PM	

B. ENROLLEE - Required Information Please Verify: (Must be age 18 through age 85)

After Initial Open Enrollment - ALL enrollees must complete a Standard Issue Health Statement.

Employees: Choose Active Employee if you work 25 or more hours per week on a regular basis at your usual place of business or at a location to which your job requires you to travel.

Modified Guaranteed Issue – Initial Open Enrollment Only.

- Active Employee New Employee Date of Hire: _____

B-1. ENROLLEE INFORMATION

Date of Birth Month/Day/Year ____/____/____	Age	Marital Status <input type="checkbox"/> Married/Domestic Partners <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight
---------------------------------------------------	-----	---------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------	--------	--------

Check ONE, if applicable: <input type="checkbox"/> Spouse/Domestic Partner is enrolling at this time. (Please submit enrollment forms together and required Domestic Partner form.) <input type="checkbox"/> Spouse/Domestic Partner is a current certificateholder.	Spouse's/Domestic Partner's Social Security Number (Required if Spouse/Domestic Partner is applying or a certificateholder) _____
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------

C. BENEFIT SELECTIONS (Please Complete Sections 1-2)

1) Benefit Period:

- 730 days (2 Years)
- 1095 days (3 Years)
- 1825 days (5 Years)

2) Daily Benefit Amount:

Nursing Facility, Assisted Living Facility, Hospice Program, Home Care, Adult Day Care

- \$100
- \$130

3) Lifetime Elimination Period:

- 90 Days

D. OPTIONAL BENEFITS APPLIED FOR (Please Complete Sections 1-3)

1) Inflation Protection Option (Choose ONE)

- Compound Inflation (5% annually for life)
- Simple Inflation (5% annually for 20 years)
- No Inflation Benefit

2) Spousal Benefit Transfer Rider

- Yes No

3) Monthly Home Care Benefit Rider

- Yes No

E. PAYMENT TERM

- Lifetime

F. PAYMENT METHOD (Choose ONE of the following three options)

1.) Direct Bill

Payment Frequency (Choose One)

- Quarterly
- Semi-Annual
- Annual

2.) Bank Account Draft OR Credit Card

- VISA Mastercard

Payment Frequency (Choose ONE)

- Monthly Quarterly Semi-Annual Annual

Account Type Checking Credit Card

(Account withdrawal is the 5th of the month.)

Bank Name

Bank Account #

Attach Voided Check

Credit Card #

Expiration Date

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 or credit card company and MedAmerica Insurance Company in writing.

X _____
Signature of Account Holder

X _____
Signature of Joint Account Holder

3.) Payroll Deduction

(Must be pre-approved by your employer.)

I authorize my employer to deduct the applicable premium from my salary.

I authorize MedAmerica Insurance Company to adjust these deductions based on rate changes or changes in coverage as provided by the Group Policy.

I may revoke this authorization at any time by written notice to my employer and to MedAmerica Insurance Company

X _____
Employee Signature

G. INSURANCE INFORMATION

1. Are you covered by a state assistance program (Medicaid)? Yes No

2. **List all** accident, sickness, disability, **nursing home, home health care and long-term care insurance policies**, including any health care service contracts and health maintenance organization contracts **that are currently in force**. (Include any MedAmerica Insurance Company policies.)

Company Name (Use extra paper if necessary)	Address (street, city, state, zip)	Policy Type	Policy Number	Intend to Replace <input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Have you ever been turned down for nursing home, home health care, long-term care or disability insurance? Yes No

If Yes, please explain: _____

G1-A. HEALTH STATEMENT

Please answer “Yes” or “No” by checking the box.

Yes No

- Do you need assistance or supervision in performing activities of daily living, such as walking, dressing, eating, taking medication, getting in and out of bed, bathing, toileting, bowel and bladder control or are you currently receiving, or have you received in the past 12 months: nursing home care, home care, or adult day care services?

In most cases, answering “Yes” to this question will disqualify you from acceptance into the program at this time. If you feel you have fully recovered or are no longer requiring the services described above, please attach an explanation including conditions, services used, and time frames.

Use this space for additional information.

H. OPTIONS AND SIGNATURE

1. **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 Address City State Zip Telephone ()

2. **INFLATION PROTECTION OPTION:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection, and

I **ACCEPT** inflation protection (see **Optional Benefits, Page 2**).

I **REJECT** inflation protection.

Declaration and Enrollment Form Conditions

To the best of my knowledge and belief, I have answered all questions completely and truthfully. I understand this enrollment form and my health statement, if applicable, is for consideration and the company will use this enrollment form and my health statement, if applicable, or require, at their expense, that I see a health care professional to determine if I am accepted. My coverage will begin on the effective date noted on the schedule page issued to me provided that payment of the first premium has been made. To receive benefits under this certificate, I will satisfy the elimination period and the benefit eligibility requirements as set forth in the certificate.

Authorization to Obtain and Disclose Information

I agree to permit company representatives to contact me to discuss my enrollment.

I understand that only information contained on this enrollment form and my health statement, if applicable, may be used to rescind my Certificate.

I authorize any physician, medical practitioner, hospital, clinic, other health care provider or health-related facility, insurance or reinsuring company or employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to furnish MedAmerica Insurance Company and/or insurance support organizations representing MedAmerica Insurance Company any information needed to determine eligibility for insurance or benefits. THIS AUTHORIZATION EXPRESSLY INCLUDES INFORMATION ABOUT DRUGS, ALCOHOLISM, MENTAL ILLNESS AND COMMUNICABLE DISEASES.

I agree that a photocopy of this release and authorization shall be as valid as this original.

I agree that this authorization will be valid for 24 months from the date this enrollment form is signed.

I acknowledge receipt of "A Shopper's Guide to Long-Term Care Insurance," published by the National Association of Insurance Commissioners, and the Outline of Coverage.

Dated at _____ City/State _____ Month _____ Day _____ Year _____

Enrollee's Signature X

CAUTION: If your answers on this enrollment form or your health statement, if applicable, are incorrect or untrue, MedAmerica Insurance Company has the right to deny benefits or rescind your policy.

FRAUD NOTICE: Any person who knowingly presents false or fraudulent claim for payment of a benefit or knowingly presents false, incomplete or misleading information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COMPANY USE

Ap Rec _____ Ap Status _____ Effective Date _____ UW/Date _____



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

Enrollment Form B
CARE DIRECTIONS[®] Premier

The Clarksville-Montgomery Employees' Insurance Trust — Group #8204
 Long-Term Care Insurance Certificate # GRP11-342-MA-TN-200 (Rev. 601)

A Separate Enrollment Form Must be Completed for Each Enrollee.

Please check the appropriate box:

- Clarksville-Montgomery County School System Employee
- Montgomery County Government and Highway Employee

A. GENERAL INFORMATION

ELIGIBLE EMPLOYEE NAME: (Last) (First) (M.I.)			Social Security Number
Address			
City	County	State	Zip
Home Phone: ()	Work Phone: ()	Best Time to be Reached: <input type="checkbox"/> AM <input type="checkbox"/> PM	

B. ENROLLEE - Required Information Please Verify: (Must be age 18 through age 85)

For Increase in Coverage OR after Initial Open Enrollment - ALL enrollees must complete a Standard Issue Health Statement. Employees: Choose Active Employee if you work 25 or more hours per week on a regular basis at your usual place of business or at a location to which your job requires you to travel.

Standard Issue – (Standard Issue Health Statement required)

<input type="checkbox"/> Active Employee— <i>after initial open enrollment</i>	<input type="checkbox"/> Child (incl. adopted & step)	<input type="checkbox"/> Parent
<input type="checkbox"/> Retired Employee	<input type="checkbox"/> Spouse of Child	<input type="checkbox"/> Parent-in-law
<input type="checkbox"/> Spouse/Domestic Partner of Active Employee	<input type="checkbox"/> Brother (incl. in-law, adopted & step)	<input type="checkbox"/> Grandparent
<input type="checkbox"/> Spouse/Domestic Partner of Retired Employee	<input type="checkbox"/> Sister (incl. in-law, adopted & step)	<input type="checkbox"/> Grandparent-in-law

B-1. ENROLLEE INFORMATION

Name (Last) (First) (M.I.)			Social Security Number:		
Address					
City	County	State	Zip		
Home Phone: ()	Work Phone: ()	Best Time to be Reached: <input type="checkbox"/> AM <input type="checkbox"/> PM			
Date of Birth Month/Day/Year ____/____/____	Age	Marital Status <input type="checkbox"/> Married/Domestic Partners <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight

Check ONE, if applicable:

Spouse/Domestic Partner is enrolling at this time.
 (Please submit enrollment forms together and required Domestic Partner form.)

Spouse/Domestic Partner is a current certificateholder.

Spouse's/Domestic Partner's Social Security Number
 (Required if Spouse/Domestic Partner is applying or a certificateholder)

C. BENEFIT SELECTIONS (Please Complete Sections 1-2)

1) Benefit Period:

- 730 days (2 Years)
- 1095 days (3 Years)
- 1825 days (5 Years)

2) Daily Benefit Amount:

Nursing Facility, Assisted Living Facility, Hospice Program, Home Care, Adult Day Care

- \$100
- \$130

3) Lifetime Elimination Period:

- 90 Days

D. OPTIONAL BENEFITS APPLIED FOR (Please Complete Sections 1-3)

1) Inflation Protection Option (Choose ONE)

- Compound Inflation (5% annually for life)
- Simple Inflation (5% annually for 20 years)
- No Inflation Benefit

2) Spousal Benefit Transfer Rider

- Yes No

3) Monthly Home Care Benefit Rider

- Yes No

E. PAYMENT TERM

- Lifetime

F. PAYMENT METHOD (Choose ONE of the following three options)

1.) Direct Bill

Payment Frequency (Choose One)

- Quarterly
- Semi-Annual
- Annual

2.) Bank Account Draft OR Credit Card

- VISA Mastercard

Payment Frequency (Choose ONE)

- Monthly Quarterly Semi-Annual Annual

Account Type Checking Credit Card

(Account withdrawal is the 5th of the month.)

Bank Name

Bank Account #

Attach Voided Check

Credit Card #

Expiration Date

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 or credit card company and MedAmerica Insurance Company in writing.

X _____

Signature of Account Holder

X _____

Signature of Joint Account Holder

3.) Payroll Deduction

(Must be pre-approved by your employer.)

I authorize my employer to deduct the applicable premium from my salary.

I authorize MedAmerica Insurance Company to adjust these deductions based on rate changes or changes in coverage as provided by the Group Policy.

I may revoke this authorization at any time by written notice to my employer and to MedAmerica Insurance Company

X _____

Employee Signature

G. INSURANCE INFORMATION

1. Are you covered by a state assistance program (Medicaid)? Yes No

2. **List all** accident, sickness, disability, **nursing home, home health care and long-term care insurance policies**, including any health care service contracts and health maintenance organization contracts **that are currently in force**. (Include any MedAmerica Insurance Company policies.)

Company Name (Use extra paper if necessary)	Address (street, city, state, zip)	Policy Type	Policy Number	Intend to Replace <input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

3. **Did you have another** nursing home, home health care or long-term care insurance policy or certificate **in force during the last twelve (12) months?** Yes No

If Yes, Name of Company _____

If Policy Lapsed, **Date of Lapse** _____

4. Have you ever been turned down for nursing home, home health care, long-term care or disability insurance? Yes No

If Yes, please explain: _____

G1-B. PHYSICIAN INFORMATION

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

Use this space for additional information.

Standard Issue Health Statement

Name: _____ **Phone #:** _____ **Social Security #:** _____

MEDICAL PROFILE PART I Please answer "Yes" or "No" by checking the box.

- | | | |
|------------|-----------|--|
| Yes | No | |
|------------|-----------|--|
1. Do you need assistance or supervision in performing activities of daily living, such as walking, dressing, eating, taking medication, getting in and out of bed, bathing, toileting, bowel and bladder control?
2. Do you currently need and use a wheelchair, walker, quad cane, catheter, dialysis machine, hospital bed or oxygen?
3. Do you have Diabetes **AND** have you **EVER** had one of the following conditions:
 Skin Ulcers, Renal Failure, Progressive Neuropathy or Retinopathy, Vascular or Circulatory Disease?
4. In the past **5 YEARS** have you received Medical Advice, Consultation, or Treatment for:
- | | | | |
|------------------------------|--------------------------|-----------------------------|----------------------------------|
| • AIDS* | • Muscular Dystrophy | • Alzheimer's Disease | • Double Heart Valve Replacement |
| • Liver Cirrhosis | • Multiple Strokes | • Amputation-Due to Disease | • Spinal Cord or Brain Tumor |
| • Parkinson's Disease | • Organic Brain Syndrome | | • Myasthenia Gravis |
| • Multiple Sclerosis | • Senile Dementia | • Internal Lupus (SLE) | • Shunts |
| • Lou Gehrig's Disease (ALS) | • Chronic Memory Loss | • Neurogenic Bladder | |
| | | • Renal Failure | |

*** You need not answer "yes" if you have only been diagnosed as a carrier of AIDS. In addition, you need not answer "yes" if you do not have, or have never been tested for AIDS. You are obliged to answer "yes" if you have actually been diagnosed as having AIDS.**

5. In the past **3 YEARS** have you received Medical Advice, Consultation, or Treatment for Internal Cancer, except for Breast, Prostate, Colon or Uterine Cancer?
6. In the past **2 YEARS** have you:
- A. Been confined to or medically advised to be confined to a Nursing Home, Adult Day Care, Mental Institution, or Alcohol Rehabilitation, or received services of a Home Care Agency?
- B. Received Medical Advice, Consultation, or Treatment for Drug Addiction or for Compression Fractures?
7. In the past **YEAR** have you:
- A. Received Medical Advice, Consultation, or Treatment for Stroke or Transient Ischemic Attacks (TIA)?
- B. Received Medical Advice, Consultation, or Treatment for Breast, Prostate, Colon or Uterine Cancer?
8. In the past **6 MONTHS** have you had or been medically advised to have: Angioplasty, a Coronary Bypass Graft, Vascular Surgery, or a Pacemaker, or have you had a Heart Attack?
9. In the past **3 MONTHS** have you had or been medically advised to have Back, Knee, or Hip Surgery?

In most cases, checking any box above "yes" will disqualify you from program acceptance at this time. If you feel you have fully recovered or are no longer requiring the services described above, please attach an explanation including conditions, services used, and time frames.

(Long Form Health Statement Continued on Reverse Side)

PART II If any question in Part II is answered Yes, give full details in **Part IV**.

Yes No

- 1. During the past **2 YEARS** have you been hospitalized for any medical condition or special tests?
- 2. During the past **2 YEARS** have you had or been medically advised to have any surgery?
- 3. Are you **CURRENTLY** receiving Physical Therapy, Occupational Therapy, or Rehabilitation Services?
- 4. Are you **CURRENTLY** receiving disability income, worker's compensation, or Social Security **Disability** benefits?

PART III If any question in Part III is answered Yes, give full details in **Part IV**.

Yes No During the past **5 Years** have you received Medical Advice, Consultation, or Treatment for any of the following:

- 1. Heart problem or heart failure, heart or vascular surgery, circulatory or blood disease, stroke, TIA, angina, or high blood pressure?
- 2. Arthritis, osteoporosis, bone or joint problem, or any condition causing limitations or use of medical equipment?
- 3. Any respiratory problem, asthma, Chronic Obstructive Pulmonary Disease (COPD), or emphysema?
- 4. Any diabetes, cancer, loss of vision, neurological or muscular disorder?
- 5. Any bowel, bladder, digestive, kidney or liver problem?
- 6. Any memory loss, mental or emotional disorder or alcohol/drug problem?

PART IV List **ALL** Medications **AND** Detail **ALL CONDITIONS** noted in Part II and Part III.

Part/ Question #	Description of Accident or Sickness	Date of Onset	Type of Treatment/Medication	Length of time on Medication

Use this space for additional information

SIGNATURE:

I certify that the forgoing statements and answers are true and complete to the best of my knowledge and belief. I certify that no material information has been **withheld** or **omitted** concerning the past and present state of my health.

I agree to advise you if, prior to the date my insurance takes effect, there is a change to the answers to these questions.

I understand that this health statement will be made a part of the certificate applied for and that false and/or incomplete responses or statements may result in rescission of coverage and/or non payment of claims under the certificate during the two-year incontestability period.

X _____

Enrollee's Signature

Date



**GROUP LONG-TERM CARE INSURANCE CERTIFICATE
OUTLINE OF COVERAGE**

**Certificate Form Number GRP11-342-MA-TN-200
Group Number 8204**

This Policy is intended to be a qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code.

Caution: The issuance of this long-term care Certificate is based upon your responses to the questions on your enrollment form. A copy of your enrollment form is enclosed. If your answers are incorrect or untrue, the Company has the right to deny Benefits or rescind your Certificate. 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 Certificate 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 Certificate limitations.

1. **POLICY.** This is a Group Policy which was issued in Tennessee.
2. **PURPOSE OF OUTLINE OF COVERAGE.** This Outline of Coverage provides a very brief description of the important features of the Group 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 Group Policy contains governing contractual provisions. This means that the Group 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 CERTIFICATE CAREFULLY!**
3. **TERMS UNDER WHICH THE CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.** If you feel this Certificate does not meet your insurance needs, return it to us or your agent within 30 days. If you do so, we will return any premium you may have paid. We also will void your Certificate from its effective date.

When we are notified of your death, we will make a pro-rata refund to your estate of any premium paid for the period beyond your death. There is no refund when the Certificate is surrendered.

4. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company. Neither MedAmerica Insurance Company nor its agents represent Medicare, the federal government, or any state government.

5. **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 Certificate provides coverage of 100% of actual charges incurred up to the Daily Benefit Amount as listed on the Schedule page of your Certificate, for qualified long-term care services. Coverage is subject to Group Policy and Certificate limitations and an elimination period.

6. **BENEFITS PROVIDED BY THIS POLICY.**

- (a) **Benefit Eligibility:** To be eligible for Benefits provided by the Group Policy, we must receive periodic proof from a Licensed Health Care Practitioner that you are a person who meets the following conditions:

- You need Substantial Assistance from another person to perform at least two of the Activities of Daily Living (Bathing, Dressing, Eating, Toileting, Transferring, Continence) for a period expected to last at least 90 days; or
- You need Substantial Supervision to protect you from threats to health and safety due to Severe Cognitive Impairment.

Each of the following is an **Activity of Daily Living**:

Bathing: 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.

Continence: 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).

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

Eating: 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.

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

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

We will work with you, your family and your physician when we need information about your condition. We will review the status of your Activities of Daily Living and cognitive function. We will use this information to make an evaluation of your condition to determine whether you qualify or continue to qualify for Benefits under the Group Policy. This information may be gathered by us or one of our representatives.

We must receive certification from a Licensed Health Care Practitioner at least every 12 months that you meet the above conditions.

- (b) There is a once-in-a-**Lifetime Elimination Period**, which you have selected and which is listed in your Schedule, for which you must pay qualified long-term care expenses for Benefits covered in this Certificate.

A day is credited toward the Lifetime Elimination Period for each eligible day paid in part or in full by Medicare. Days used to satisfy your Lifetime Elimination Period do not need to be consecutive.

There is no Lifetime Elimination Period for Hospice Program, Respite Care, Caregiver Training, Family Member Assistance or Supportive Equipment Benefits. These Benefits may not be used to satisfy the Lifetime Elimination Period. If you are receiving Hospice Program Benefits paid by another insurer, we will waive the Lifetime Elimination Period.

- (c) To calculate your **Lifetime Benefit Amount**, multiply the daily benefit amount listed in your Certificate schedule, by the number of days which you have selected. We will deduct from this amount all Benefits we pay for all covered services provided under this Certificate.
- (d) Our **Personal Care Advisor** is available to help you and/or your family members plan for your care through our benefit planning service. This service is provided at your option and without cost to you.
- (e) Qualified Long-Term Care Services must be provided by **Approved Providers** in order to be reimbursed. Approved Providers are any of the following:
- **Nursing Facility;**
 - **Assisted Living Facility;**
 - **Hospice Program;**
 - **Home Health Care Agency; or**
 - **Adult Day Care Center.**
- (f) The maximum amount we will pay for all charges you incur on any one day whether under one or more of the categories of Benefits is the Daily Benefit Amount shown in your Schedule.
- (g) If you meet Benefit Eligibility, we will provide Benefits at 100% of the actual charges incurred up to the Daily Benefit Amount listed in your Schedule for **services provided in a Nursing Facility, Assisted Living Facility, or by an Adult Day Care** that are Qualified Long-Term Care Services.
- (h) If you meet Benefit Eligibility, we will provide Benefits at 100% of the actual charges incurred up to the Daily Benefit Amount shown in your Schedule for **services provided by a Hospice Program** that are Qualified Long-Term Care Services.

This benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

- (i) If you meet Benefit Eligibility, we will provide Benefits at 100% of the actual charges incurred up to the Daily Benefit Amount listed in your Schedule for **services provided by a Home Health Care Agency** that are Qualified Long-Term Care Services and are:
- nursing services;
 - respite services;
 - physical, occupational, respiratory and speech therapy;
 - home health aide or personal care attendant services including such things as: personal hygiene, performing Activities of Daily Living, managing medications, and other related supportive services; or
 - homemaker services including light work, household tasks, preparing meals, doing laundry and other incidental household tasks that do not require the services of a trained aide or attendant.
- (j) If you meet Benefit Eligibility, **Alternative Care Benefits** may be paid for Qualified Long-Term Care Services including, but not limited to, medically necessary transportation to and from Adult Day Care.
- (k) **Bed Reservation Benefits** will be paid if we are paying for Benefits in a Nursing Facility or Assisted Living Facility and that facility charges you a fee to reserve your bed. We will pay to reserve your bed for up to 21 days per calendar year.
- (l) If you meet Benefit Eligibility, **Caregiver Training Benefits** will be paid if you are at home and you, or a person designated by you and agreed to by us, requires training in the proper use and care of supportive equipment, medical aids or assistance with the performance of your Activities of Daily Living or other supportive needs.

The total Caregiver Training Lifetime Maximum Benefit that is listed in your Schedule is five times your Daily Benefit Amount. Benefits paid for Caregiver Training will be deducted from your Lifetime Benefit Amount. This benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

- (m) If you meet Benefit Eligibility, **Supportive Equipment Benefits** will be paid for the rental, lease or purchase of Supportive Equipment that is used to provide you with Qualified Long-Term Care Services.

We will pay this Benefit up to a maximum of \$1,000 each calendar year and a maximum of \$5,000 over the lifetime of your Certificate. Benefits paid for Supportive Equipment will be deducted from your Lifetime Benefit Amount. This benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

- (n) If you meet Benefit Eligibility, **Family Member Assistance Benefits** will be paid up to 50% of the Daily Benefit Amount shown in your Schedule for each day a member of your family, who does not reside with you, provides Qualified Long-Term Care Services at home.

The total Family Member Assistance Lifetime Maximum Benefit that is listed in your Schedule is 30 times your Daily Benefit Amount. Benefits paid for Family Member Assistance will be deducted from your Lifetime Benefit Amount. This benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

- (o) If you meet Benefit Eligibility and you are at Home, **Respite Care Benefits** will be paid for Respite Care provided in your Home, in a Nursing Facility, or in an Assisted Living Facility.

We will pay Benefits for up to the Daily Benefit Amount shown in your Schedule for a maximum of 30 days per calendar year. Benefits paid for Respite Care will be deducted from your Lifetime Benefit Amount. This Benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

- (p) **Worldwide Coverage** is provided to cover services by approved providers anywhere in the world.

7. **LIMITATIONS AND EXCLUSIONS.**

- (a) **Pre-existing conditions:** There are no pre-existing condition limitations in this Certificate.
- (b) **Exclusions:** Expenses for the following will not be reimbursed under the Group Policy:
- Substance abuse treatment for alcohol or drug addiction;
 - Treatment for illness or medical condition arising out of war or any act of war, declared or undeclared;
 - Services for intentionally self-inflicted injury;
 - Treatment provided in a government facility except as otherwise required by State or Federal law;
 - Services for which any Benefits are provided under Workers' Compensation, employer's liability program, occupational disease law or mandatory no-fault insurance;
 - Services provided by a member of your family, except as provided in Family Member Assistance and Caregiver Training Benefits;
 - Services for which no charge is normally made in the absence of insurance;
 - Expenses for medications, prescription and/or non-prescription.
- (c) **Nonduplication:** We will not pay Benefits for services or expenses to the extent that they are reimbursable under Medicare or under any other federal, state, or other governmental health care plan or law (except Medicaid). This exclusion also applies to services or expenses that would be reimbursable by Medicare but have been applied to a deductible or coinsurance amount.

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

8. **RELATIONSHIP OF COST OF CARE AND BENEFITS.**

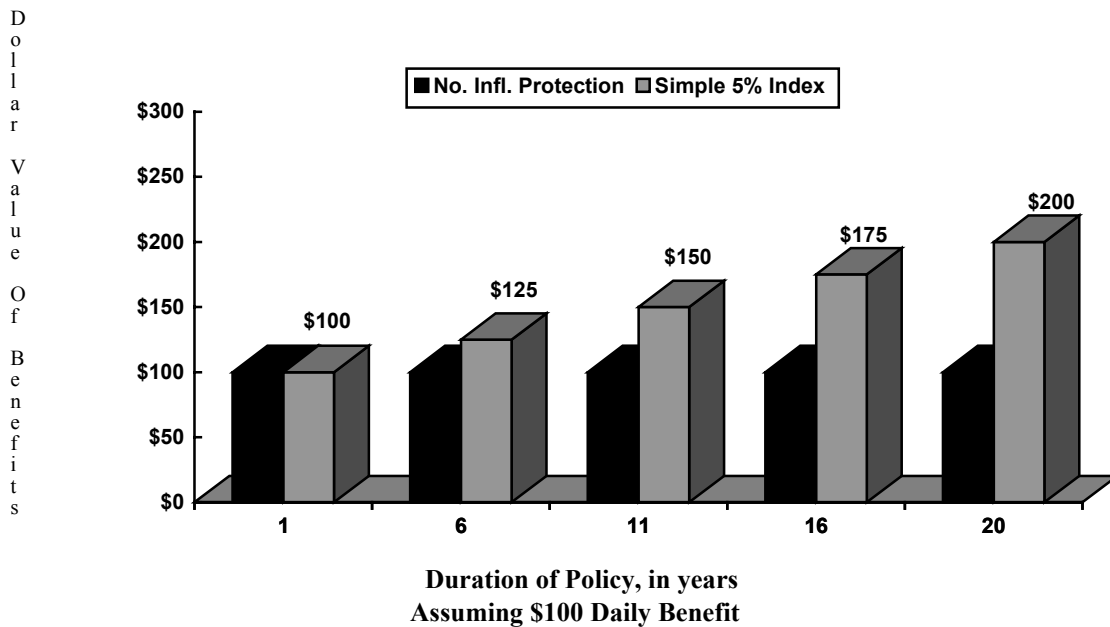
Because the costs of long-term care services will likely increase over time, you should consider whether and how the Benefits of this plan may be adjusted.

- (a) Your coverage under your Certificate may include other inflation protection options or may provide for the option of purchasing such protection. *Please refer to your enrollment forms to see which option, if any applies to your group benefits plan.*
- (b) Benefit adjustment provisions:

If you purchase \$100 per day nursing facility coverage, following are your Benefits over time:

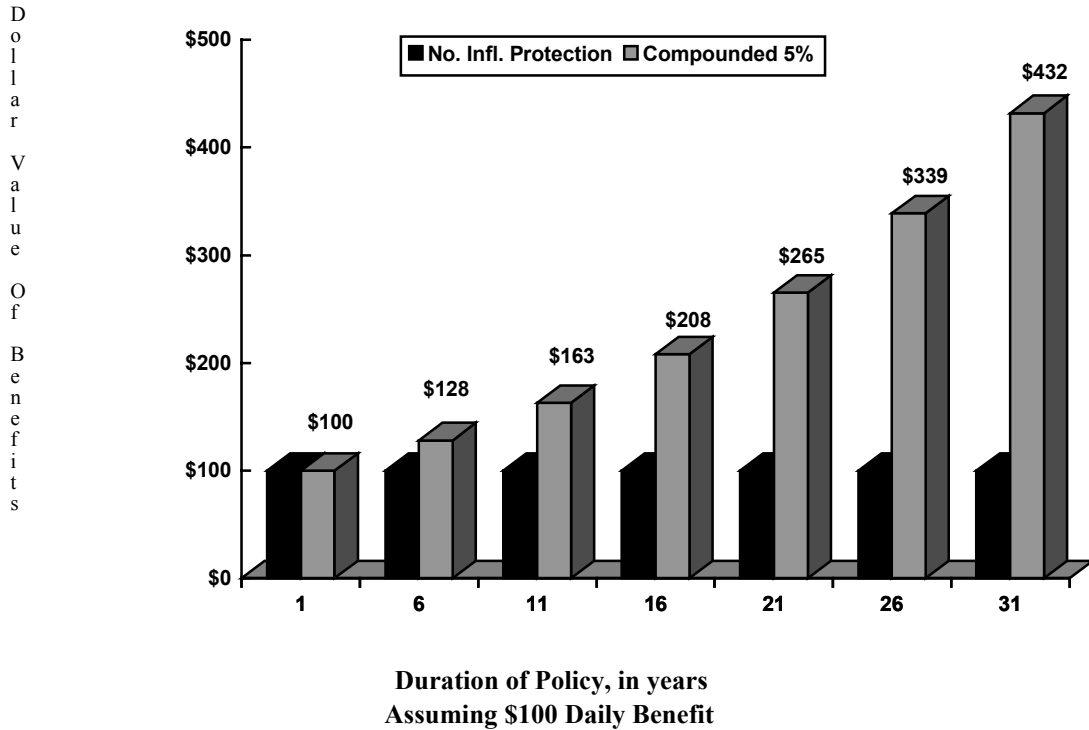
If you purchase simple indexing Benefits, your Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of your Certificate for the first 20 years the Certificate is in force. Annual increases will apply to Benefits payable for any expenses you incur on or after the date of the increase. Each increase will be equal to 5% of your original amounts and will be without regard to health status.

**Comparison of Daily Benefit Level
with and without Inflation Protection
Simple 5% Interest - 20-year Duration**



If you purchase compound indexing Benefits, your Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of your Certificate. Annual increases will apply to Benefits payable for any expenses you incur on or after the date of the increase. This first increase will be equal to 5% of your original amounts. Each increase thereafter will be equal to 5% of the increased amounts that applied on the date of the prior increase. Benefits increase without regard to health status.

**Comparison of Daily Benefit Level
with and without Inflation Protection
Compounded 5% Interest - Lifetime Duration**



- (c) The difference in premium for a certificate with or without inflation protection is based on the differences of the expected Benefits over your lifetime.

9. TERMS UNDER WHICH THE CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

- (a) **RENEWABILITY: THIS CERTIFICATE IS GUARANTEED RENEWABLE.** This means that you have the right, subject to the terms of your Certificate, to continue your coverage as long as you pay your premiums on time. MedAmerica Insurance Company cannot change any of the terms of your Certificate on its own, except that, in the future, IT MAY CHANGE THE PREMIUM YOU PAY.
- (b) **CONTINUATION OF COVERAGE:** If We are notified that You are no longer eligible for coverage under the Group Policy for any reason, You may continue coverage without interruption as long as You pay all premiums when due. If Your premium was paid by payroll deduction, You must pay premiums directly to us.

You will not be eligible for continuation of coverage if the Group Policy terminates.

- (c) **CONVERSION:** If the Group Policy terminates, You may elect to purchase a new individual direct payment contract which provides benefits identical to the benefits provided under the Group Policy without proof of insurability and at the same premium rates. In order to purchase such coverage You must make written application for the conversion policy and pay the first premium due within thirty-one (31) days of the termination date of the Group Policy,

The new policy will be effective on the date your coverage under the Group Policy ended and will be guaranteed renewable.

- (d) **WAIVER OF PREMIUM.** Your premium payments will be waived on a monthly basis starting on the first day we will pay for Benefits in a Nursing Facility, Assisted Living Facility, or Hospice Program OR on the 91st day we will pay for Benefits for Home Health Care or Adult Day Care.

- (e) **OUR RIGHT TO CHANGE PREMIUM.** We can change your premium with thirty (30) days written notice, but only if we change the premiums for all persons in the same payment class.

- 10. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.** The Group Policy provides coverage if you are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Coverage is contingent upon documentation by a licensed health care practitioner that you are severely cognitively impaired requiring substantial supervision. This benefit is subject to the same benefit eligibility provisions and lifetime elimination period limitations as other Benefits.

11. **PREMIUM.**

- (a) The total annual premium for your long-term care coverage is shown in your Certificate Schedule. The cost of any optional benefits or riders is also shown.
- (b) If you selected the 10-year Paid-in-Full premium payment plan, you will not be charged for any premium increase in year 11 or thereafter. If you selected the 20-year Paid-in-Full premium payment plan, you will not be charged for any premium increase in year 21 or thereafter. *Please refer to your enrollment forms to see which option, if any, applies to your group benefits plan.*
- (c) An initial grace period of 30 days will be granted for each premium that is unpaid on the date due. After 30 days, a notice will be sent to you, if you pay premium to us directly, explaining that a payment has been missed and that your Certificate risks lapsing. You will have an additional 35 days from the date we mail notice to you during which any unpaid premium must be paid. Payment will allow your Certificate to continue in force without interruption. Failure to pay any unpaid premium by the end of this Grace Period will result in the termination of your Certificate as of the premium due date.

12. **ADDITIONAL FEATURES.**

- (a) Medical underwriting of your enrollment form is used to determine your eligibility for long-term care insurance, unless you qualify for guaranteed issue.
- (b) Benefits may be available after termination if you are receiving Benefits covered under the Group Policy. See the “Extension of Benefits” section of your Certificate for specific requirements.
- (c) If the coverage under your Certificate terminates because of non-payment of premium, you may apply for reinstatement of your Certificate.
- (d) No prior hospitalization is required before you can receive coverage for services under this Certificate.
- (e) Appeal rights are available if you disagree with a claim decision.
- (f) **Shortened Benefit Period Nonforfeiture Rider**

Please refer to your enrollment forms to see which option, if any applies to your group benefits plan. If you purchase this Rider, the following Benefit applies:

Shortened Benefit Period Nonforfeiture Benefit

We will continue the coverage provided by the Group Policy, subject to a reduced Lifetime Benefit Amount, if your coverage under the Group Policy has been in force for three years or more and your coverage lapses due to cancellation or nonpayment of premium. This reduced Lifetime Benefit Amount is called your Nonforfeiture Maximum Benefit. If the eligibility requirements are met, we will provide Benefits at 100% of the actual charges incurred for any Qualified Long-Term Care Services, otherwise covered under your Certificate, up to your Nonforfeiture Maximum Benefit.

Amount of Benefit

Your Nonforfeiture Maximum Benefit will be the greater of:

1. The sum of all premiums paid for your coverage under the Group Policy and any attached Riders; or
2. Thirty (30) times the Amount of Daily Benefit in effect on the date your coverage under the Group Policy lapses.

However, your Nonforfeiture Maximum Benefit will never be greater than your Certificate Lifetime Benefit Amount at time of lapse.

(g) Enhanced Return of Premium Rider

Please refer to your enrollment forms to see which option, if any applies to your group benefits plan. If you purchase this Rider, the following Benefit applies:

Upon notification of Your death, We will refund to your estate all premiums paid for Your Policy and any Riders less any Benefits paid or payable. The amount of the refund is determined by calculating the total sum of premiums paid and reducing that amount by (A) and (B):

(A) = Any premiums which were waived and any unearned premiums refunded at Your death.

(B) = Your total benefits paid or payable.

(h) Spousal Benefit Transfer Rider

Please refer to your enrollment forms to see which option, if any applies to your group benefits plan. If you and your spouse each purchase one of these riders, the following Benefits apply:

Spousal Benefit Transfer Rider Benefit

When you and your spouse each purchase a Spousal Benefit Transfer Rider, you are increasing the Lifetime Benefit Amount each of you would be entitled to use when qualifying for Benefits payable under your Certificate. By purchasing the Riders, you are agreeing to accomplish this by first using your own Lifetime Benefit Amount and then, at the option of your Spouse, using a portion or all of your spouse's Lifetime Benefit Amount.

Benefits will be charged against your Lifetime Benefit Amount until it is exhausted and then they will be charged against your spouse's Lifetime Benefit Amount. Both Certificates and both Riders must remain in force for the provisions to be in effect.

Surviving Spouse Benefit

If one spouse dies when both Certificates and Riders are in force, the surviving spouse will inherit the total remaining combined pool of Lifetime Benefit Amounts. The surviving spouse will be responsible for continuing only his or her own Certificate premium and Rider premium payments. If the surviving spouse cancels the Rider at any time, he or she will be entitled only to the Benefits which remain unused under his or her own Certificate.

Discontinuation of Rider and/or Lapse of Base Certificate

Either spouse may choose at any time to maintain his or her Certificate and discontinue the Rider or to discontinue both the Certificate and the Rider. Please note that these changes will affect you in the following ways:

1. You must agree that, if one spouse cancels the Rider, the Rider for the second spouse is automatically cancelled. In this instance, both spouses can retain their Certificates, and each pays his or her original premium amount. Each spouse retains his or her own remaining Lifetime Benefit Amount.
2. You must agree that, if one spouse cancels both the Certificate and Rider, the Rider for the second spouse is automatically cancelled. The second spouse can retain his or her Certificate and pay the original premium amount. The spouse retaining the Certificate will retain his or her own remaining Lifetime Benefit Amount.

Benefit Transfer Purchase Requirements

1. At the time you apply for your Certificate, you and your spouse must agree to make the same selections of benefit features (Daily Benefit Amounts, Lifetime Benefit Amounts, Inflation Protection Features and Riders) and payment terms. You must also agree to have the same effective date of coverage if both of you are accepted and issued a Certificate.
2. You agree to accept the fact that if your spouse uses his or her total Certificate Benefits and then accesses your Benefits, you will have fewer Benefits available to you than you would have had under your own Certificate if you had not purchased this Rider.

(i) Survivorship Benefit Rider

Please refer to your enrollment forms to see which option, if any applies to your group benefits plan. If you and your spouse each purchase one of these riders, the following Benefit applies:

Benefit

We will not require the payment of premium under the Group Policy after both of the following events have occurred:

- Your Certificate and your spouse's Certificate have been in force with us for ten consecutive years; and
- Your spouse is deceased.

Discontinuation of Rider and/or Lapse of Base Certificate

You may choose at any time to discontinue both your Certificate **and** this rider, **or** to discontinue **only** this rider. The following conditions apply:

1. If you cancel this rider, your spouse's rider is automatically cancelled. You and your spouse each have the option to retain your base Certificates;
2. If you cancel both your base Certificate and this rider, your spouse's rider is automatically cancelled. Your spouse can retain his or her base Certificate;
3. Your rider and your spouse's rider are automatically cancelled as of the date of a divorce or a legal separation.

Survivorship Purchase Requirements

At the time you apply for your Certificate, you and your spouse must agree to purchase the same benefit features. These benefit features include: the Daily Benefit Amount, Lifetime Benefit Amount, any options and riders.

Both you and your spouse must also agree to purchase this rider and choose the same payment terms. The effective date of both Certificates must also be identical.

(j) Restoration of Benefits Rider

Please refer to your enrollment forms to see which option, if any applies to your group benefits plan. If you purchase this Rider, the following Benefit applies:

We will restore your Certificate's Lifetime Benefit Amount to the amount that would have applied if no Benefits had been paid under it. This Restoration of Benefits applies whenever a period of 180 consecutive days elapses in which:

- You were not eligible for or being paid for Benefits; and
- Your Certificate did not lapse and all premiums were paid; and
- You have not reached your Lifetime Benefit Amount; and
- Your Certificate is currently in force.

(k) Monthly Home Health Care Benefit Rider with Enhanced Waiver of Premium.

Please refer to your enrollment forms to see which option, if any applies to your group benefits plan. If you purchase this Rider, the following Benefit applies:

This rider provides for payment of a monthly home health care and adult day care benefit. The maximum amount payable for this benefit is 100% of the actual charges incurred in a calendar month up to thirty one (31) times your daily home care benefit amount subject to the lifetime elimination period. This rider also replaces your premium waiver benefit provided in the policy by the following:

- On the first day of policy-paid services in a Nursing Facility, Assisted Living Facility Hospice Program, or;
- After an amount equal to thirty (30) times your daily benefit amount for home health care or adult day care services has been paid.

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.

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. 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, 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.

Contingent Nonforfeiture Rights

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:

- (a) 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) The amount of coverage, new lifetime maximum benefit amount, etc., you will keep will equal the total amount of premiums you have paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining

maximum benefit amount is less than the total amount of premiums you have paid, the amount of coverage will be that remaining amount.

- (c) Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

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%	70	40%
30-34	190%	71	38%
35-39	170%	72	36%
40-44	150%	73	34%
45-49	130%	74	32%
50-54	110%	75	30%
55-59	90%	76	28%
60	70%	77	26%
61	66%	78	24%
62	62%	79	22%
63	58%	80	20%
64	54%	81	19%
65	50%	82	18%
66	48%	83	17%
67	46%	84	16%
68	44%	85	15%
69	42%		