The Federal Long Term Care Insurance Program

John Hancock MetLife®

- Sponsored by the U.S. Office of Personnel Management
- Offered by John Hancock Life Insurance Company and Metropolitan Life Insurance Company
- Administered by Long Term Care Partners, LLC

FULL UNDERWRITING APPLICATION

Valid beginning January 1, 2003

New and newly eligible employees and their spouses and newly married spouses of employees applying within 60 days of becoming eligible should NOT use this form.

Call for a different application.

PART A | PERSONAL INFORMATION

(AFFIX LABEL HERE)

Name _____
FIRST MIDDLE INITIAL LAST

Street Address _____

_____

_____

City _____ State/Territory _____

Country _____ ZIP/Foreign Postal Code _____

☐ **Check here if this is a Foreign Address**

<<< IMPORTANT

If you are the individual named on the address label affixed to the front of your Plan Proposal, and are applying for coverage, remove the address label, and place it here. If your label is misplaced or if you are an eligible individual who is not named on the address label, please fill out the required information.

Gender ☐ **Male** ☐ **Female**

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

☐ Check here if you don't have a Social Security Number

Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
MONTH DAY YEAR

Home Phone _____

Work Phone _____

Email _____

THIS APPLICATION IS ONLY FOR THE GROUPS SHOWN.

Tell us which of these makes YOU an eligible individual.

(Please check only one.)

Employee or current spouse
Check type (required):

- ☐ Federal civilian employee
- ☐ U.S. Postal Service employee
- ☐ Active member of the uniformed services
- ☐ Current spouse of one of the above

Annuitant or current spouse
Check type (required):

- ☐ Federal civilian or U.S. Postal Service annuitant
- ☐ Retired member of the uniformed services
- ☐ Current spouse of one of the above

Other eligible family members
Check type (required):

- ☐ Surviving spouse receiving a survivor annuity
- ☐ Parent, parent-in-law, or stepparent of a living Federal or Postal employee or active member of the uniformed services
- ☐ Adult child (age 18 or older, including a natural, adopted or stepchild) of a living Federal or Postal employee or annuitant or active member or living retired member of the uniformed services

Each eligible individual wishing to apply for coverage must complete a separate application. If you need any help filling out this form, call 1-800-LTC-FEDS (1-800-582-3337) (TTY: 1-800-843-3557).

PART B | ANSWER THESE QUESTIONS FIRST

1. ☐ YES ☐ NO **Do you currently *reside* in, or has a health professional *advised* you to enter, a nursing home or any type of assisted living facility?**

2. ☐ YES ☐ NO **Are you currently *receiving* home health care services or *attending* adult day care?**

3. ☐ YES ☐ NO **Do you currently *require* or *receive* human help or supervision with any of these activities?**

- Bathing
- Dressing
- Eating
- Transferring yourself from bed to chair
- Toileting (getting to and using the toilet, completing hygiene-related functions after use)
- Continence (changing protective undergarments, managing ostomy bags and catheters, completing hygiene-related functions)

4. ☐ YES ☐ NO **Do you currently *have*, or have you ever been *diagnosed* with, or ever been *treated* for, any of the following conditions?**

- AIDS or AIDS-related Complex
- Alzheimer's Disease, Organic Brain Syndrome, or Dementia
- Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)
- Cancer within 2 years (excluding basal cell or squamous cell cancer of the skin)
- Cirrhosis
- Diabetes with amputation or ongoing complication affecting the kidney
- HIV
- Multiple Sclerosis
- Muscular Dystrophy
- Organ Transplant (excluding kidney, bone marrow or cornea transplants)
- Parkinson's Disease
- Schizophrenia
- Spinal Cord Injury (e.g., paraplegia, quadriplegia)
- Stroke (CVA): multiple
- Stroke (CVA): within 5 years
- Stroke (CVA): with residual impairment (e.g., paralysis, weakness, gait disturbance, vision disturbance, mental impairment)
- Transient Ischemic Attack (TIA): multiple
- Transient Ischemic Attack (TIA): within 3 years

5. ☐ YES ☐ NO **Do you currently use any of the following medical devices, aids, or treatments?**

- Hospital bed
- Dialysis
- Motorized scooter
- Wheelchair
- Oxygen (except CPAP)
- Walker
- Stair lift
- Multi-prong cane

6. ☐ YES ☐ NO **Do you currently *require* or *receive* human help or supervision with any of these activities because of mental retardation?**

- Living independently
- Preparing meals
- Taking medications
- Using transportation
- Shopping
- Walking
- Making decisions about your money

If the answer is "YES" to any of questions 1-6, you are not eligible for any of the insurance options under this program shown in Part G of this form. If you would like to receive information about a non-insurance package providing access to care coordination and discounts, make sure that Parts A and B are complete and mail this application. Do not complete the rest of this application.

PART C | ANSWER THESE QUESTIONS NEXT

A registered nurse may call or visit you to get more information on your answers to the following questions.

1. ☐ YES ☐ NO **Do you currently *have*, or have you been *diagnosed* with, or *treated* for, any of the following conditions?**

- Kidney transplant
- Kidney failure
- Mental retardation
- Paralysis of the extremities

2. ☐ YES ☐ NO **Do you currently *require* or *receive* human help or supervision with any of these activities?**

- Preparing meals
- Making decisions about your money
- Taking medications
- Using transportation
- Shopping
- Walking

3. ☐ YES ☐ NO **Do you currently *use* crutches, a cane, prosthetics, braces, or a catheter?**

4. ☐ YES ☐ NO **Are you currently receiving *disability income* such as disability retirement annuity payments, VA disability compensation, worker's compensation, any Federal or state disability payments, or any other type of disability payment?**

5. **Within the *last 10 years*, have you *had*, been *diagnosed with* or been *treated for* any of the following conditions?**

A.	☐ YES	☐ NO	Stroke or Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Carotid Artery Disease
B.	☐ YES	☐ NO	Peripheral Vascular Disease
C.	☐ YES	☐ NO	Coronary Artery Disease (e.g., heart attack, angina), Heart Arrhythmia, Cardiomyopathy, Congestive Heart Failure, Aneurysm, Valvular Disease
D.	☐ YES	☐ NO	Diabetes (excluding gestational diabetes)
E.	☐ YES	☐ NO	Cancer (excluding basal cell cancer or squamous cell cancer of the skin)
F.	☐ YES	☐ NO	Chronic Kidney Disease (e.g., nephritis), Incontinence, Prostate Disorder
G.	☐ YES	☐ NO	Liver Disorder (e.g., hepatitis), Ulcerative Colitis, Crohn's Disease
H.	☐ YES	☐ NO	Any Psychiatric Disorder (e.g., depression, bipolar disorder)
I.	☐ YES	☐ NO	Disorder of the Brain (e.g., tremor, seizure disorder, head injury, tumor, infection), Neuropathy, Syncope, Paralysis, any Chronic or Progressive Neurological Disorder
J.	☐ YES	☐ NO	Chronic Lung Disease [e.g., COPD, emphysema, sarcoidosis, chronic bronchitis, asbestosis, asthma (excluding seasonal asthma), bronchiectasis, sleep apnea]
K.	☐ YES	☐ NO	Memory Loss
L.	☐ YES	☐ NO	Rheumatoid Arthritis, any other type of Arthritis, Osteoporosis, Back Disorder, Scoliosis, Spinal Stenosis, Disc Disease
M.	☐ YES	☐ NO	Connective Tissue Disorder (e.g., scleroderma, systemic lupus, CREST syndrome)
N.	☐ YES	☐ NO	Muscle Disorder (e.g., fibromyalgia, polymyalgia rheumatica, chronic fatigue syndrome)
O.	☐ YES	☐ NO	Fracture or Amputation
P.	☐ YES	☐ NO	High Blood Pressure
Q.	☐ YES	☐ NO	Macular Degeneration, Glaucoma, Retinitis Pigmentosa, Meniere's Disease
R.	☐ YES	☐ NO	Anemia, Polycythemia Vera, Thrombocytopenia, Hemochromatosis
S.	☐ YES	☐ NO	Alcoholism, Drug Dependency

If the answer is "YES" to any of questions 1-5, explain below. Attach a separate piece of paper if necessary.

Question Number	Diagnosis or Disorder	Date of Onset	Treatment Dates	Name, Address and Phone Number of Treating Health Professional
				NAME _____ ADDRESS _____ _____ PHONE _____
				NAME _____ ADDRESS _____ _____ PHONE _____

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

Medications: List all prescription medications taken over the past 6 months. Attach a separate piece of paper if necessary.

Medication	Dosage (e.g.: 10mg)	Frequency (e.g.: 2 times a day)	Reason Prescribed	Name and Address of Prescribing Health Professional
				NAME _____ ADDRESS _____ _____
				NAME _____ ADDRESS _____ _____

PART D | ANSWER THESE ADDITIONAL QUESTIONS

1. **Height:** ☐ feet ☐ inches **Weight:** ☐ lbs.

2. ☐ YES ☐ NO — Are you employed outside the home or engaged in any hobbies, social activities or volunteer work? If yes, describe:

_____

_____

3. ☐ YES ☐ NO — Do you exercise regularly? If yes, describe: _____

_____

Frequency: _____

4. ☐ YES ☐ NO — Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months? If yes, type: _____ Frequency: _____

5. ☐ YES ☐ NO — Within the past 2 years, have you had a complete physical exam? If yes: Month: _____ Year: _____ Physician's Name: _____

6. ☐ YES ☐ NO — Do you currently drink alcoholic beverages on a daily basis? If yes, please indicate number of drinks per day: ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

7. ☐ YES ☐ NO — Have you ever had an application for Life, Health, or Long Term Care Insurance declined, postponed, modified or rated (offered insurance at a higher premium rate than the standard premium rate)?

8. ☐ YES ☐ NO — Within the last 5 years, has a health professional recommended that you should have any surgeries, tests, or procedures that you have *not* had performed?

9. ☐ YES ☐ NO — Have you *ever resided in* a nursing home or any type of assisted living facility?

10. ☐ YES ☐ NO — Have you *ever attended* adult day care or *received* home health care services?

11. ☐ YES ☐ NO — Within the last 5 years, have you ever been *hospitalized, consulted* with, or *received treatment* from a health professional for a disease or condition not previously stated in any section of this application (excluding childbirth without complications, the common cold, flu or routine exams)?

If the answer is "YES" to any of questions 7-11, explain below. Please attach a separate piece of paper if necessary.

Question Number	Diagnosis or Disorder	Date of Onset	Treatment Dates	Name, Address, Phone Number of Treating Health Professional
				NAME _____ ADDRESS _____ _____ PHONE _____
				NAME _____ ADDRESS _____ _____ PHONE _____
				NAME _____ ADDRESS _____ _____ PHONE _____

PART E | AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION ABOUT ME

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

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

I understand that:

- If I do not sign this authorization, my application for long term care insurance may not be processed and any claim for long term care insurance benefits may be denied.
- I may revoke this authorization at any time, except to the extent that:
  - action has already been taken in reliance on it prior to my revocation, or
  - Long Term Care Partners or my insurer has a right to contest my long term care insurance claim or coverage.
- If I do revoke this authorization, I understand that my application for long term care insurance may not be processed and any claim for long term care insurance benefits may be denied.
- To revoke this authorization I must notify Long Term Care Partners, LLC, 100 Arboretum Drive, Suite 100, Portsmouth, NH 03801-7833, in writing.
- If I do not revoke this authorization, it will be valid for 24 months from the date I sign it.
- My health information may be redisclosed and no longer protected by applicable law, including federal health information privacy regulations. This can occur only if such redisclosure is required or allowed by law (for example in response to a subpoena).
- A copy of this authorization is as valid as the original.

Applicant's Signature X _____ **Date** _____ / _____ / _____
MONTH DAY YEAR
(Required) **(Required)**

PART F | YOUR PRIMARY PHYSICIAN INFORMATION

Name of Your Primary Physician or Health Care Practitioner: _____

Address: _____

_____ Phone Number: _____

☐ **Check here if you do not have a Physician or Health Care Practitioner that you see on a regular basis.**

PART G | CHOOSE A PRE-PACKAGED PLAN OR CUSTOMIZE YOUR PLAN

If the answer is "YES" to Question 1 in Part C, you are not eligible for the Unlimited Benefit Period.
If you have any questions about details or premiums, please refer to your *Plan Proposal* in your kit or call **1-800-LTC-FEDS** (1-800-582-3337) (TTY: 1-800-843-3557) or visit the web site at **www.LTCFEDS.com**.

OPTION #1: Choose one of the following pre-packaged plans

SELECT A PLAN	DAILY BENEFIT AMOUNT	BENEFIT PERIOD	WAITING PERIOD
☐ Facilities 100	$100	3 years	90 Days
☐ Comprehensive 100	$100	3 years	90 Days
☐ Comprehensive 150	$150	5 years	90 Days
☐ Comprehensive 150+	$150	Unlimited	90 Days

SELECT AN INFLATION PROTECTION OPTION. You must select one Inflation Protection Option.
If you have any questions about Inflation Protection, please refer to your *Inflation Protection Options Brochure* in your kit.

☐ **Automatic Compound Inflation Option** ☐ **Future Purchase Option**

OR Do not complete Option #2 if you have selected a pre-packaged plan in Option #1 above.

OPTION #2: Customize your plan

1. **Type of Plan:** ☐ Facilities Only ☐ Comprehensive
2. **Daily Benefit Amount:**
   Daily Benefit Amount ($50 to $300 in $25 increments) **$**_____
   ☐ If you would prefer a weekly benefit equal to seven times (7x) your Daily Benefit Amount and you have selected the **Comprehensive Plan** above in question 1, check here. This feature is available at an additional cost.
3. **Benefit Period:** ☐ 3 years ☐ 5 years ☐ Unlimited
4. **Waiting Period:** ☐ 30 days ☐ 90 days
5. **Inflation Protection:** ☐ Automatic Compound Inflation Option ☐ Future Purchase Option
   You must select one Inflation Protection Option. If you have any questions about Inflation Protection, please refer to your *Inflation Protection Options Brochure* in your kit.

PART H | REPLACEMENT COVERAGE QUESTIONS

Please review and consider the following questions about replacement of existing coverage. Federal law requires that we ask you these questions about Medicaid and other current long term care insurance coverage. Please check "yes" only if the situation addressed in a question applies to you. Your answers to these questions will NOT affect your eligibility for insurance under the Federal Long Term Care Insurance Program. If you answer "yes" to question 2, we will notify your current insurance carrier that you have applied for coverage under this Program. You should not replace any existing medical or health insurance coverage with Federal Long Term Care Insurance. These are different types of insurance that cover different types of care.

1. Medicaid is the state/Federal program that helps pay medical costs for some people with low incomes and limited resources. It is known as Medi-Cal in California. Please note that Medicaid is NOT the same as Medicare.

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

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

   ☐ YES ☐ NO **Are you replacing another long term care insurance policy or certificate currently in force? If yes, please provide the following information:**

   Policy # _____ Insurance Company Name _____

   Insurance Company Address _____

PART I | CHOOSE ONE BILLING OPTION

IF YOU DO NOT SELECT AN OPTION, YOU WILL BE BILLED DIRECTLY.

☐ **OPTION 1:** **Check here if you wish to pay through AUTOMATIC BANK WITHDRAWAL (Automatic Bank Withdrawals occur on the third business day of every month).**

I authorize Long Term Care Partners to initiate automatic bank withdrawals from the account number provided on my voided check or savings deposit slip. I also authorize my bank to charge my account for such withdrawals, payable to Long Term Care Partners.

This authorization will remain in effect until either I, my bank or Long Term Care Partners terminates it by a thirty (30) day written notice to the others. I understand that I won't receive any bills or other notices of the withdrawals from Long Term Care Partners.

I agree that if the automatic bank withdrawal isn't honored by my bank, for whatever reason, Long Term Care Partners will have no liability for the payments. I understand that my insurance coverage may be terminated because of non-payment of premiums. I also understand that I will receive notice of such non-payment from Long Term Care Partners before my insurance coverage is terminated.

Complete this Authorization, attach a voided check or a voided savings account deposit slip which includes routing and transit number and then sign below:

Staple Voided Check or Voided Savings Deposit Slip Here

Name of bank (and branch if applicable) _____

Depositor's Signature X_____ Date ____ / ____ / ____
MONTH DAY YEAR
(Required) (Required)

Depositor's Signature X_____ Date ____ / ____ / ____
MONTH DAY YEAR
(Required) (Required)

Signature must be signature of depositor(s) as shown on bank records for this account. If joint account, both depositors must sign and date.

☐ **OPTION 2:** **Check here if you wish to pay through PAYROLL/ANNUITY DEDUCTION.**

Refer to your Payroll/Annuity Deduction Instruction Guide in your kit to locate the identifier to use for your payroll office (for employees) or annuity office (for those who are retired). You must provide the correct Payroll/Annuity Office Identifier and any other information required below. If you do not, YOU WILL BE BILLED DIRECTLY.

Please provide the Payroll/Annuity Office Identifier for the Payroll/Annuity Office from which deductions will be made.

Payroll/Annuity Office Identifier: ☐☐☐☐☐☐☐☐ **(5 - 8 DIGITS/CHARACTERS)**

If deductions will be made from a Federal Civilian annuity, and there is an Annuity Claim Number, please provide it.

Annuity Claim Number: C S ☐ ☐☐☐☐☐☐☐☐

INSERT (A, F, OR I) ABOVE AND FILL IN THE REMAINING 7 OR 8 DIGITS/CHARACTERS

If you are requesting payroll/annuity deduction from someone else's pay/annuity, that person must complete the information above, provide the following information, and sign the authorization below:

Name of Employee/Annuitant: _____
FIRST MIDDLE INITIAL LAST

Social Security Number of Employee/Annuitant: ☐☐☐ - ☐☐ - ☐☐☐☐

I hereby authorize Long Term Care Partners to deduct from my pay/annuity the amount necessary to pay the premiums for the Federal Long Term Care Insurance coverage for this applicant. This authorization may be cancelled only upon written notification to Long Term Care Partners from me or the applicant.

Payroll/Annuity Authorization Signature X_____ Date ____ / ____ / ____
MONTH DAY YEAR
(Required) (Required)

☐ **OPTION 3:** **Check here if you wish to pay through DIRECT BILLING. You may request an alternate billing address by filling out the information below. If you leave this blank, we will use your address on page 1.**

Care Of _____
FIRST MIDDLE INITIAL LAST

Street Address _____

City _____ State/Territory _____

Country _____ ZIP Code/Foreign Postal Code _____

PART J | PROTECTION AGAINST UNINTENDED LAPSE

It's a good idea to designate at least one person living outside of your household to receive notice if your insurance coverage is about to lapse because Long Term Care Partners did not receive your premiums. Note: This person will NOT be responsible for your premiums. The person you designate can help find out why you stopped paying premiums. We will not contact this person until 30 days after a premium was due and is unpaid.

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

☐ **YES.**
Please provide all information requested.

☐ **NO.**
I REJECT THIS OFFER.

Name (First, Middle Initial, Last) _____

Address _____ Apt. #_____

City _____ State/Territory_____

Country _____ ZIP Code/Foreign Postal Code _____

PART K | AGREEMENT AND ACKNOWLEDGEMENT

I am applying for insurance coverage under the Federal Long Term Care Insurance Program. All of the answers and explanations I've given on this form, including my status as an eligible individual, are true and complete. I understand that the decision to approve my application will be based on my answers and explanations on this form.

I also agree to inform Long Term Care Partners, in writing, if between the date I sign this form and the date my insurance coverage is effective: (1) my health changes in a way that would cause any answer I've given on this application to no longer be correct, or (2) I receive any medical advice or treatment from a physician or other health care practitioner for a condition that would affect an answer to any question on this form.

I understand that the conditions and provisions of my coverage may not be waived, changed or otherwise affected unless in writing by Long Term Care Partners, and that the U.S. Office of Personnel Management must agree to any change affecting benefits and premiums.

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

Caution: If you are approved for coverage, but you shouldn't have been because one or more of your answers or explanations are not true, we may have the right to deny benefits or cancel your insurance even if you did not knowingly misrepresent the facts as shown in your medical records.

NOTE:

Your signature below also confirms the elections you made in Part G, Inflation Protection, Part I, Billing Options, and Part J, Protection Against Unintended Lapse.

- If you rejected Automatic Compound Inflation Protection in Part G by choosing the Future Purchase Option, you are confirming that you reviewed the descriptions and graphs of the inflation protection options in the Outline of Coverage. You also understand that if you elect the Automatic Compound Inflation Option you may switch to the Future Purchase Option at any time, and if you elect the Future Purchase Option you may switch to the Automatic Compound Inflation Option under certain circumstances.
- If you elected Payroll/Annuity Deduction from your own pay/annuity in Part I, you are authorizing Long Term Care Partners to deduct from your pay/annuity the amount necessary to pay the premiums for the Federal Long Term Care Insurance coverage issued to you. Your payroll/annuity deduction may be cancelled only upon written notification.
- If you did not name someone in Part J to receive a notice if your coverage is about to lapse, you are confirming that you understand that such notices do not obligate such person in any way and are not sent until 30 days after your premium was due but unpaid. You also understand that you may identify a person to receive notice of pending lapse at any time in the future (and/or name a different person).

Applicant's Signature X_____ Date _____ / _____ / _____
MONTH DAY YEAR

(Required) **(Required)**

MAIL TO: Long Term Care Partners, P.O. Box 5725, Hopkins, MN 55343-5725