



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

TAX QUALIFIED COVERAGE

Please Indicate: Individual List Bill
If List Bill, name of Company or Association: _____
Company or Association #: _____

GENERAL INFORMATION

Name (Last)		(First)	(M.I.)	Social Security Number	
Address					
City		County	State	CT	Zip
Home Phone Number () ()		Work Phone Number () ()		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 or 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 or Domestic Partner is applying at this time.
 (Please submit enrollment forms together & required Domestic Partner form.)
 Spouse or Domestic Partner is a current policyholder.

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

POLICY CHOICE

POLICY CHOICE		BENEFIT SELECTIONS		
		1) Daily Benefit Amount:	2) Benefit Period:	3) Lifetime Elimination Period:
Long-Term Care Insurance <input type="checkbox"/> PRT11-336-MA-CT-601 Nursing Facility, Home Care, Assisted Living Facility, Hospice Program, Adult Day Care *Partnership minimums adjust annually	\$ _____ per day (Partnership minimum \$140/2003, \$150/2004, \$160/2005 no maximum multiple of \$10)	<input type="checkbox"/> 730 days (2 Years) <input type="checkbox"/> 1095 days (3 Years) <input type="checkbox"/> 1460 days (4 Years) <input type="checkbox"/> 1825 days (5 Years) <input type="checkbox"/> Unlimited (Lifetime)	<input type="checkbox"/> 0 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 20 Days <input type="checkbox"/> 90 Days	
Nursing and Assisted Living Facility Insurance <input type="checkbox"/> PNQ11-337-MA-CT-601 Nursing & Assisted Living Facility *Partnership minimums adjust annually	\$ _____ per day (Partnership minimum \$140/2003, \$150/2004, \$160/2005 no maximum multiple of \$10)			

Inflation Protection Compound (5% for Life) (Daily Benefit & Lifetime Benefit) (Required for Ages 18-64)
 Compound (5% for Life) (Daily Benefit Only) (Available as option to above, ages 65+ only)

OPTIONAL BENEFITS APPLIED FOR (Please complete each section 1-7)

1) Shortened Benefit Period Nonforfeiture Rider	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Spousal Benefit Transfer Rider (not available for the Unlimited Benefit Period)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Restoration of Benefits Rider (not available for Unlimited Benefit Period)	<input type="checkbox"/> Yes <input type="checkbox"/> No
4) Monthly Home Care Benefit Rider (Not available for PNQ11 Policy)	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Survivorship Benefit Rider	<input type="checkbox"/> Yes <input type="checkbox"/> No
6) Return of Premium Nonforfeiture Rider (not available for age 75 & Over)	<input type="checkbox"/> Yes <input type="checkbox"/> No
7) Enhanced Return of Premium Rider (not available for age 75 & Over)	<input type="checkbox"/> Yes <input type="checkbox"/> No

COMPANY USE

Ap Rec _____ Ap Status _____ Eff. Date _____ UW/Date_MUIRate Group 1 2 3

MEDICAL PROFILE : PART IIf any question in Part I is answered Yes, you are not eligible for coverage.

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 |
| • Liver Cirrhosis | • Multiple Strokes | • Amputation-Due to Disease | Replacement |
| • Parkinson's Disease | • Organic Brain Syndrome | • Internal Lupus (SLE) | • Spinal Cord or Brain Tumor |
| • Multiple Sclerosis | • Senile Dementia | • Neurogenic Bladder | • Myasthenia Gravis |
| • Lou Gehrig's Disease (ALS) | • Chronic Memory Loss | • Renal Failure | • Shunts |
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 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?

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?

AGENT USE

Agent's Statement

I have sold the following health insurance policies to the applicant:

- 1. Policies sold which are still in force _____
- 2. Policies sold in the past five (5) years which are no longer in force _____

I have reviewed the current accident and health coverage of the applicant and find that the indicated replacement, or the additional coverage of the type and amount applied for, is appropriate for the applicant's needs.

I certify that the information provided to me by the applicant has been truthfully and accurately recorded on this application and that I know of no risk except that which appears on this application.

I further certify that I personally interviewed the applicant and, in doing so, fully complied with MedAmerica Insurance Company's "Agent Code of Ethics."

Agent's Signature X _____ Date _____

Use this space for additional information/requests/instructions:

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

- I ACCEPT the Shortened Benefit Period Nonforfeiture Rider (see Optional Benefits, Page 1).
- I REJECT the Shortened Benefit Period Nonforfeiture Rider

3. **WAIVER OF INFLATION PROTECTION ON LIFETIME MAXIMUM BENEFIT (ONLY For persons age 65 or older)** - If you are age 65 or older, you may elect to waive the Automatic 5% Compounded Inflation Protection on your Lifetime Maximum Benefit. This means that the Lifetime Maximum Benefit will not increase over time, while the Daily benefits will increase according to the Automatic 5% Compound Inflation Protection provision. You should be aware that if your Lifetime Maximum Benefit does not increase over time, it might not provide all of the Medicaid Asset Protection that you need. To elect this Waiver, you must sign below.

I have reviewed the graph in the Outline of Coverage comparing the benefits and premiums with and without the Automatic 5% Compound Inflation Protection, and I reject the Automatic 5% Compound Inflation Protection for the Lifetime Maximum Benefit. This waiver is most appropriate for individuals who do not expect their assets to increase after taking this optional waiver.

Applicant's Signature: _____ Date: _____

Declaration and Application Conditions

To the best of my knowledge and belief, I have answered all questions completely and truthfully. I understand this application is for consideration and the company will use this application or require, at their expense, that I see a health care professional to determine if my application is accepted. I understand that the premium for the coverage I have applied for is based on medical underwriting. The premium I was quoted includes certain assumptions regarding my health. Therefore, the premium for my policy may be different from the premium I was quoted. My coverage will begin when I am notified of the effective date of coverage. To receive benefits under this policy, I will satisfy the elimination period and the benefit eligibility requirements as set forth in the policy.

OPTIONS AND SIGNATURE Cont.

Authorization to Obtain and Disclose Information

I agree to permit company representatives to contact me to ascertain my health status to determine if my application is accepted.

I understand that only information contained on this application may be used to rescind my policy.

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. **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 application is signed.

I acknowledge that I have received a copy of "Before You Buy", a complete description of the Connecticut Partnership for Long-Term Care, prepared by the State of Connecticut, including the States toll-free number, 1-800-547-3443. I have also been advised that I can request individual consumer information/assistance from the State of Connecticut. I have also received a graphic comparison of inflating vs. fixed benefits and premiums, and the notice to Applicant Regarding Mandatory Inflation Protection contained in the Outline of Coverage.

X _____ Dated at _____ on _____
Applicant's Signature (City/State) (Month/Day/Year)

SHARED BENEFIT – SEPARATE MEDICAID ASSET PROTECTION.

You and your spouse or domestic partner must read and sign in this section if you both have applied for the Spousal Benefit Transfer Rider

We acknowledge that under the Spousal Benefit Transfer Rider we will both be able to draw benefits from each other's policies. We also acknowledge that under the Spousal Benefit Transfer Rider, Medicaid Asset Protection is earned separately. Only those benefits paid for one individual's care will earn Medicaid Asset Protection for that insured. We acknowledge that Medicaid Asset Protection earned by one spouse/domestic partner cannot be transferred to the other spouse/domestic partner. We further acknowledge that under the Spousal Benefit Transfer Rider it is possible that only one spouse/domestic partner will use all the benefits of both spouses'/domestic partner's policies. Should that happen, we acknowledge that the spouse/domestic partner that received all the benefits will receive all the Medicaid Asset Protection, while the other spouse/domestic partner receives no benefits and no Medicaid Asset Protection.

X _____ X _____
Applicant's Signature Spouse or Domestic Partner Signature

Release of Records I hereby agree to the release of my insurance records, pertaining to this long-term care insurance policy by MedAmerica Insurance Company, to the State of Connecticut for the purpose of documenting a claim for Medicaid Asset Protection under the Connecticut Medicaid Program, evaluating the Connecticut Partnership for Long-Term Care, and meeting Medicaid audit Requirements. I understand that my records will be used for no purpose other than those stated above, and will be kept strictly confidential by the State of Connecticut.

X _____ Dated at _____ on _____
Applicant's Signature (City/State) (Month/Day/Year)

CAUTION: If your answers on this application are incorrect or untrue, or you fail to include all material medical information requested, MedAmerica Insurance Company may have 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.

_____	Agent's Name <i>(Please Print)</i>
Agent's Writing Number	Rate Group Applied For 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
_____	Conditional Payment Received \$ _____
Agency Name <i>(Please Print)</i>	



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CONDITIONAL RECEIPT

All premium checks must be made payable to the company. Do not make check payable to the agent or leave the payee blank.

Payment of premium does not provide insurance coverage until the conditions specified below are satisfied.

The Company acknowledges receipt of the sum of \$ _____
from _____

(Applicant's Name)

to apply to the first premium if the policy applied for is issued.

Important Notice: The premium for the coverage you have applied for is based on our medical underwriting guidelines. The premium you were quoted includes certain assumptions regarding your health. Therefore, the premium for your policy may be different from the premium you were quoted.

If coverage is declined, this amount will be returned in full within 30 days.

Conditions Which Must Be Satisfied Before Coverage Is Effective:

- 1) This receipt bears the same date and is signed by the same agent as the application;
- 2) An amount equal to the first premium has been collected with the application; and
- 3) The Company, upon investigation, is satisfied that on the Effective Date of Coverage, such person was insurable according to the Company's rules and regulations.

Effective Date of Coverage

If the applicant is insurable, the policy issued will become effective on the latest of the following dates:

- 1) Date of completion of all parts of the application and supplements thereto on all persons proposed for insurance;
or
- 2) Date of completion of all reports, medical examinations or tests, including re-examination or re-testing as requested for any person to be insured because of age, medical history, the plan or amount of insurance applied for; or
- 3) The date as requested on the application, which may be no greater than sixty days beyond the Company assigned Effective Date and not earlier than the application signature date.

No agent, producer or representative of the Company has any power or authority to change or modify any of the provisions of this Conditional Receipt.

Received by _____ on ____ / ____ / ____.
(Agent's Signature)

LEAVE WITH APPLICANT