Continental Casualty Company

Group Long-Term Care Enrollment Form

Fairfax County Public Schools

Policy Number: 9580-IS

For use by new employees or employees who are enrolling during the initial enrollment period.

If any part of Sections 1 through 4 is blank, we cannot process your enrollment form.

SECTION 1 – EMPLOYEE INFORMATION

Applicant's Name: First, Middle Initial, Last	**Date of Birth:**	**Sex:** (M or F)
Applicant's Address: Number and Street	**Employee ID Number:**	
Social Security Number:		
City:	**State:**	**Zip Code:**
Daytime Phone Number:	**Evening Phone Number:**	**Date of Hire:**

SECTION 2 – BENEFIT SELECTIONS

Select ***ONE*** Daily Benefit / Lifetime Maximum:

3-Year Option

- ❑ $100 Daily Benefit / $109,500 Lifetime Maximum
- ❑ $200 Daily Benefit / $219,000 Lifetime Maximum
- ❑ $250 Daily Benefit / $273,750 Lifetime Maximum

5-Year Option

- ❑ $100 Daily Benefit / $182,500 Lifetime Maximum
- ❑ $200 Daily Benefit / $365,000 Lifetime Maximum
- ❑ $250 Daily Benefit / $456,250 Lifetime Maximum

Select *ONE* Home Based Care Benefit:

- ❑ 60% Home Based Care Benefit
- ❑ 100% Home Based Care Benefit

Select *ONE* Inflation Option:

(See Page 17 of the enrollment brochure for a complete description of the inflation features available.)

- ❑ Guaranteed benefit increase (Standard Inflation)
- ❑ Lifetime automatic benefit increase (Optional Inflation)

Inflation Protection Rejection: I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this insurance with and without inflation protection, and I reject the Automatic Benefit Increase Option.

Applicant's Signature _____ Date ____/____/____

OVER, PLEASE

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SECTION 3 – OTHER INSURANCE COVERAGES

Do you currently have long-term care insurance in force or have you recently applied for such insurance? **YES** ☐ **NO** ☐

***If yes*, please list all such coverages in the space provided below. Indicate if you intend to replace any medical or health insurance coverage, including health care service contract or health maintenance organization with the insurance applied for with this application.**

Company Name	Company Address	Policy Number	Is coverage to be replaced?	When
			YES ❑ NO ❑	

SECTION 4 – EMPLOYEE AUTHORIZATION

To the best of my knowledge and belief, the information on this enrollment form is true and complete. I understand that the insurance I have selected for myself will begin on the Certificate Effective Date shown in my Certificate of Insurance provided that I am actively at work on that date with **Fairfax County Public Schools**. If I am not actively at work on that date, my insurance will not take effect until the first day of the month after I return and remain actively at work. **Actively at Work** means the Employee is physically at his or her usual place of business performing the regular duties of his or her work. **AN EMPLOYEE WHO IS ON PAID OR UNPAID ABSENCE BUT WHO IS ACTIVELY PARTICIPATING IN THE Fulbright Teachers Program, on Administrative leave, on Organizational leave as defined by Fairfax County Public Schools policy IS DEEMED TO BE ACTIVELY AT WORK.**

I authorize **Fairfax County Public Schools** to make the appropriate **payroll deduction** for the above-specified coverage and release other necessary information to the administrators of the program.

Signature _____ **Date** ____/____/____