Continental Casualty Company

Fairfax County Public Schools

Policy Number: 9580-IS

Group Long-Term Care
Long Form Application

For use by parents, grandparents, retirees, and spouses of retirees.

SECTION 1 – APPLICANT INFORMATION

Applicant's Name: First, Middle Initial, Last	**Date of Birth:**	**Sex:** (M or F)

Applicant's Address: Number and Street	**Social Security Number:**

City:	**State:**	**Zip Code:**

Daytime Phone Number:	**Evening Phone Number:**

SECTION 2 – BENEFIT SELECTIONS

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

3-Year Option	5-Year Option
☐ $100 Daily Benefit / $109,500 Lifetime Maximum	☐ $100 Daily Benefit / $182,500 Lifetime Maximum
☐ $200 Daily Benefit / $219,000 Lifetime Maximum	☐ $200 Daily Benefit / $365,000 Lifetime Maximum
☐ $250 Daily Benefit / $273,750 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** ____/____/____

SECTION 3 – ELIGIBILITY

I certify that I am:

☐ An employee's parent or parent-in-law

☐ An employee's grandparent or grandparent-in-law

☐ A retiree

☐ The spouse of a retiree

Employee/Retiree Name	**Employee ID / Retiree Social Security Number**

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SECTION 4 – STATEMENT OF INSURABILITY

Height __________ ft. _______ in. Weight __________ lbs.

		YES	NO
1.	At any time in the last five years have you applied for or received Social Security disability benefits or Medicaid?	☐	☐
2.	During the last seven years have you been diagnosed, received medical advice, or been treated by a member of the medical profession for any of the following:		
a.	Auto or Acquired Immune Disorder.	☐	☐
b.	Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC).	☐	☐
c.	Internal Lupus Erythematosus or any other connective tissue disease or disorder.	☐	☐
d.	Alzheimer's Disease, Dementia, or change in cognitive functioning.	☐	☐
e.	Parkinson's Disease, Multiple Sclerosis, Huntington's Disease, or Amyotrophic Lateral Sclerosis.	☐	☐
f.	Seizures, Epilepsy or any other Neurologic Disease or Disorder.	☐	☐
g.	Emphysema, Asthma or Chronic Bronchitis.	☐	☐
h.	Diabetes Mellitus, Glucose Intolerance, or Hyperglycemia.	☐	☐
i.	Internal Cancer or Melanoma.	☐	☐
j.	Disorder, Disease or Surgery of the Heart or Circulatory System.	☐	☐
k.	Cerebral Vascular Accident, Stroke or Transient Ischemic Attack.	☐	☐
l.	High Blood Pressure.	☐	☐
m.	Osteoporosis.	☐	☐
n.	Arthritis, or any other Bone, Spine, Joint or Muscular Disease, Disorder or Surgery.	☐	☐
o.	Reproductive, Kidney or Urinary System Disease, Disorder or Surgery.	☐	☐
p.	Liver, Digestive, Colon or Rectal Disease Disorder or Surgery.	☐	☐
q.	Alcoholism or Substance Abuse.	☐	☐
r.	Any Mental, Emotional or Nervous Disease or Disorder, Depression or Chemical Imbalance.	☐	☐
3.	During the past 12 months have you consulted a physician, been diagnosed or treated for any of the following?	☐	☐

If yes, check those which apply:

☐ dementia ☐ dizziness ☐ loss of appetite
☐ unstable gait ☐ falling ☐ deterioration of vision
☐ disorientation ☐ fainting ☐ bladder control

		YES	NO
4.	At any time during the past 12 months have you needed assistance or supervision or were you limited in any way physically or cognitively from performing any of the following daily activities?	☐	☐

If yes, check those which apply:

☐ bathing ☐ dressing ☐ toileting ☐ continence
☐ eating ☐ managing medications ☐ housekeeping ☐ preparing meals
☐ mobility

		YES	NO
5.	At any time during the past 12 months have you used any of the following medical devices?	☐	☐

If yes, check those which apply:

☐ cane ☐ walker ☐ wheelchair ☐ oxygen equipment ☐ catheter

		YES	NO
6.	Have you been confined in a long-term care facility or received home health care or adult day care services during the past 12 months?	☐	☐
7.	Have you used any tobacco products at any time during the last three years?	☐	☐
8.	During the past five years, have you received any medical advice, treatment or diagnosis for any condition other than those stated in questions 2 through 7?	☐	☐

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9. **Are you taking any prescription drugs?** **YES ☐ NO ☐**
***If yes*, please provide the name and daily dosage below.**

Drug Name	Daily Dosage	Take for (diagnosis or condition)	Prescribing Doctor

10. **If you answered "Yes" to any part of questions 2 through 9 provide details below.**
For more details attach a separate signed and dated sheet.

Question Number	Diagnosis	Date Treatment Began	Ongoing OR Date or Recovery/Control	Name of Doctor or Facility

11. **Please list all physicians which you have consulted or been treated by in the past five years.**
For more details attach a separate signed and dated sheet.

Name of Doctor	Specialty	Phone Number	Address

12. **Does someone else hold your power of attorney?** **YES ☐ NO ☐**
***If yes*, explain why, what type of power of attorney, and if that power of attorney is being actively used at this time. To provide more details, attach a separate sheet of paper which is signed and dated.**

____

13. **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 contracts or health maintenance organizations with the insurance applied for with this application.**

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

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SECTION 5 – PAYMENT METHOD

Direct Bill: ☐ **Quarterly** ☐ **Semi-Annual** ☐ **Annual** ***OR:*** ☐ **Monthly Electronic Funds Transfer**

SECTION 6 – ALTERNATE BILLING DESIGNEE

I understand I have the right to designate at least one person other than myself to receive notice before my coverage terminates for nonpayment of premium. I designate:

First Designee Name: ____

Home Address: ____
Number and Street

City ______________________ State __________ ZIP code __________

Second Designee Name: ____

Home Address: ____
Number and Street

City ______________________ State __________ ZIP code __________

OR

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 long-term care insurance for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate any person to receive such notice.

Applicant's Signature ______________________________ **Date** ____/____/____

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SECTION 7 – AUTHORIZATION

NOTICE: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law in which he or she resides.

I understand and agree that the statements in this application are complete and true to the best of my knowledge and belief and that they will form a part of the contract of insurance. I also understand and agree that the insurance for which I am applying, if issued, shall be based on these statements.

Authorization to Obtain Information

"Information Provider" as used herein may include any physician, medical practitioner, hospital, clinic, other medical or medically related facility, clearinghouse, insurance or reinsuring company, agent, broker, service provider, Medical Information Bureau, Inc. (MIB), credit bureau or other consumer reporting agency, employer or the Veterans Administration.

"Information" received from an Information Provider may include advice, diagnosis, prognosis, treatment or care of any physical or mental condition concerning me, including information about HIV or AIDS, drug or alcohol abuse or mental illness (except psychotherapy notes) and/or financial, consumer report, or any other non-medical information concerning me.

I AUTHORIZE any Information Provider to give Continental Casualty Company (the Company) any and all Information regardless of any previous restriction or limitation on disclosure of such Information. In order to expedite my request, I further authorize an Information Provider (except MIB) to release Information to the Company's agents, brokers, service providers, its reinsurers, or any other third party retained by the Company to collect and transmit such Information.

I UNDERSTAND that the Information obtained by use of this Authorization is at my request and will be collected by the Company to determine eligibility for insurance. I understand that this Authorization to Obtain Information shall remain valid for two years from the date shown below. I understand that if I do not sign this Authorization, the Company may not accept my application for insurance.

I UNDERSTAND that the Company may maintain or have access to personal information acquired separately through any previous insurance applications with the Company or its affiliates for insurance even in instances where insurance was not placed with me. I authorize the Company to use or disclose such information for consideration of my current application for insurance.

I UNDERSTAND that I may revoke this Authorization at any time by providing written notice to the Company, except: (i) to the extent that an individual has taken action in reliance upon such authorization prior to notice of the revocation, or (ii) to the extent that this authorization was provided as a condition of obtaining insurance coverage and other law provides the Company with the right to contest a claim for coverage under the policy or the insurance coverage under the policy itself.

I UNDERSTAND that Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer the responsibility of the Information Provider or protected by the privacy rule under the Health Insurance Portability and Accountability Act.

I UNDERSTAND that I may request to receive a copy of this Authorization and I agree that a photographic copy shall be as valid as the original.

I CERTIFY that I have read, or had read to me, the completed application and any false statement or misrepresentation in the application may result in loss of coverage under the policy. All statements in this application are representations and not warranties. If this application is accepted, the insurance will take effect on the effective date shown on the schedule page attached to the certificate of coverage.

Caution Notice: If your answers on this application are incorrect or untrue, the Continental Casualty Company may have the right to deny benefits or rescind your coverage, subject to the incontestability provisions in the policy.

Applicant's Signature ______________________________ **Date** ____/____/____

Coverage is not guaranteed and is based on the information provided.