



**Fairfax County Public Schools**

**Group Long-Term Care  
Short Form Application**

Policy Number: 9580-IS

*For use by spouses and employees who are required to provide evidence of insurability.*

*If any part of Sections 1 through 6 is blank, we cannot process your application.*

**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**

**5-Year Option**

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

- \$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**

### SECTION 3 – EMPLOYEE INFORMATION

I certify that I am:  An employee  The spouse of an employee

<b>Employee Name:</b> First, Middle, Last	<b>Employee ID Number:</b>	<b>Employee Social Security Number:</b>	<b>Date of Hire:</b>

### SECTION 4 – PAYMENT METHOD

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

**Employee's Signature** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### SECTION 5 – STATEMENT OF INSURABILITY

1. Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs.
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:
- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| a. Acquired Immune Deficiency Syndrome (AIDS) or any other immune system disorder.                 | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Alzheimer's Disease, Dementia or change in cognitive functioning.                               | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Multiple Sclerosis, Huntington's Disease, Parkinson's Disease or Amyotrophic Lateral Sclerosis. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Emphysema, Chronic Bronchitis or Asthma.  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Internal Lupus Erythematosus or any other connective tissue disease or disorder.                | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Cancer which has spread or metastasized.  | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Heart Disorder.   | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Diabetes Mellitus, Glucose Intolerance or Hyperglycemia.  | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Cerebral Vascular Accident, Stroke or Transient Ischemic Attack.                                | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Alcoholism or Substance Abuse.  | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Bone or Joint disease or disorder requiring prescription medication or surgery.                 | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Mental, Emotional or Nervous disease or disorder, Depression, or Chemical Imbalance.            | <input type="checkbox"/> | <input type="checkbox"/> |
3. Have you used any tobacco products more than once a month at any time during the last three years?  YES  NO
4. At any time during the last two years have you needed assistance or supervision or were you limited in any way physically or cognitively from performing any of the daily activities of bathing, dressing, toileting, mobility, eating or managing medications?  YES  NO
5. At any time in the last seven years have you applied for or received Social Security disability benefits or Medicaid?  YES  NO
6. Do you currently have or have you had in the past 12 months any long-term care insurance in force other than Group Long-Term Care Insurance from Continental Casualty Company or have you applied for such insurance? If yes, what company and if the policy lapsed, when did it lapse?  YES  NO
7. Do you intend to replace any medical or health insurance coverage including a health care service contract or health maintenance organization with insurance applied for with this application other than with Group Long-Term Care from Continental Casualty Company?  YES  NO

**NEXT PAGE, PLEASE**

## SECTION 6 – 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 KNOW that I may request a copy of this Authorization or have a copy of this Authorization provided to me or my authorized representative. I agree that a copy of this Authorization is 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 a 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. However, the insurance will not take effect unless the employee is actively at work as determined by the employer.

**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.**

**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.**