

The University of Utah

Long Form Application

Group Long Term Care

Please check appropriate box below

Employee/Spouse 01-A-9533

Retiree/Spouse 02-A-9533

Parent/Grandparent 03-A-9533

New Coverage Change To Existing Coverage

TIPS ON COMPLETING YOUR APPLICATION

By completing your application carefully, you will help us speed up our response. Here are a few tips to avoid common problems that cause delays.

- Under the "Daily Benefit Selected" section, be sure to check the option you want to select. We cannot process your application unless an option is selected.
- Under "Statement of Insurability", question 1 asks about Medicaid eligibility. This is not Medicare. Medicare is a medical program for individuals over 65 and certain disabled individuals. Medicaid is a medical program for individuals who have met their state's definition of poverty. Individuals eligible for Medicaid do not need long term care insurance.
- Under question 2, if someone else holds a power of attorney, please explain on a separate sheet of paper why, what type of power of attorney, and if that power of attorney is being actively used at this time. If a separate sheet of paper is used, please sign and date it.
- Under the list of medical conditions beginning on page 2, be sure to check "Yes" or "No" to each question. We cannot process your application if there are any blanks.
- If any item is checked "Yes", provide details in question 9 and list medications in question 10. Also, in question 10, list any prescription drugs that you are taking even if the condition is not shown previously. The information on name and dosage can be found on the label of the medication container.
- Be sure to write the name and social security number of the employee or retiree who is affiliated with **The University of Utah** under the authorization section.

Thank you.

APPLICATION FOR GROUP LONG TERM CARE FROM CONTINENTAL CASUALTY COMPANY

Employee Name: Last, First, Middle Initial		Social Security Number	Date Hired
Date of Birth	Sex (M or F)	Daytime Phone Number	Evening Phone Number
Home Address: Street & Number		City	State Zip Code

APPLICANT'S NAME: Last, First, Middle Initial			Social Security Number
Date of Birth	Sex (M or F)	Daytime Phone Number	Evening Phone Number
Home Address: Street & Number		City	State Zip Code

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Plan Design Selected:

- Plan A \$150,000 LM
 Plan B \$150,000 LM with ABI
- Plan C Unlimited LM
 Plan D Unlimited LM with ABI

EMPLOYEES/SPOUSES ONLY:

(check one mode)
 Monthly

**RETIREEES/SPOUSES, PARENTS/
GRANDPARENTS/SPOUSES ONLY:**

(check one mode)

- Quarterly
 Semi-annual Annual

Applicant's Height Weight
ft. in. lbs.

Billing Name: Last, First, Middle Initial *(if different from Applicant's)*

Billing Address: Street & Number *(if different from Applicant's)* City State Zip Code

STATEMENT OF INSURABILITY

Yes No

1. Are you receiving Medicaid or do you have a current Medicaid eligibility card?
2. Does someone else hold your Power of Attorney?
3. During the past 5 years have you been diagnosed or treated for any of the following?
- Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)
 - Alzheimer's Disease
 - Parkinson's Disease
 - Chronic Organic Brain Syndrome
 - Multiple Sclerosis
 - Emphysema or chronic obstructive pulmonary disease
 - Alcoholism or Substance Abuse
 - Internal Lupus Erythematosus
 - Insulin dependent diabetes
 - Internal cancer or melanoma
 - Disorder or disease of the heart, circulatory system, coronary bypass, paralysis or stroke
 - Osteoporosis, crippling arthritis, or bone, spine, joint or muscular disease, disorder or surgery
 - Liver, digestive, colon, rectal, kidney, or urinary system disorder
 - Any mental, emotional or nervous disease or disorder
4. Have you been hospitalized on 2 or more occasions during the past 6 months?
5. During the past 12 months have you consulted a physician, been diagnosed or treated for:
- Disorientation, dementia, deterioration of vision or depression?
 - Loss of appetite, falling, fainting, unstable gait, bladder control, or dizziness?
6. Do you need assistance or supervision or are you limited in any way from performing the following daily activities? If yes, check those which apply:
- bathing dressing toileting mobility continence eating
 - managing medications meal preparation housekeeping
7. Do you use any of the following medical devices?
If yes, check those which apply:
- walker wheelchair oxygen equipment respirator catheter
 - dialysis machine
8. 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?

9. If you answered Yes to any part of questions 3 through 8 provide details below.
 (To provide more details attach a separate signed and dated sheet.)

Question Number	Description of Problem or Disease	Name of Treatment or Medication	Date of Treatment	Date of Recovery/ Control	Names and Addresses of Attending Physician, Hospital and/or Long Term Care Facility

Yes No

10. Are you taking prescription drugs? If **Yes**, please provide the name and daily dosage below.

Drug Name	Daily Dosage	Doctor's Name

Yes No

11. Do you currently have long term care insurance in force or have you recently applied for such insurance? If **Yes**, please list all such coverages in the space below. Indicate if any such coverage is to be replaced by the insurance applied for with this application.

Company Name	Policy Number (if known)	Elimination Period (if any)	Days Payable	Amount of Coverage	Is coverage to be replaced?	If Yes , When?

AUTHORIZATION

To be eligible for this coverage, you must be:

- A full-time employee;
- Spouse of a full-time employee;
- Full-time employee's parent or grandparent;
- Retiree;
- Spouse of Retiree.

Name of Employee/Retiree

Social Security Number of
Employee/Retiree

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.

I authorize any insurance company, reinsuring company, insurance reporting agency, employer, the Veterans Administration, licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility having any records or knowledge of me, or my health, to give to the Continental Casualty Company any such information in order to evaluate my application for Long Term Care Insurance. A photostatic copy of this authorization is as valid as the original.

This authorization shall remain in effect for 2 years and 6 months from the date shown below.

I have read this authorization and understand I can receive a copy.

I certify that I have read, or had read to me, the completed application. All statements in this application are representations and not warranties. The insurance will take effect on the effective date shown on the schedule page attached to the certificate of coverage.

Caution: If your answers on this application are incorrect or untrue, the Continental Casualty Company has the right to deny benefits or rescind your coverage.

Signature of APPLICANT

Date Signed

Z1-100333-C

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

A NOTE ABOUT UNDERWRITING

As part of our underwriting process, we sometimes call prospective insureds shortly after we receive your application. The purpose of this short interview is to make sure we fully understand the facts about your health as noted on the application. If interviewed, we greatly appreciate your cooperation during this process.

For Administration Purposes Only

Employee: Effective Date

Payroll Deduction
Amount

Circle One Premium Mode:

Monthly Semimonthly

Spouse: Effective Date

Payroll Deduction
Amount

Biweekly Weekly

Annual Semiannual Quarterly