Short Form Application

Group Long Term Care

The University of Utah

Policy Number: 01-A-9533

❑ **New Coverage** ❑ **Change To Existing Coverage**

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

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

STATEMENT OF INSURABILITY

Yes No

❑ ❑ 1. 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?

❑ ❑ 2. During the last 7 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 or Chronic Organic Brain Syndrome
- ❑ Multiple Sclerosis
- ❑ Emphysema or chronic obstructive pulmonary disease
- ❑ Internal Lupus Erythematosus
- ❑ Parkinson's Disease
- ❑ Heart Attack
- ❑ Stroke
- ❑ Alcoholism or Substance Abuse
- ❑ Arthritis which has limited your mobility or noticeably deformed your joints

Yes No

❑ ❑ 3. During the last 24 months have you needed assistance or supervision or were you limited in performing the daily activities of bathing, dressing, toileting, mobility, eating or managing medication?

❑ ❑ 4. Do you currently have long term care insurance in force or have you recently applied for such coverage?

❑ ❑ 5. Do you intend to replace any medical or health insurance coverage with insurance applied for with this application?

❑ ❑ 6. Are you receiving Medicaid or do you have a current Medicaid eligibility card?

ELIGIBILITY & AUTHORIZATION

To be eligible for this coverage, you or your spouse must be a full time salaried employee of **The University of Utah** actively at work.

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

Z1-102932-C

Coverage is not Guaranteed

❑ I authorize **The University of Utah** to make the payroll deduction

Signature of Employee Date Signed

For Administration Purposes Only

Employee: Effective Date	Payroll Deduction Amount	Circle One Premium Mode:	Employee's Payroll Deduction Date:	Continental Casualty Company
Spouse: Effective Date	Payroll Deduction Amount	Monthly Semimonthly Biweekly Weekly		