GROUP LONG TERM CARE INSURANCE APPLICATION

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

The policy for long term care insurance is intended to be a federally qualified long term care insurance policy and may qualify you for federal and state tax benefits.

THE COVERAGE YOU ARE APPLYING FOR IS PROVIDED UNDER AN APPROVED LONG TERM CARE INSURANCE POLICY UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THE POLICY WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG TERM CARE. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE CALIFORNIA PARTNERSHIP FOR LONG TERM CARE, CALL THE HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM AT THE TOLL-FREE NUMBER, 1-800-434-0222.

Please advise if you have received the following documents with this application:

- **Outline of Coverage** ☐ Yes ☐ No
- **HICAP Notice (Item 13 in the Outline of Coverage)** ☐ Yes ☐ No
- **A Consumer's Guide to Long Term Care** ☐ Yes ☐ No
- **Things You Should Know Before You Buy Long Term Care** ☐ Yes ☐ No
- **Long Term Care Insurance Personal Worksheet** ☐ Yes ☐ No
- **Notice to Applicant Regarding Replacement of Accident and Sickness, Nursing Home or Long Term Care Insurance** ☐ Yes ☐ No

7600-04

PLEASE OPEN FORM COMPLETELY BEFORE WRITING ON EACH PAGE.
FILL IN ALL SECTIONS. PROCESSING MAY BE DELAYED IF INCOMPLETE.

Applicant, answer all questions and sign.
Alterations to the pre-printed text will void this Application.

SEND ORIGINAL TO: **Unum Life Insurance Company of America**
Attn: Group Long Term Care Client Service Center
2211 Congress Street, Portland, ME 04122-2295

Policyholder's (i.e. association, employer) Name	Policyholder's ID or Policy No.

I. General Information

Your Name:

(First) (Initial) (Last)

Complete Address:

(Street/PO Box) (City) (State) (Zip Code)

Social Security Number:	Date of Birth: Month Day Year	Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Are you presently working? ☐ Yes ☐ No If yes, list occupation:	Daytime Telephone Number: ( )
Primary Physician's Name:	Date of Last Physical Exam: Month Day Year
Primary Physician's Address:	Primary Physician's Telephone Number: ( )

REJECTION OF INFLATION PROTECTION OPTION:
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 this option. ☐ Yes ☐ No

II. Statement of Health - Part 1

Do you use a:

☐ Yes ☐ No	Wheelchair	☐ Yes ☐ No	Walker	☐ Yes ☐ No	Quad Cane
☐ Yes ☐ No	Crutches	☐ Yes ☐ No	Hospital Bed	☐ Yes ☐ No	Dialysis Machine
☐ Yes ☐ No	Oxygen	☐ Yes ☐ No	Stairlift	☐ Yes ☐ No	Hover Lift

II. Statement of Health - Part 2

Do you currently need or receive help in doing any of the following:

☐ Yes ☐ No	Bathing	☐ Yes ☐ No	Eating	☐ Yes ☐ No	Dressing
☐ Yes ☐ No	Toileting	☐ Yes ☐ No	Transferring	☐ Yes ☐ No	Maintaining Continence

If you checked "Yes" to any of the questions in Part 2 above, please provide the appropriate details as requested below (include both prescribed and over the counter medications).

Physician (Name & Specialty):	Address (Street, City, State, Zip Code):
Clinic/Office Name:	Telephone Number: ( )
Condition checked in Statement of Health-Part 1 and/or Part 2:	Medication(s) you are taking for the condition:

Date you last visited this physician:

III. Medical Profile - Part 1

	Your Height: _____ Your Weight: _____
☐ Yes ☐ No	Have you had a weight gain of 10 or more pounds in the last 12 months?
☐ Yes ☐ No	Have you had a weight loss of 10 or more pounds in the last 12 months?
☐ Yes ☐ No	Was the weight change due to a medical condition?
In the next 6 months, do you plan to:	
☐ Yes ☐ No	be hospitalized?
☐ Yes ☐ No	have surgery?
☐ Yes ☐ No	have any diagnostic tests (e.g. EKG, MRI, x-ray)?
In the last 12 months, have you:	
☐ Yes ☐ No	experienced episodes of falling, fainting, dizziness or imbalance?
☐ Yes ☐ No	used tobacco products (smoked, chewed, or used a nicotine delivery system), including pipes and cigars?

In the last 36 months, have you:

☐ Yes ☐ No been advised by a physician to limit, reduce, discontinue or seek counseling for the use of alcohol or drugs?

Have you:

☐ Yes ☐ No been confined to any hospital or facility in the past 5 years?

☐ Yes ☐ No been diagnosed or treated by a member of the medical profession for AIDS or the AIDS Related Complex (ARC)?

III. Medical Profile - Part 2

Within the past five (5) years, have you been diagnosed with, treated or consulted with a licensed physician or been referred to another licensed physician for any of the following conditions?

Yes	No		Yes	No		Yes	No	
☐	☐	Alzheimer's Disease	☐	☐	Ambulation Problems	☐	☐	Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
☐	☐	Ataxia	☐	☐	Blindness	☐	☐	Cardiomyopathy
☐	☐	Catheter use	☐	☐	Cerebral Palsy	☐	☐	Chronic Obstructive Pulmonary Disease
☐	☐	Cirrhosis of the Liver	☐	☐	Confusion	☐	☐	Crohn's Disease
☐	☐	Defibrillator use	☐	☐	Dementia	☐	☐	Drug Abuse
☐	☐	Hairy Cell Leukemia	☐	☐	Hodgkin's Disease	☐	☐	Huntington's Chorea
☐	☐	Hydrocephalus	☐	☐	Incontinence, bowel or bladder	☐	☐	Memory Loss
☐	☐	Mental Retardation	☐	☐	Multiple Myeloma	☐	☐	Multiple Sclerosis
☐	☐	Muscular Dystrophy	☐	☐	Myasthenia Gravis	☐	☐	Organ Transplant (except cornea)
☐	☐	Organic Brain Syndrome	☐	☐	Ostomy	☐	☐	Paraplegia
☐	☐	Paralysis	☐	☐	Parkinson's Disease	☐	☐	Poliomyelitis (Polio)
☐	☐	Polycythemia Vera	☐	☐	Progressive Muscular Atrophy	☐	☐	Post Polio Syndrome
☐	☐	Pulmonary Fibrosis	☐	☐	Quadriplegia	☐	☐	Schizophrenia
☐	☐	Scleroderma	☐	☐	Sjogren's Syndrome	☐	☐	Systemic Lupus Erythematosis
☐	☐	Temporal Arteritis	☐	☐	Thrombocytopenia	☐	☐	Wilson's Disease

If you checked "Yes" to any of the questions in Medical Profile-Part 2 above, please provide the appropriate details as requested below (include both prescribed and over the counter medications).

Physician (Name & Specialty):	Address (Street, City, State, Zip Code):
Clinic/Office Name:	Telephone Number: ( )
Condition checked in Medical Profile-Part 2:	Medication(s) you are taking for the condition:
Date you last visited this physician:	

III. Medical Profile - Part 3

Within the past five (5) years, have you been diagnosed with, treated or consulted with a licensed physician or been referred to another licensed physician for any of the following conditions?

Yes	No		Yes	No		Yes	No	
☐	☐	Amputation	☐	☐	Anemia	☐	☐	Aneurysm
☐	☐	Angina	☐	☐	Anxiety	☐	☐	Arrhythmia/ Irregular Heart Beat
☐	☐	Arthritis	☐	☐	Asthma/ Bronchitis	☐	☐	Atrial Fibrillation
☐	☐	Back Disorder	☐	☐	Barrett's Esophagus	☐	☐	Cancer
☐	☐	Carotid Artery Disease/ Stenosis	☐	☐	Cataracts	☐	☐	Chronic Fatigue Syndrome
☐	☐	Chronic Pain	☐	☐	Colitis/Irritable Bowel Syndrome/Ulcerative Colitis	☐	☐	Congestive Heart Failure
☐	☐	Coronary Heart/Artery Disease	☐	☐	Depression	☐	☐	Diabetes
☐	☐	Emphysema	☐	☐	Endocarditis	☐	☐	Epilepsy/Seizures
☐	☐	Eye Disorders	☐	☐	Fibromyalgia	☐	☐	Fractures, including compression fractures of the spine
☐	☐	Gout	☐	☐	Head Injury	☐	☐	Heart Attack (Myocardial Infarction)
☐	☐	Hemophilia	☐	☐	Hepatitis	☐	☐	Hip Fractures/ Disorders/ Replacement
☐	☐	Hyperglycemia	☐	☐	Hypertension	☐	☐	Hypoglycemia
☐	☐	Joint Disease	☐	☐	Kidney Disease/ Renal Failure	☐	☐	Knee Replacement
☐	☐	Leukemia	☐	☐	Lymphoma	☐	☐	Neuropathy
☐	☐	Osteoarthritis	☐	☐	Osteoporosis	☐	☐	Paget's Disease of Bone
☐	☐	Pancreatitis	☐	☐	Peripheral Vascular Disease	☐	☐	Prostatic Hypertrophy, Benign (BPH)
☐	☐	Polymyalgia Rheumatica	☐	☐	Rheumatoid Arthritis	☐	☐	Sarcoidosis
☐	☐	Sleep Apnea	☐	☐	Spinal Stenosis	☐	☐	Steroid Therapy
☐	☐	Stroke/ Transient Ischemic Attack/ Cerebral Vascular Accident	☐	☐	Tic/ Tremor	☐	☐	Transient Global Amnesia
☐	☐	Thrombophlebitis/ Phlebitis	☐	☐	Valvular Heart Disease			

If you checked "Yes" to any of the questions in Medical Profile-Part 3 above, please provide the appropriate details as requested below (include both prescribed and over the counter medications).

Physician (Name & Specialty):	Address (Street, City, State, Zip Code):
Clinic/Office Name:	Telephone Number: ( )
Condition checked in Medical Profile-Part 3:	Medication(s) you are taking for the condition:
Date you last visited this physician:	

IV. Insurance History (Required by Law)

A.	☐ Yes ☐ No	Do you have another long term care insurance policy in force, including health care service contract, or health maintenance organization contract?
B.	☐ Yes ☐ No	Have you had another long term care insurance policy or certificate in force during the last 12 months? If so, with which company? _____ If it has lapsed, when did it lapse? _ _/_ _/_ _ _ _
C.	☐ Yes ☐ No	Are you covered by Medicaid (not Medicare)?
D.	☐ Yes ☐ No	Are you receiving Disability, Worker's Compensation, or Social Security Disability Benefits?
E.	☐ Yes ☐ No	Do you intend to replace any of your medical or health coverage with the coverage applied for?
F.	☐ Yes ☐ No	Have you signed a Power of Attorney authorizing another individual to manage your personal affairs?

V. Authorization to Obtain Information

I authorize any **medical related personnel or organization** to give Unum Life Insurance Company of America, or its subsidiaries or representatives, if any, any of the following:

- information about any injury or illness I have or I have had, including mental illness or drug or alcohol abuse;
- information about my medical history including any consultations, prescriptions, treatments or benefits; and
- copies of all records that may be requested concerning me.

The term **medical related personnel or organization**, which is used above, means any of the following:

- a medical professional;
- a medical care institution; or
- Medical Information Bureau

I understand that the information obtained by use of this authorization will be used by Unum Life Insurance Company of America or its subsidiaries or representatives, if any, to determine eligibility for insurance. Unum Life Insurance Company of America will not release any of the obtained information to any other person or organization except:

- reinsuring companies; or
- persons or organizations performing business or legal services in connection with my application as may be otherwise lawfully required or, as I may further authorize.

I understand that I have the right to ask for and get a copy of this authorization. I agree that a copy of this authorization will be as valid as the original and will remain valid for two and a half years from the date shown on the application.

VI. Applicant's Signature

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE MISSTATED OR UNTRUE, UNUM LIFE INSURANCE COMPANY OF AMERICA MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR INSURANCE.

X_____ Date: _____
Applicant's Signature Month Day Year

_____
Signed at (City/State)

Printed Name of Applicant: _____
(First Name) (MI) (Last Name)

Social Security Number: _____

Policy Number: _____

NOTE: The Health Insurance Policy and Accountability Act (HIPAA) requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or process your application. Please sign and return this authorization to: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory or other medically related facility or service; insurance company; insurance service provider; third party administrator; producer; and employer that has information about my health; employment; or other insurance coverage, claims and benefits to disclose any and all of this information to persons who evaluate and process applications for, Unum, Unum Life Insurance Company of America, and duly authorized representatives ("Unum"). Information about my health may relate to any disorder of the immune system including, but not limited to, AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information Unum obtains pursuant to this authorization will be used for evaluating and processing my application for coverage. I further understand that the information is subject to redisclosure and might not be protected by HIPAA.

This authorization is valid for two (2) years from the date below. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Unum has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Unum may not be able to evaluate or process my application and this may be the basis for denying my application. I may revoke this authorization by sending written notice to: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or process my application and this may be the basis for denying my application.

_____ _____
(Applicant Signature) (Date Signed)

I, _____, signed on behalf of the applicant as the applicant's Personal Representative. Please circle the type of Personal Representative: Power of Attorney Designee, Guardian, Conservator; and attach a copy of the document granting authority.

Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122