Continental Casualty Company

THE UNIVERSITY OF DAYTON

Policy #9591

CNA

Long Form Application

TIPS and GENERAL INFORMATION for completing the application

As part of our underwriting process, we may call you 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 and to answer any questions you may have about the application process. We greatly appreciate your cooperation during this process.

If any question is not answered or information not provided – we cannot process your application. Please do not hesitate to call our Customer Service Center (800) 528-4582 if we can be of assistance in completing this form.

Instructions for Sections I II III

Section I - Complete all information about you, the applicant.

Section II - Select the eligible class which applies to you. Be sure to include the employee's or retiree's name information.

Section III - Select ONE maximum daily amount and any optional benefits which you are applying for. Very Important - if you do NOT choose the Inflation Protection Options, it is required by the state that you, the applicant sign the Inflation Protection Rejection!

SECTION I - APPLICANT INFORMATION

Applicant's Name: First, Middle Initial, Last			**Social Security Number**
Date of Birth	**Sex** (M or F)	**Daytime Phone Number**	**Evening Phone Number**
Home Address: Number and Street		**City**	**State** **Zip Code**

SECTION II - ELIGIBILITY

I certify that I am:

- ☐ An employee's parent and/or parent-in-law;
- ☐ An employee's grandparent and/or grandparent-in-law;
- ☐ A retiree;
- ☐ A spouse of a retiree.

Employee/ Retiree Name	**Date of Hire/Retirement**	**Social Security Number**

SECTION III - BENEFIT SELECTION

Select *ONE* Daily Benefit Amount/ Lifetime Maximum:

- ☐ $ 80 Daily Benefit Amount / $146,000 Lifetime Maximum
- ☐ $100 Daily Benefit Amount / $182,500 Lifetime Maximum
- ☐ $120 Daily Benefit Amount / $219,000 Lifetime Maximum

Select ONE: **Non Forfeiture Benefit:**

- ☐ **Yes** *with* Return of Premium at Death *(Refer to outline of coverage for specific details)*
- ☐ **No** *without* Return of Premium at Death *(Refer to outline of coverage for specific details)*

APPLICANT'S Signature _____ **Date** _____

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Instructions for SECTION IV

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 the medical conditions listed in Question 2, be sure to check "Yes" or "No" to ***every*** *question. We cannot process your application if there are any blanks.*

Question 9 asks about 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.

SECTION IV - STATEMENT OF INSURABILITY

Height _____ **Weight** _____

	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 (7) years have you been diagnosed, received medical advise, or 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 ☐ disorientation ☐ dizziness ☐ fainting ☐ falling		
☐ unstable gait ☐ bladder control ☐ loss of appetite ☐ deterioration of vision		
4. At any time during the past 12 month 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 ☐ mobility ☐ continence ☐ eating		
☐ managing medications ☐ housekeeping ☐ preparing meals		
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		

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	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 5 years, have you received any medical advice, treatment or diagnosis for any condition other than those stated in questions two (2) through seven (7)?	☐	☐
9 Are you taking any prescription drugs? **If Yes**, please provide the name and daily dosage below.	☐	☐

Drug Name	Daily Dosage	Taken for (diagnosis or condition)	Doctor's Name

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

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

11. Please list all physicians which you have consulted or been treated by in the past five (5) years. For more details attach a separate signed and dated sheet.

Name of Doctor	Specialty	Phone Number	Address

	Yes	No
12. Does someone else hold your power of attorney? 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 recently applied for such insurance? If yes, please list all such coverage's in the space provided below. Indicate if you intend to replace any medical or health insurance coverage including health care service contract or health maintenance organization 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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Instructions for SECTIONS V VI VII

Section V - Select the method of payment which you choose. Do NOT send any money with this application. If your application is approved, you will be sent a bill based on the payment method you choose.

Section VI - Unintentional lapses of payment could result in cancellation of your long term care certificate. To help eliminate this possibility, please designate an alternate party we could notify in the event a premium payment is missed. The person you designate does NOT have the responsibility of paying your long term care premiums. It you choose NOT to designate any person, please read and sign the Declination Statement of Alternate Billing Designation below.

Section VII - Read the authorization section carefully, sign, and date. This must be signed and dated by you, the applicant.

SECTION V - PAYMENT METHOD

☐ Quarterly ☐ Semi-Annual ☐ Annual

SECTION VI - ALTERNATE BILLING DESIGNEE

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

First Designee Name: First, Middle Initial, Last	**Social Security Number**		
Home Address: Number and Street	**City**	**State**	**Zip Code**
Second Designee Name: First, Middle Initial, Last	**Social Security Number**		
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 prem is due and unpaid. I elect not to designate any person to receive such notice.

Applicant's Signature _____ Date _____

SECTION VII - AUTHORIZATION

NOTICE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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 medical 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. 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 provision in the policy.

Signature of Applicant _____ Date _____

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