Continental Casualty Company

THE UNIVERSITY OF DAYTON
Policy Number: 9591

CNA GROUP BENEFITS

Short Form Application

Tips and Reminders for Completing this Application

This application is for actively at work employees end their spouse who wishes to apply for long-term care insurance.

If the applicant is the employee *1) Complete Sections 1, II, III and V*
2) Read and Sign Sections IV and V
If the applicant is a spouse: *- Spouse 1) Complete Sections I, II, and V 2) Read and Sign Section VI*
- Employee 1) Complete Section III 2) Read and Sign Section IV

If any part of Sections I through VI is not completed, we cannot process your application.

SECTION I - APPLICANT INFORMATION

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 - BENEFIT SELECTION

Select ONE Daily Benefit Amount Lifetime Maximum Benefit:	Select ONE Non Forfeiture Benefit:
☐ $ 80 Daily Benefit Amount / $146,000 Lifetime Maximum ☐ $100 Daily Benefit Amount / $182,500 Lifetime Maximum ☐ $120 Daily Benefit Amount / $219,000 Lifetime Maximum	☐ YES - Return of Premium *(Refer to outline of coverage)* ☐ NO *without* Return of Premium *(Refer to outline of coverage)*

SECTION III - EMPLOYEE INFORMATION

Name: First, Middle Initial, Last			Social Security Number
Date of Hire	Payroll Location	Employee ID Number	Affiliate Name

SECTION IV - EMPLOYEE AUTHORIZATION

I authorize **The University of Dayton** to make payroll deductions for the above-specified coverage and release other necessary information to the administrators of this program.

EMPLOYEE'S Signature _____ Data _____

SECTION V - STATEMENT OF INSURABILITY

1) Height _____ Weight

	YES	NO
2) During the last seven (7) years have you been diagnosed, received medical advice or treatment by a member of the medical profession for any of the following	☐	☐
a. Acquired Immune Deficiency Syndrome (AIDS)) or any other immune system disorder	☐	☐
b. Alzheimer's disease, dementia, or change in cognitive functioning	☐	☐
c. Multiple Sclerosis, Huntington's disease, Parkinson's Disease, or Amyotrophic Lateral Sclerosis	☐	☐
d. Emphysema, Chronic Bronchitis, or Asthma	☐	☐
e. Internal Lupus Erythematosus or any other connective tissue disease or disorder	☐	☐
f. Cancer, which has spread or metastasized	☐	☐
g. Heart Disorder	☐	☐
h. Diabetes Mellitus, hyperglycemia, or glucose intolerance	☐	☐
i. Cerebral Vascular Accident, Stroke, or Transient Ischemic Attack	☐	☐
j. Alcoholism or Substance Abuse	☐	☐
k. Bone or joint disease or disorder requiring prescription medications or surgery	☐	☐
l. Mental, Emotional, Nervous disease or disorder, depression, or chemical imbalance	☐	☐
3) Have you used any tobacco products more than once a month at any time during the last three years?	☐	☐
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 in performing any of the daily activities of bathing, dressing, toileting, mobility, eating, or managing medications?	☐	☐
5) At any time in the last seven years have you applied for or received Social Security Disability benefits or Medicaid?	☐	☐
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 from Continental Casualty Company or have you applied for such insurance?	☐	☐
7) Do you intend to replace any medical or health insurance coverage including health care service contract or health maintenance organization with insurance applied for with this application other than Group Long Term Care from Continental Casualty Company?	☐	☐

SECTION VI - 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. [However, the insurance will not take effect unless I am actively at work as determined by my employer.]

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.

APPLICANT'S Signature _____ Date _____
Coverage is not guaranteed and is based on the information provided.