

Application for Long-Term Care MUTUAL CARE® – PENNSYLVANIA



Mutual Care®

Long-Term Care Insurance

Application Submission Checklist for Producers

*** TO PREQUALIFY YOUR APPLICANT(S), CALL 800-551-2059.**

*** AFTER COMPLETING THIS APPLICATION, YOU, THE AGENT, SHOULD CALL 866-544-1617 TO INITIATE THE PERSONAL HEALTH INTERVIEW.**

This application packet includes the application and other important forms. Detach and leave with the applicant(s) the indicated forms. The Outline(s) of Coverage and Shopper's Guide are also to be left with the applicant(s).

Return the remainder of the packet, including the fully completed application, and applicable completed forms. Unanswered questions on the application or missing or incomplete forms will result in underwriting delays as we attempt to secure the information.

If the question does not apply to your client, answer it as "No" or "None" rather than "N/A."

If the applicant answers "Yes" to any question in Section C, he/she is ineligible for coverage. Do not submit the application.

Inform the applicant(s) that we will conduct a telephone interview or face to face interview. Provide the applicant(s) a copy of "Preparing for the Health Interview."

Premium Payment with Application

If a monthly mode (Bank Draft) is selected, we recommend that you collect two months premium. If a quarterly, semi-annual or annual mode is elected, the full premium for that mode should be submitted. There is no Policy Fee. The applicant's check should be made payable to Mutual of Omaha Insurance Company. One check is acceptable for joint applicants.

ATTACHED APPENDIX FORMS

HIPAA Compliant Authorization

Sign and date the form and leave it attached to the application.

Authorization to Withdraw Funds by Mutual of Omaha Insurance Company (Monthly Bank Draft)

If using this method of payment, complete, sign and date. Payments will be deducted monthly on the date specified. Please attach a voided check or deposit slip. If not provided, account information will be taken from the accompanying premium check.

Producer Statement

Include your telephone number and e-mail address.

If someone other than you should be contacted for questions regarding the pending application, provide the name, phone number, and e-mail address of that party.

Either a Conditional Premium Receipt or Temporary Insurance Agreement and Receipt ("Agreement") is Attached to this Application

If a Conditional Premium Receipt is attached, detach and leave with applicant(s). If a Temporary Insurance Agreement and Receipt ("Agreement") is attached, submit one copy to LTC Service Office and detach and leave one copy with applicant(s).

Notice of Information Practices and Investigative Consumer Reports Notice

Detach and leave these forms with the applicant(s).

Insurance Underwritten By:
 Mutual of Omaha Insurance Company
 Mutual of Omaha Plaza
 Omaha NE 68175

Submit Application To:
 Long-Term Care Service Office
 P.O. Box 64901
 St. Paul, MN 55164-0901

Overnight Submission:
 Long-Term Care Service Office
 7805 Hudson Rd, Ste 180
 Woodbury, MN 55125-1591



Individual Long-Term Care Insurance Application

Mutual Care

- New Business
- Reinstatement

If Group or Association, List Name _____

A General Questions

Applicant A

1 Name

First Name, Middle Initial, Last Name

Male
 Female

Applicant B

1 Name

First Name, Middle Initial, Last Name

Male
 Female

2 Legal Residence Address

Number, Street, Apartment Number

City, State, ZIP Code

2 Legal Residence Address

Number, Street, Apartment Number

City, State, ZIP Code

3 Contact Information

Daytime Phone Number (____) _____ - _____

Evening Phone Number (____) _____ - _____

Best Time to Call ____ : ____ am ____ : ____ pm

E-mail Address _____

3 Contact Information

Daytime Phone Number () _____ - _____

Evening Phone Number () _____ - _____

Best Time to Call ____ : ____ am ____ : ____ pm

E-mail Address _____

4 Social Security Number

□□□□ - □□ - □□□□□□

4 Social Security Number

□□□□ - □□ - □□□□□□

5 Birth Date and Age

□□ / □□ / □□□□□□ Age □□

mm dd yyyy

5 Birth Date and Age

□□ / □□ / □□□□□□ Age □□

mm dd yyyy

6 U.S. Citizenship

Are You a citizen of the United States? Yes No

If "No," do You have a Permanent Resident Card-Form I-551 (also known as an "Alien Registration Receipt Card" or "Green Card")?

Yes. Card Number _____ and Date of Arrival in the U.S. _____

No. You are not eligible for this coverage.

6 U.S. Citizenship

Are You a citizen of the United States? Yes No

If "No," do You have a Permanent Resident Card-Form I-551 (also known as an "Alien Registration Receipt Card" or "Green Card")?

Yes. Card Number _____ and Date of Arrival in the U.S. _____

No. You are not eligible for this coverage.

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B Policy Forms/Other Coverage

1 You may be eligible for a policy with a lower rate based on Your answers to the statements in this Section B1 appearing below. Complete these statements by answering "Yes" or "No."

- a I am married and my spouse is also applying for this coverage
- b I am married and my spouse has an existing Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company long-term care policy or certificate
- If "Yes," name and policy or certificate number(s) _____
- c I am married and my spouse is not applying for this coverage.....
- d I am single and have continuously resided with another person for the last 12 months and they are also applying for this coverage.....
- e I have or I am applying for a medicare supplement policy or certificate with Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company or United World Life Insurance Company ...
- If "Yes," policy or certificate number(s) if known _____
- f I am a member of an association endorsing this long-term care product
- If "Yes," complete Association Sales Appendix.

| Applicant A | | Applicant B | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| / / | | / / | |
| mm dd yyyy | | mm dd yyyy | |

2 Provide Other Coverage Information. If "Yes" is answered to any of the following questions, provide coverage details below.

- a Do You currently have another long-term care policy or certificate in force (including health care service contracts or health maintenance organization contracts)?
- b Did You have another long-term care policy or certificate in force during the last 12 months?.....
- c Do You intend to replace other long-term care coverage or any of Your medical or health insurance coverage with this policy?.....

If "Yes,":

- (1) Requested Effective Date of Coverage (up to 60 days from application date If issued, coverage will be effective on the date indicated), and
- (2) Please read and sign the Notice to Applicant Regarding Replacement form included with this application.

| Applicant Name | Company Name | Policy/Certificate # | Plan Type | Daily Benefit | Annual Premium | Lapse Date |
|----------------|--------------|----------------------|-----------|---------------|----------------|------------|
| | | | | | | |
| | | | | | | |
| | | | | | | |

- d Producer(s) shall list all health insurance policies You have which are still in force _____ or None
- Producer(s) shall list all health insurance policies they sold to You in the past five years, which are no longer in force _____ or None
- Producer(s) shall list all health policies they sold to You which are still in force _____ or None

- e Have You ever been declined, rated, or denied reinstatement for long-term care insurance?.....
- If "Yes," provide details below

| Applicant Name | Company Name | When | Why |
|----------------|--------------|------|-----|
| | | | |
| | | | |

- f Are You currently eligible for benefits under, or covered by, Medicaid (not Medicare), disability income, worker's compensation, social security disability or any federal or state disability plan? ...
- If you are eligible or covered by Medicaid you may not need to purchase this coverage since it may provide duplicate benefits.

| Yes | No | Yes | No |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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C Health Insurability Questions

If “Yes” is answered to any of the questions 1-6 of this Section C, do not continue. We will be unable to accept this application or offer You Long-Term Care Insurance.

Applicant A Applicant B

Yes No Yes No

1 Do You currently use any of the following:
 • wheelchair • walker • nebulizer • electric scooter • quad cane • oxygen

2 Within the past 6 months have You been confined to, or been medically advised to have, any of the following
 • residential care, assisted living, or adult day care facility
 • nursing home or home health care services
 • physical, occupational or speech therapy

3 Do You require the assistance or supervision of another person or a device of any kind for any of the following:
 • bathing • toileting • dressing • eating • medication management
 • getting in and out of a chair or bed • Your inability to control Your bowel or bladder

4 In the past 2 years have You been medically diagnosed as having or received medical advice or medical care from a physician or health care provider for any of the following
 • Cancer (except basal or squamous cell skin cancers; Stage I/A breast, bladder, prostate or thyroid cancers)
 • Stroke

5 Have You ever had, been medically diagnosed as having, or received medical advice or medical care from a physician or health care provider for, any of the following:.....

- Alzheimer’s Disease • Amyotrophic Lateral Sclerosis (ALS) • Chronic Hepatitis
- Dementia • Huntington’s Chorea • Cirrhosis
- Memory Loss • Kidney Failure or received Dialysis • Myasthenia Gravis
- Mental Retardation • Parkinson’s Disease • Paralysis
- Schizophrenia • Multiple Sclerosis • Scleroderma
- Psychosis • Muscular Dystrophy • Systemic Lupus
- Stroke or Transient Ischemic Attack (TIA) with residuals • Organ Transplant
- Two or more Strokes or TIAs
- Chronic Obstructive Pulmonary Disease (COPD), Emphysema or Chronic Bronchitis and have used tobacco in the past 12 months
- Diabetes in combination with a Stroke, TIA, or diabetic complications, or are You currently taking more than 50 units of insulin daily

6 Have You been medically diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic)?

D Medication Information

Are You taking or have You taken any prescription medications within the past 12 months, or are You currently taking any over-the-counter medication(s) on a daily or weekly basis?

If “Yes” is answered below, please list the medication name(s) using pharmacy label, dosage/frequency and reason prescribed.

Applicant A Yes No

| |
|--|
| |
| |
| |
| |
| |
| |
| |
| |

Medication Name
Dosage/Frequency
Disease/Disorder/Condition

Medication Name
Dosage/Frequency
Disease/Disorder/Condition

Medication Name
Dosage/Frequency
Disease/Disorder/Condition

Medication Name
Dosage/Frequency
Disease/Disorder/Condition

Medication Name
Dosage/Frequency
Disease/Disorder/Condition

Medication Name
Dosage/Frequency
Disease/Disorder/Condition

Medication Name
Dosage/Frequency
Disease/Disorder/Condition

Applicant B Yes No

| |
|--|
| |
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| |
| |

E Primary Care Physician Information

Provide the name, complete address and phone number of Your Primary Care Physician.

| |
|--|
| |
|--|

Primary Care Physician
Address
City, State, ZIP
Phone Number
Date & Reason for Last Visit

| |
|--|
| |
|--|

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F Additional Health Questions

Applicant A

1

Height: _____ Weight: _____

2 Do You have, or have You ever received any medical advice or treatment from a physician or health care provider for, any of the following conditions? (Check below all that apply):

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol or Drug Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia or Blood Disease/Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, Bone or Joint Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Balance Disorder or Difficulty Walking |
| <input type="checkbox"/> | <input type="checkbox"/> | Bowel or Bladder Disease/Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Broken Bones |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Circulatory Disease/Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression/Other Mental Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness or Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Falls |
| <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease/Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Immune System Disease/Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney or Liver Disease/Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurological Disease/Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Disease/Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures, Epilepsy, Tremors |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke or Transient Ischemic Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness or Fatigue |

Applicant B

1

Height: _____ Weight: _____

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol or Drug Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia or Blood Disease/Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, Bone or Joint Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Balance Disorder or Difficulty Walking |
| <input type="checkbox"/> | <input type="checkbox"/> | Bowel or Bladder Disease/Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Broken Bones |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Circulatory Disease/Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression/Other Mental Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness or Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Falls |
| <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease/Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Immune System Disease/Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney or Liver Disease/Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurological Disease/Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Disease/Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures, Epilepsy, Tremors |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke or Transient Ischemic Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness or Fatigue |

- 3** Have You received inpatient or outpatient treatment at a hospital, surgical center or rehabilitation facility in the past 12 months?
- 4** Are You scheduled for, or have You been medically advised by a physician or health care provider to have additional testing, surgery or consultation(s) to evaluate Your health?
- 5** Are there any pending test results which You have not yet received?.....
- 6** Have You been seen by Your physician, health care provider or any specialist more than three times in the past 12 months?.....
- 7** Do You have, for Your use, a handicap sticker or handicap license plate?
- 8** Have You used tobacco in any form in the past 2 years?

| Applicant A | | Applicant B | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

F Additional Health Questions (continued)

9 If You checked a condition or answered “Yes” to any health questions in this Section F, please provide the following information for each:

Applicant A

| Disease/Disorder/Condition | Date of Occurrence | Date of Last Visit | Physician/Facility Information |
|----------------------------|--------------------|--------------------|--------------------------------|
| | | | Name Address Phone # |
| | | | Name Address Phone # |
| | | | Name Address Phone # |
| | | | Name Address Phone # |
| | | | Name Address Phone # |

Applicant B

| Disease/Disorder/Condition | Date of Occurrence | Date of Last Visit | Physician/Facility Information |
|----------------------------|--------------------|--------------------|--------------------------------|
| | | | Name Address Phone # |
| | | | Name Address Phone # |
| | | | Name Address Phone # |
| | | | Name Address Phone # |
| | | | Name Address Phone # |

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**Long-Term Care – Mutual Care
One Maximum Benefit
Tax Qualified Only**

IN 1 BELOW SELECT EITHER MUTUAL CARE 3 OR MUTUAL CARE 5. YOU CAN SUBSTITUTE ONE OR MORE BENEFITS CONTAINED IN EITHER PACKAGE BY CHOOSING FROM THE DIFFERENT BENEFITS LISTED IN 2 AND/OR 3 BELOW. COMPLETE 2 BELOW IF YOU WANT TO CHANGE THE \$100 MAXIMUM DAILY BENEFIT (MDB) TO A DIFFERENT MAXIMUM DAILY BENEFIT (MDB). COMPLETE 3 BELOW IF YOU WANT TO CHANGE THE 1) 100% OF THE MDB FOR ASSISTED LIVING FACILITY/100% OF THE MDB FOR HOME HEALTH CARE AND/OR 2) 5% SIMPLE INFLATION PROTECTION – LIFETIME BENEFIT.* COMPLETE 4 BELOW IF YOU WANT TO ADD THE OPTIONAL BENEFIT(S) SHOWN.**

Applicant A

1 Select Mutual Care 3 or Mutual Care 5:

- Mutual Care 3**
Three (3) Year Benefit Period***
\$100 Maximum Daily Benefit (MDB)
100% of the MDB for Assisted Living Facility/
100% of the MDB for Home Health Care
90 Day Elimination Period
5% Simple Inflation Protection – (Lifetime)*
- Mutual Care 5**
Five (5) Year Benefit Period***
\$100 Maximum Daily Benefit (MDB)
100% of the MDB for Assisted Living Facility/
100% of the MDB for Home Health Care
90 Day Elimination Period
5% Simple Inflation Protection – (Lifetime)*

2 I want to change my \$100 Maximum Daily Benefit (MDB) to (select one):

- \$125 Maximum Daily Benefit
- \$150 Maximum Daily Benefit
- \$175 Maximum Daily Benefit
- \$200 Maximum Daily Benefit
- \$250 Maximum Daily Benefit
- \$300 Maximum Daily Benefit

3 I want to change my Package Benefit(s) as shown below (select the Benefit(s) You wish to apply for):

- 50% of the MDB for Assisted Living Facility/
50% of the MDB for Home Health Care
- No Inflation Protection Benefit
- 5% Compound Inflation Protection (Lifetime)*

4 I want to add Optional Benefit(s) as shown below (select the Benefit(s) You wish to apply for):

- Spouse Shared Benefit (Please refer to the outline regarding limitations)
- Nonforfeiture Benefit – Shortened Benefit Period**

Applicant B

1 Select Mutual Care 3 or Mutual Care 5:

- Mutual Care 3**
Three (3) Year Benefit Period***
\$100 Maximum Daily Benefit (MDB)
100% of the MDB for Assisted Living Facility/
100% of the MDB for Home Health Care
90 Day Elimination Period
5% Simple Inflation Protection – (Lifetime)*
- Mutual Care 5**
Five (5) Year Benefit Period***
\$100 Maximum Daily Benefit (MDB)
100% of the MDB for Assisted Living Facility/
100% of the MDB for Home Health Care
90 Day Elimination Period
5% Simple Inflation Protection – (Lifetime)*

2 I want to change my \$100 Maximum Daily Benefit (MDB) to (select one):

- \$125 Maximum Daily Benefit
- \$150 Maximum Daily Benefit
- \$175 Maximum Daily Benefit
- \$200 Maximum Daily Benefit
- \$250 Maximum Daily Benefit
- \$300 Maximum Daily Benefit

3 I want to change my Package Benefit(s) as shown below (select the Benefit(s) You wish to apply for):

- 50% of the MDB for Assisted Living Facility/
50% of the MDB for Home Health Care
- No Inflation Protection Benefit
- 5% Compound Inflation Protection (Lifetime)*

4 I want to add Optional Benefit(s) as shown below (select the Benefit(s) You wish to apply for):

- Spouse Shared Benefit (Please refer to the outline regarding limitations)
- Nonforfeiture Benefit – Shortened Benefit Period**

*** YOU HAVE THE OPTION TO PURCHASE THE 5% COMPOUND INFLATION PROTECTION (LIFETIME) BENEFIT. IF YOU DO NOT WANT TO PURCHASE THIS BENEFIT, COMPLETE SECTION K1 OF THIS APPLICATION. YOU ARE NOT REQUIRED TO PURCHASE AN INFLATION PROTECTION BENEFIT (SEE SECTION 3 ABOVE).**

**** REQUIRED OFFER - COMPLETE SECTION K2 IF THE NONFORFEITURE BENEFIT – SHORTENED BENEFIT PERIOD OPTION IS REJECTED.**
***** MAXIMUM LIFETIME BENEFIT AMOUNT = THE MAXIMUM DAILY BENEFIT (MDB) x APPLICABLE YEARLY BENEFIT PERIOD (3 OR 5) x 365.**

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H Beneficiary Information

Applicant A

Provide Beneficiary Name

First Name, Middle Initial, Last Name

Street Address, Apartment Number

City, State, ZIP Code

Relationship to You

Applicant B

Provide Beneficiary Name

First Name, Middle Initial, Last Name

Street Address, Apartment Number

City, State, ZIP Code

Relationship to You

I Mode and Premium Information

Applicant A

1 Payment Mode: Select one of the following

- Annual
- Semiannual
- Quarterly
- Monthly Bank Draft
- Employee Paid - Payroll Deduction
- Employer Paid – List Bill

Payroll Location for Employee or Employer Paid mode:

City, State

2 Premium Amount and Billing Information

Modal Premium: \$ _____

Premium Collected: \$ _____

Billing Address for Premium Notices (if different from page 1):

Street Address, Apartment Number

City, State, ZIP Code

Applicant B

1 Payment Mode: Select one of the following

- Annual
- Semiannual
- Quarterly
- Monthly Bank Draft
- Employee Paid - Payroll Deduction
- Employer Paid – List Bill

Payroll Location for Employee or Employer Paid mode:

City, State

2 Premium Amount and Billing Information

Modal Premium: \$ _____

Premium Collected: \$ _____

Billing Address for Premium Notices (if different from page 1):

Street Address, Apartment Number

City, State, ZIP Code

J Notice Before Lapse or Termination

Please check the applicable box and complete the requested information. You may want to consider designating someone other than a spouse.

Applicant A

Select one:

- I wish to designate an additional person to receive notice of lapse or termination of the policy due to nonpayment of premium.

Name (Print full name of other person to receive notice of lapse or termination)

Street Address

City, State, ZIP Code

Protection against unintended lapse. I, Applicant A and Applicant B, 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 policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

OR

- I elect NOT to designate any person to receive such notice.

The Designee is not responsible for payment of the premium.

Applicant B

Select one:

- I wish to designate an additional person to receive notice of lapse or termination of the policy due to nonpayment of premium.

Name (Print full name of other person to receive notice of lapse or termination)

Street Address

City, State, ZIP Code

OR

- I elect NOT to designate any person to receive such notice.

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K Agreements and Acknowledgements

1 PLEASE READ AND CHECK BOX IF 5% COMPOUND INFLATION PROTECTION (LIFETIME) IS NOT DESIRED:

I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection (Lifetime) option. Specifically, I have reviewed options for Compound and Simple Inflation increases, and I reject the 5% Compound Inflation Protection (Lifetime) option. If I purchase another inflation protection option that is offered, that option will be included as part of my policy, as shown on the Policy Schedule/ Schedule of Benefits.

Applicant A

Applicant B

I reject the 5% Compound Inflation Protection (Lifetime).

2 PLEASE READ AND CHECK BOX IF NONFORFEITURE BENEFIT IS NOT DESIRED:

I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that has been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.

Applicant A

Applicant B

I reject the Nonforfeiture Benefit – Shortened Benefit Period option.

3 Agreement – I, the undersigned, and the undersigned Producer(s), agree that (a) all answers in this application are true and complete and Mutual of Omaha Insurance Company will rely upon these answers to determine insurability, and (b) incorrect or misleading answers may void this application and any policy issued from its effective date.

If the full initial premium is paid on the date of the completed application and I am eligible for the insurance policy applied for, in accordance with the health and accident underwriting standards of Mutual of Omaha Insurance Company in effect on the date of the application, the effective date of the policy will be the date of the application, or, if later, the expiration of any replaced coverage.

The underwriting standards of Mutual of Omaha Insurance Company will not be applied to changes in health after the application date unless a medical examination (including a personal health interview) or medical test is required. In order for the policy applied for to be issued, all required medical examinations and tests must be completed, and Mutual must receive the reports from all required medical examinations and tests, and any other information (such as an Attending Physician’s Statement) that is requested. If all of these requirements are met, the underwriting standards of Mutual of Omaha Insurance Company will not apply to changes in health after the application date. **If I am not eligible for the insurance applied for or any substitute policy, I agree that no policy of any kind will be in effect, except for coverage provided by any Temporary Insurance Agreement.**

No Producer can: (a) waive or change any receipt or policy provision or (b) agree to issue a policy.

I acknowledge receipt of an Outline of Coverage, Shopper’s Guide to Long-Term Care Insurance, Potential Rate Increase Disclosure Form and if applicable, Guide to Health Insurance for People with Medicare.

Your signature below confirms, as of the date shown below: Your request for coverage; Your right to designate a contact person to receive notice of policy lapse or termination; and Your election or rejection of the 5% Compound Protection (Lifetime) option and Nonforfeiture Benefit – Shortened Benefit Period option.

FRAUD WARNING – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Caution: If Your answers on this application are incorrect or untrue, Mutual of Omaha Insurance Company has the right to deny benefits or rescind Your policy.

I have read and understand the Agreement Section, including the Fraud Warning Statement, and the Temporary Insurance Agreement and Receipt (“Agreement”), if one was delivered, and I approve all my answers as recorded in this application.

Signed at _____
City State

Signed at _____
City State

X _____
Signature of Applicant A Date (Mo/Day/Year)

X _____
Signature of Applicant B Date (Mo/Day/Year)

I/We, the Producer(s) have asked each question exactly as written and I/We have recorded the answers provided by the Applicant(s) completely and accurately.

Yes No (If “No,” please explain) _____

X _____
Signature of Licensed Producer(s)

SUBMIT TO LTC SERVICE OFFICE

Meanings of Terms

“Medical Persons and Entities” means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

“Personal Information” means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes.

“Psychotherapy Notes” means: notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person’s medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

“Specified Companies” means:

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, Exclusive Healthcare, Inc., additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me to Mutual of Omaha Insurance Company.

Purposes

The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with claims for insurance benefits.

Potential for Rediscovery

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

Failure to Sign

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

ATTN: Individual Underwriting
Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175-0001

I realize that my right to revoke this authorization is limited to the extent that Mutual of Omaha Insurance Company has taken action in reliance on the authorization or the law allows Mutual of Omaha Insurance Company to contest the issuance of the policy or a claim under the policy.

Copy

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

Names and Signatures

Name(s) used for medical records (if different than the name(s) below): _____

Printed Name of Applicant A

X _____
Signature of Applicant A

Date

Printed Name of Applicant B

X _____
Signature of Applicant B

Date

**THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS
SUBMIT TO LTC SERVICE OFFICE**

Appendix 2 Authorization to Withdraw Funds by Mutual of Omaha Insurance Company

Applicant A

Specify the date premiums will be withdrawn

(1st through the 28th of the month): _____
Withdrawals made on a monthly basis.

Routing Number

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

Account Number

| | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

Requires check with application or voided check from the account where premiums will be withdrawn.

Authorization to Withdraw Funds by Mutual of Omaha Insurance Company

I authorize renewal premiums for this coverage to be automatically paid, by electronic fund transfer, from my bank account identified above to Mutual of Omaha Insurance Company. I understand and agree that these automatic withdrawals from my bank account for premium payments will continue until this authorization is cancelled in writing.

Date _____

X _____
Authorized Signature as Shown on Account

Applicant B

Specify the date premiums will be withdrawn

(1st through the 28th of the month): _____
Withdrawals made on a monthly basis.

Routing Number

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

Account Number

| | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

Requires check with application or voided check from the account where premiums will be withdrawn.

Authorization to Withdraw Funds by Mutual of Omaha Insurance Company

I authorize renewal premiums for this coverage to be automatically paid, by electronic fund transfer, from my bank account identified above to Mutual of Omaha Insurance Company. I understand and agree that these automatic withdrawals from my bank account for premium payments will continue until this authorization is cancelled in writing.

Date _____

X _____
Authorized Signature as Shown on Account

Appendix 3 Employee/Employer Sale

Employer Information (if employer sponsored):

Applicant A

Company Name _____

Name of Owner/President _____

Company Address _____

City, State, ZIP Code _____

Service Group Number _____

I am a/an:

- Full Time Employee Part Time Employee Retiree
 Spouse of Employee (fill in employee name below)
 Other Qualifying Family Member (fill in employee name below)

Applicant B

Company Name _____

Name of Owner/President _____

Company Address _____

City, State, ZIP Code _____

Service Group Number _____

I am a/an:

- Full Time Employee Part Time Employee Retiree
 Spouse of Employee (fill in employee name below)
 Other Qualifying Family Member (fill in employee name below)

Appendix 4 Association Sales

Association Information: Complete if affiliated with an endorsed association

Applicant A

Full Name of Organization (no abbreviations):

Association Service Group Number _____

I am the:

- Member Spouse of Member
 Other Qualifying Family Member (Adult children age 18 and older, Parent and/or Parent-in-Law)

Name of Association Member _____

Applicant B

Full Name of Organization (no abbreviations):

Association Service Group Number _____

I am the:

- Member Spouse of Member
 Other Qualifying Family Member (Adult children age 18 and older, Parent and/or Parent-in-Law)

Name of Association Member _____

Appendix 5 Producer Statement

Yes No

1 I/We certify that the Notice of Information Practices and Investigative Consumer Reports Notice were given to the Applicant(s)

2 I/We certify that each question was asked exactly as written and that I/we recorded the answers completely and accurately in the presence of the Applicant(s).....
(If "No," explain) _____

3 To the best of my knowledge, replacement of other insurance is is not involved in this transaction. If replacement is involved, I/We shall comply with all state and/or Company replacement requirements, including completing the applicable state required replacement forms and submitting copies of these forms with the application.

Yes No

4 This coverage is written on myself (the producer) and/or my spouse.....

Date _____ Signature of Producer **X** _____
(Agent of Record)

Date _____ Signature of Producer **X** _____

Producer Information (please print clearly)

For Brokerage Only: Commission Code

| | |
|--|--|
| | |
|--|--|

 951300

(Examples:

| | |
|---|---|
| 8 | 8 |
|---|---|

 ,

| | |
|---|---|
| A | 2 |
|---|---|

 , etc. – Commission code available from your marketing organization.)

Producer's Name _____ Social Security No. _____
(Agent of Record)

Comm. % Share _____ Producer's Phone No. (_____) _____

Producer's E-mail Address _____

Producer's Identification # _____

Producer's Name _____ Social Security No. _____

Comm. % Share _____ Producer's Phone No. (_____) _____

Producer's E-mail Address _____

Producer's Identification # _____

Who should we contact with questions regarding this application:

Name _____

Phone Number (_____) _____

E-Mail _____

Appendix 6 Temporary Insurance Agreement and Receipt ("Agreement")

All Checks for Premiums Must be Made Payable to Mutual of Omaha Insurance Company

Do Not Make Checks Payable to the Producer or Leave the Payee Blank.

One check is acceptable for joint applicants.

Mutual of Omaha Insurance Company, Long-Term Care Service Office, P.O. Box 64901, St. Paul, MN 55164-0901

Policy form (rider) applied for LTC0417

| | |
|---|---|
| In consideration of the application and payment of \$ _____ by Applicant A , receipt of which is hereby acknowledged, Mutual of Omaha Insurance Company agrees to provide limited temporary long-term care insurance for Applicant A , subject to the following conditions and limitations: | In consideration of the application and payment of \$ _____ by Applicant B , receipt of which is hereby acknowledged, Mutual of Omaha Insurance Company agrees to provide limited temporary long-term care insurance for Applicant B , subject to the following conditions and limitations: |
|---|---|

Total Premium \$ _____

- 1 The temporary insurance provided by this Agreement will begin at 12:01 a.m., where the Applicant(s) live(s), on the latest of these dates:
 - (a) The date the above sum is received; or
 - (b) The date the application is signed by the Producer(s) and Applicant(s); or
 - (c) The date this Agreement is signed by the Producer(s) and Applicant(s).
- 2 The temporary insurance provided by this Agreement will **automatically terminate** at 12:01 a.m., where the Applicant(s) live(s), on the earliest of the following dates:
 - (a) 90 days from the date of this Agreement; or
 - (b) the date that insurance takes effect under the policy applied for; or
 - (c) the date a policy, other than as applied for, is offered by a Producer to the Applicant(s); or
 - (d) the date Mutual of Omaha Insurance Company mails the premium refund and letter informing the Applicant(s) that the policy applied for will not be issued; or
 - (e) the date Mutual of Omaha Insurance Company mails notice of termination of this Agreement to the Applicant(s).
- 3 The temporary insurance provided by this Agreement is subject to the provisions of the policy form applied for and accepted for issuance in this state, and has the same benefits as such policy form and series.
- 4 **No insurance exists under this Agreement for any health conditions for which there was diagnosis, treatment or consultation within one year prior to the date this Agreement begins.**
- 5 **In no event will benefits be paid for the same loss under both this Agreement and any policy issued from the application.**
- 6 If any of the answers to the questions on the application given by the Applicant(s) are incorrect or misleading, then this Agreement is void as to that Applicant and never went into effect.

This Agreement does not limit Mutual of Omaha Insurance Company in applying its underwriting standards to the application, nor does the Agreement limit or waive any rights under any policy issued. If the application of the Applicant(s) is rejected by Mutual of Omaha Insurance Company, the amount paid with the application for that Applicant will be refunded to the Applicant(s) regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the Producer(s).

I have read and received a copy of this Agreement and understand and agree to all of its terms.

Signed this _____ day of _____, _____ at _____ State _____ Zip Code
Month Year City

X _____ **X** _____ Please print name
Producer's Signature Applicant A Signature

X _____
Producer's Signature

| | | |
|---|--|---|
| Signed this _____ day of _____, _____ at _____ State _____ Zip Code <small>Month Year City</small> | | |
| X _____ <small>Producer's Signature</small> | X _____ <small>Applicant B Signature</small> | _____ <small>Please print name</small> |
| X _____ <small>Producer's Signature</small> | | |

SUBMIT TO LTC SERVICE OFFICE

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Appendix 6 Temporary Insurance Agreement and Receipt ("Agreement")

All Checks for Premiums Must be Made Payable to Mutual of Omaha Insurance Company

Do Not Make Checks Payable to the Producer or Leave the Payee Blank.

One check is acceptable for joint applicants.

Mutual of Omaha Insurance Company, Long-Term Care Service Office, P.O. Box 64901, St. Paul, MN 55164-0901

Policy form (rider) applied for LTC0417

| | |
|---|---|
| In consideration of the application and payment of \$ _____ by Applicant A , receipt of which is hereby acknowledged, Mutual of Omaha Insurance Company agrees to provide limited temporary long-term care insurance for Applicant A , subject to the following conditions and limitations: | In consideration of the application and payment of \$ _____ by Applicant B , receipt of which is hereby acknowledged, Mutual of Omaha Insurance Company agrees to provide limited temporary long-term care insurance for Applicant B , subject to the following conditions and limitations: |
|---|---|

Total Premium \$ _____

- 1 The temporary insurance provided by this Agreement will begin at 12:01 a.m., where the Applicant(s) live(s), on the latest of these dates:
 - (a) The date the above sum is received; or
 - (b) The date the application is signed by the Producer(s) and Applicant(s); or
 - (c) The date this Agreement is signed by the Producer(s) and Applicant(s).
- 2 The temporary insurance provided by this Agreement will **automatically terminate** at 12:01 a.m., where the Applicant(s) live(s), on the earliest of the following dates:
 - (a) 90 days from the date of this Agreement; or
 - (b) the date that insurance takes effect under the policy applied for; or
 - (c) the date a policy, other than as applied for, is offered by a Producer to the Applicant(s); or
 - (d) the date Mutual of Omaha Insurance Company mails the premium refund and letter informing the Applicant(s) that the policy applied for will not be issued; or
 - (e) the date Mutual of Omaha Insurance Company mails notice of termination of this Agreement to the Applicant(s).
- 3 The temporary insurance provided by this Agreement is subject to the provisions of the policy form applied for and accepted for issuance in this state, and has the same benefits as such policy form and series.
- 4 **No insurance exists under this Agreement for any health conditions for which there was diagnosis, treatment or consultation within one year prior to the date this Agreement begins.**
- 5 **In no event will benefits be paid for the same loss under both this Agreement and any policy issued from the application.**
- 6 If any of the answers to the questions on the application given by the Applicant(s) are incorrect or misleading, then this Agreement is void as to that Applicant and never went into effect.

This Agreement does not limit Mutual of Omaha Insurance Company in applying its underwriting standards to the application, nor does the Agreement limit or waive any rights under any policy issued. If the application of the Applicant(s) is rejected by Mutual of Omaha Insurance Company, the amount paid with the application for that Applicant will be refunded to the Applicant(s) regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the Producer(s).

I have read and received a copy of this Agreement and understand and agree to all of its terms.

Signed this _____ day of _____, _____ at _____ State _____ Zip Code
Month Year City

X _____ **X** _____ Please print name
Producer's Signature Applicant A Signature

X _____
Producer's Signature

Signed this _____ day of _____, _____ at _____ State _____ Zip Code
Month Year City

X _____ **X** _____ Please print name
Producer's Signature Applicant B Signature

X _____
Producer's Signature

LEAVE THIS PAGE WITH APPLICANT(S)

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Appendix 7 Company Notice of Information Practices

In the course of properly underwriting and administering Your insurance coverage, we will rely heavily on information provided by You. We may also collect information from others, such as medical professionals who have treated You, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release Your personal or privileged information in our/their files, to third parties without Your authorization. You have the right to be told about and to see a copy of items of personal information about You which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information You believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which You apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge You to review Your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: MUTUAL OF OMAHA INSURANCE COMPANY, LONG-TERM CARE SERVICE OFFICE, P.O. BOX 64901, ST. PAUL, MN 55164-0901.

Appendix 8 Investigative Consumer Reports Notice

Mutual of Omaha Insurance Company (“we”) may request that an investigative consumer report be prepared, whereby information about You is obtained through personal interviews with Your neighbors, friends, associates, acquaintances or others who may have knowledge relating to Your character, general reputation, personal characteristics, or mode of living. Upon request, we will inform You whether an investigative consumer report was done, and the nature and scope of the investigation. You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it. We will provide You the name, address and telephone number of the consumer reporting agency so that You may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

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MUTUAL CARE® LONG-TERM CARE INSURANCE

Personal Worksheet

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, Nebraska 68175

People buy long-term care insurance for many reasons. Some do not want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By Pennsylvania law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Number(s) LTC04I7 Type of Policy: Guaranteed Renewable

Applicant A

The premium for the coverage you are considering will be \$_____ per month, or \$_____ per year.

Applicant B

The premium for the coverage you are considering will be \$_____ per month, or \$_____ per year.

The Company's Right to Increase Premiums

The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History

The company has sold long-term care insurance since 1987 and has sold this policy form since 2006. The company has not raised its premium rates on this policy form, but has on similar policy forms. The following is a summary of the rate increases for comprehensive coverage that the company has sold.

| Policy Form* | Years Available for Purchase | Rate History |
|--------------|------------------------------|--------------------------------|
| NH23/NH24 | 1987 - 1993 | No Rate Increase |
| LTC1/LTM1 | 1992 - 1997 | No Rate Increase |
| LT50/NH50 | 1997 - 2004 | No Rate Increase |
| NHA/LTA/HCA | 1998 - 2004 | 23% overall rate increase 2003 |
| LTC04 | 2004 - Present | No Rate Increase |
| LTC04I7 | 2006 - Present | No Rate Increase |

The rate increases listed above represent the overall comprehensive rate increases filed nationally in 2003. The availability, rate increase amounts, and dates of approvals vary by state.

*Or state equivalent.

Questions Related to Your Income

Applicant A

How will you pay each year's premium? (Check one)

- From my Income
 From my Savings/Investments
 My Family will Pay

Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What is your annual income? (Check one)

- Under \$10,000 \$30-50,000
 \$10-15,999 Over \$50,000
 \$16-29,999

How do you expect your income to change over the next 10 years? (Check one)

- No Change Increase Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Applicant A

Will you buy inflation protection? (Check one)

- Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? (Check one)

- From my Income
 From my Savings/Investments
 My Family will Pay

The national average annual cost of nursing home care in 2005 was \$66,153, but this figure varies across the country. In ten years the national average annual cost would be about \$107,756 if costs increase 5% annually.

Applicant A

What elimination period are you considering?

Number of days _____

Approximate cost \$_____ for that period of care.

How are you planning to pay for your care during the elimination period? (Check one)

- From my Income
 From my Savings/Investments
 My Family will Pay

Applicant B

How will you pay each year's premium? (Check one)

- From my Income
 From my Savings/Investments
 My Family will Pay

Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What is your annual income? (Check one)

- Under \$10,000 \$30-50,000
 \$10-15,999 Over \$50,000
 \$16-29,999

How do you expect your income to change over the next 10 years? (Check one)

- No Change Increase Decrease

Applicant B

Will you buy inflation protection? (Check one)

- Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? (Check one)

- From my Income
 From my Savings/Investments
 My Family will Pay

Applicant B

What elimination period are you considering?

Number of days _____

Approximate cost \$_____ for that period of care.

How are you planning to pay for your care during the elimination period? (Check one)

- From my Income
 From my Savings/Investments
 My Family will Pay

Questions Related to Your Savings and Investments

Applicant A

Not counting your home, about how much are all your assets (your savings and investments) worth? (Check one)

- Under \$20,000 \$30,000-\$50,000
 \$20,000-\$30,000 Over \$50,000

How do you expect your assets to change over the next 10 years? (Check one)

- Stay about the same Increase Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

Applicant B

Not counting your home, about how much are all your assets (your savings and investments) worth? (Check one)

- Under \$20,000 \$30,000-\$50,000
 \$20,000-\$30,000 Over \$50,000

How do you expect your assets to change over the next 10 years? (Check one)

- Stay about the same Increase Decrease

Disclosure Statement

Applicant A

(Check one)

The answers to the questions on this Personal Worksheet describe my financial situation.

or

I choose not to complete this information. (Please also sign Authorization to Process when Choosing NOT to Disclose)

(This box must be checked)

I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**

Signed: X _____ (Applicant A)

Date: _____

Applicant B

(Check one)

The answers to the questions on this Personal Worksheet describe my financial situation.

or

I choose not to complete this information. (Please also sign Authorization to Process when Choosing NOT to Disclose)

(This box must be checked)

I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**

Signed: X _____ (Applicant B)

Date: _____

I explained to the applicant(s) the importance of completing this information.

Signed: X _____ (Producer) _____ (Date)

Producer's Printed Name: _____

Applicant A

My producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: X _____ (Applicant A)

Date: _____

Applicant B

My producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: X _____ (Applicant B)

Date: _____

The company may contact you to verify your answers.

Authorization to Process when Choosing NOT to Disclose

Applicant A

I hereby confirm that I elect not to complete the Long-Term Care Insurance Personal Worksheet. However, I request that you continue to process my application for Long-Term Care Insurance coverage.

Signed: X _____ (Applicant A)

Date: _____

Applicant B

I hereby confirm that I elect not to complete the Long-Term Care Insurance Personal Worksheet. However, I request that you continue to process my application for Long-Term Care Insurance coverage.

Signed: X _____ (Applicant B)

Date: _____

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MUTUAL CARE[®]

LONG-TERM CARE INSURANCE

Potential Rate Increase Disclosure Form

1. **Premium Rate:** Premium rate that is applicable to you and that will be in effect until a request is made and approved for an increase is: Applicant A \$ _____
Applicant B \$ _____

2. **The premium for this policy will be shown on the schedule page of your policy.**

3. **Rate Schedule Adjustments:**

The premium rates for this policy may change. Any change will be effective on the next billing date after the company has provided you at least 60 days written notice before we change premiums.

4. **Potential Rate Revisions:**

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rate can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)

- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter. Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual

premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).

- Your “paid-up” policy benefits are \$10,000 (provided you have at least \$10,000 of benefits remaining under your policy).

**CONTINGENT NONFORFEITURE
CUMULATIVE PREMIUM INCREASE OVER INITIAL PREMIUM
THAT QUALIFIES FOR CONTINGENT NONFORFEITURE**

(Percentage increase is cumulative from date of original issue. It does NOT represent a one time increase.)

| ISSUE AGE | PERCENT INCREASE OVER INITIAL PREMIUM |
|------------------|--|
| 29 and under | 200% |
| 30-34 | 190% |
| 35-39 | 170% |
| 40-44 | 150% |
| 45-49 | 130% |
| 50-54 | 110% |
| 55-59 | 90% |
| 60 | 70% |
| 61 | 66% |
| 62 | 62% |
| 63 | 58% |
| 64 | 54% |
| 65 | 50% |
| 66 | 48% |
| 67 | 46% |
| 68 | 44% |
| 69 | 42% |
| 70 | 40% |
| 71 | 38% |
| 72 | 36% |
| 73 | 34% |
| 74 | 32% |
| 75 | 30% |
| 76 | 28% |
| 77 | 26% |
| 78 | 24% |
| 79 | 22% |
| 80 | 20% |
| 81 | 19% |
| 82 | 18% |
| 83 | 17% |
| 84 | 16% |
| 85 | 15% |
| 86 | 14% |
| 87 | 13% |
| 88 | 12% |
| 89 | 11% |
| 90 and over | 10% |

THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG-TERM CARE INSURANCE

LONG-TERM CARE INSURANCE

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

MEDICARE

Medicare does **not** pay for most long-term care.

MEDICAID

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

- When Medicaid pays your spouse's healthcare service bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

SHOPPER'S GUIDE

Make sure the insurance company or producer gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

COUNSELING

Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Senior Health Counseling Notice

Please be advised that senior health insurance counseling is available at:

APPRISE - Health Insurance Counseling
And Assistance Program
1-800-783-7067
or
Area Agency on Aging