CONNECTICUT APPLICATION PACKET

Helpful Hints: The applicant's signature is required on pages 7, 9 and 12.
The applicant's signature may be required on pages 5, 6, 13, 14 and 15.
Page 6 could require 2 signatures.
Page 7 requires 2 signatures.

Your signature is required on pages 8 and 12. Your signature could be required on page 15, if applicable.

RETURN ENTIRE APPLICATION PACKAGE

PLEASE RETURN ENTIRE PACKAGE

Application Instruction Sheet

PLEASE RETURN ENTIRE PACKAGE

To help save time in the application process, it is important that the application be filled out completely and accurately. Once the application has been completed, review all answers with the applicant and have the applicant sign where indicated. Your signature is also required on the application and on the Personal Worksheet. Your signature may be required on the replacement notice, if applicable.

Unless otherwise indicated below, all answers to the questions on the application form must be completed or checked off, both for the affirmative and negative responses. This includes the Rejection of Nonforfeiture Benefit, if applicable.

BUSINESS INFORMATION – Complete this section of the application to identify the Service Group Name and who is applying for coverage (an employee, an employee's spouse/partner, or an employee's eligible family member). This is required to ensure discounts are applied and billing is correct.

PERSONAL INFORMATION – If a spouse/partner is also applying, write the Spouse's/Partner's name in the APPLICANT STATUS section where requested [after the box for COUPLE].

SECTION A – This is the only section required for **Modified Guaranteed Issue (MGI)**.

SECTION A and B – These two sections are completed for **Simplified Issue (SI)**.

SECTIONS A, B and C – All sections are completed for **Full Underwriting**.

QUESTIONS B 1 – 4 and C 1 – 2 – Please note if any question is answered "Yes" or if a condition is checked, the applicant is not eligible for coverage.

QUESTIONS C 3 – 6 – In section C, if question 3, 4, 5 and/or 6 is answered "Yes", give details in question 7.

PLAN SELECTION – Please note if a couple is applying, each must select the same coverage in order to get the maximum couple's discount.

DAILY BENEFIT – Please note that the Connecticut Partnership for Long-Term Care has minimum Daily Benefit amount requirements. Please adhere to the current minimum requirement rules.

COMPOUND INFLATION COVERAGE – The applicant must select either Compound 5% or Daily Benefit Compound 5%.

REJECTION OF NONFORFEITURE BENEFIT – If the applicant did not select the Nonforfeiture Benefit, check the Rejection of Nonforfeiture Benefit box. Please note the applicant's **signature** is required in this section if the box is checked.

OTHER BENEFITS – Check the box next to the rider to be included as selected by the applicant. *Note. If the Shared Care Rider is checked, the Spouse/Partner must also apply for coverage, and the benefits that they select must be identical to the applicants. The spouse/partner's name must also be completed.*

BENEFICIARY NAME – This section should be completed only if the applicant is applying for the Return of Premium Rider.

PREMIUM PAYMENT – Select the payment method for initial premium payment and recurring payments and check the applicable boxes. Unless premiums will be paid through Payroll Deduction, at least two months premium must be submitted with the application. If premium is submitted with the application, note the amount submitted in the box **Payment w/Application**. This amount should match the amount on the Conditional Receipt [in the Disclosure Package].

FAMILY HISTORY PROFILE – If information is known about the applicant's biological parents, complete this section. If information is not known, check the **Not Applicable** box. **Do not complete this section for MGI or SI underwriting.**

PROTECTION AGAINST UNINTENDED LAPSE – If the applicant wishes to designate a third party to receive a notice if his/her policy is about to lapse, fill in the applicable information. If he/she does not wish to designate a third party, check the applicable box.

SHARED CARE BENEFIT – SEPARATE MEDICAID ASSET PROTECTION – If the Shared Care Benefit Rider was elected, the applicant must **sign** and **date** this section of the application.

WAIVER OF INFLATION PROTECTION ON THE POLICY MAXIMUM AMOUNT – The applicant must **sign** and **date** this section of the application if the Daily Benefit Compound Increase option is selected.

RELEASE OF DATA – The applicant must **sign** and **date** this section of the application. This allows the release of the applicant's long term care insurance information to the State of Connecticut for the purpose of documenting a claim for Medicaid Asset Protection.

STATEMENT OF RECEIPT – In this section of the application, the applicant will acknowledge that all required disclosure forms have been received. [You should check each box as you go over this section with the applicant,] and you have proposed a plan that is suitable for the applicant's needs. The Applicant's **signature** and the **date** and **place signed [City/State]** are required.

EFFECTIVE DATE – The Effective Date Rules for each worksite group are provided in the worksite Implementation Memo.

FOR AGENT/INSURANCE PRODUCER – Complete this part of the application. The Agent/Insurance Producer's writing number provided on this page will be used to process commissions.

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION – Please note the applicant's **signature** is required on the Authorization. Without his/her signature, we cannot proceed with the application process, and the application will be returned to you. Please **date** this form with the date that you complete the application.

LONG TERM CARE INSURANCE PERSONAL WORKSHEET – Answer all questions. You and the applicant must **sign** and **date** the personal worksheet. If the applicant does not wish to complete this information, check the applicable box and have the applicant **sign** and **date** the personal worksheet. The application cannot be processed until this personal worksheet is completed.

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION – If the initial premium payment or recurring premium payments are to be drafted from the applicant's bank account, complete this form. Please note the applicant's **signature** and the **date** are required on this form, if applicable.

INITIAL CREDIT CARD PAYMENT AUTHORIZATION – If the initial premium payment is to be paid by credit card, this form should be completed. This authorization must be **signed** and **dated** by the Cardholder, if applicable.

NOTICE TO APPLICANT REGARDING REPLACEMENT – If the applicant is replacing coverage, this form should be completed. Please note your signature, the applicant's **signature** and the **date** are required on this form, if applicable. Be sure to also complete the same form found in the Disclosure Package and tell the applicant to keep a copy of this form for his/her records.

TRANSAMERICA®
LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Long Term Care Division
P.O. BOX 95302
Hurst, TX 76053-5302
1-800-227-3740

AN APPROVED PARTICIPANT IN
The Connecticut PARTNERSHIP FOR LONG-TERM CARE™

Application for Long Term Care Insurance (ABC)

ID Number	Application No. (Home Office Use)
07032801	

APPLICANT INFORMATION - PLEASE PRINT

APPLYING FOR: ☐ New Coverage ☐ Reinstatement ☐ Upgrade Please provide policy #:_____

BUSINESS INFORMATION (to be completed by the Agent/Insurance Producer)

SERVICE GROUP NAME (includes employers/association):

SERVICE GROUP # (from implementation memo):

☐ Employee: Date of Hire _____ ☐ Employee's Spouse/Partner ☐ Family Member

PERSONAL INFORMATION

First MI Last

Name:

Date of Birth: / /

State of Birth:

Social Security No.: / /

Sex: ☐ Male ☐ Female

Height: _____ Feet _____ Inches

Weight:_____ lbs.

APPLICANT STATUS:

☐ COUPLE, and Spouse/Partner is also applying for (or has) Transamerica Life coverage. Spouse's/Partner's name _____

☐ INDIVIDUAL who is part of a couple, but Spouse/Partner is not applying. Why is Spouse/Partner not applying?_____

☐ INDIVIDUAL who is single, divorced or widowed.

TOBACCO STATUS:

Do you currently use any form of tobacco products?..... ☐ Yes ☐ No

If no, have you ever used any tobacco products?..... ☐ Yes ☐ No

If yes, have you used within the last..... ☐ 2 yrs. ☐ 3 yrs. ☐ 3+ yrs.

CONTACT INFORMATION

PLEASE CHECK YOUR PREFERRED METHOD OF CONTACT & COMPLETE PHONE NUMBER AND E-MAIL ADDRESS

☐ Home Phone: ☐ Work Phone: ☐ Cell Phone:

E-Mail Address: BEST TIME TO CONTACT: _____ ☐ A.M. ☐ P.M.

ADDRESS/Apt No.: _____ **CITY:** _____

_____ **STATE:** CONNECTICUT **ZIP:**_____

OCCUPATION, PROFESSION OR BUSINESS (If retired, give year retired and from what occupation)

_____

DRIVER'S LICENSE NO. AND STATE (If applicant does not have a driver's license, please give passport number instead)

☐ Driver's License No.

#_____ State:_____

☐ Passport No.

#_____ State:_____

OTHER INSURANCE INFORMATION

		Yes	No
1.	Are you covered by Medicaid (not Medicare)? If Yes, this coverage is not suitable and you should not submit this application.	☐	☐
2.	Have you received any long term care benefits, disability income benefits, or Social Security Disability benefits?	☐	☐

OTHER INSURANCE INFORMATION

		Yes	No
3.	In the last 5 years, have you been declined long term care insurance, life insurance, disability income insurance or offered such insurance with an increased premium or restricted benefits?…… If Yes, give company name, when and why:	☐	☐
4.	Do you currently have another long term care policy or certificate in force (including health care service contract, health maintenance organization contract)?…… If Yes, please give details in the chart below question 9.	☐	☐
5.	Do you currently have a rider in force that provides long term care benefits attached to a life insurance policy or an annuity contract?…… If Yes, please give details in the chart below question 9.	☐	☐
6.	Did you have a long term care insurance policy or certificate in force in the last twelve (12) months?…… If Yes, with which company? And if that policy lapsed, when did it lapse? Please provide details in the chart below question 9.	☐	☐
7.	Have you currently applied for, or do you intend to apply for any other long term care insurance?…… If Yes, please provide details in the chart below question 9.	☐	☐
8.	Do you intend to replace any in force medical or long term care insurance with this policy?…… If Yes, please provide details in the chart below question 9 and complete the required replacement form.	☐	☐
9.	In the last 12 months, have you allowed any medical/health/long term care insurance to lapse?…… If Yes, please provide details below.	☐	☐

Name	Name of Company	Company Address	Policy #	Type of Plan	Lapse Date

☐ Check here if more space is needed, attach a signed and dated additional sheet.

MODIFIED GUARANTEE ISSUE – Answer Questions in SECTION A Only.
SIMPLIFIED ISSUE – Answer Questions in SECTIONS A & B.
FULL UNDERWRITING - Answer Questions in SECTIONS A, B & C.

A

		Yes	No
1.	During the last 6 MONTHS, with the exception of vacation, have you been continuously and actively working for your current employer for a minimum of 30 hours per week? If NO, please give the number of hours you work per week. _____ hrs..……	☐	☐
2.	During the last 6 MONTHS, have you missed more than 5 consecutive days of work due to accidents, injury, sickness or any physical or cognitive impairment?……	☐	☐
3.	During the last 12 MONTHS, have you ever required assistance or supervision of any kind to perform any everyday activity, such as mobility (including the use of pronged canes), taking medications, dressing, eating, walking, bathing, transferring, or toileting?……	☐	☐

Please provide details if question 1 is answered 'NO' or if question 2 or 3 are answered 'YES'.

If any question B 1-4 is answered Yes, You are not eligible for coverage.

B

		Yes	No
1.	Have you EVER had, or been diagnosed or treated by a member of the medical profession, or had symptoms of any of the following conditions?.....	☐	☐

If Yes, please check the applicable condition(s):

- ☐ AIDS (Acquired Immune Deficiency Syndrome), or tested positive for HIV
- ☐ Alzheimer's disease or Dementia
- ☐ Amputation due to disease
- ☐ ALS (Lou Gehrig's disease)
- ☐ Arthritis with narcotic pain medication
- ☐ Multiple Strokes/CVA's/TIA's*
- ☐ Organ Transplant (other than Corneal)
- ☐ Multiple Sclerosis
- ☐ Huntington's Chorea
- ☐ Muscular Dystrophy
- ☐ Myasthenia Gravis
- ☐ Organic Brain Syndrome
- ☐ Osteoporosis with fractures
- ☐ Parkinson's disease
- ☐ Polymyositis
- ☐ Scleroderma
- ☐ Memory loss
- ☐ Unplanned weight loss greater than 15 pounds within last 2 years
- ☐ Polycystic Kidney Disease

*If applicant has had a single Stroke/CVA/TIA more than 2 years ago, complete Sections B & C.

		Yes	No
2.	During the last 3 YEARS, have you used over 60 units of insulin per day to treat Diabetes, or have you been diagnosed or treated for Diabetes WITH COMPLICATIONS (Neuropathy, Retinopathy, Heart Disease, Stroke), alcohol abuse, drug or prescription drug addiction?.....	☐	☐
3.	During the last 12 MONTHS:		
	• Have you used a catheter, dialysis, oxygen equipment, a quad or three-pronged cane, respirator, walker, wheelchair, crutches, motorized scooter or chair lift?.....	☐	☐
	• Have you been advised to enter, do you reside in or are you confined to a nursing home, assisted living facility, long term care facility, CCRC (Continuing Care Retirement Community), rehabilitation facility, attended an adult day care facility, or required home health care?.....	☐	☐
4.	Have you ever consulted a member of the medical profession about the possibility of developing Huntington's Chorea or Polycystic Kidney Disease?.....	☐	☐

B

PRIMARY PHYSICIAN'S NAME:	**TELEPHONE NUMBER:**

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

DATE LAST CONSULTED:	**YOUR HEALTH INSURANCE OR PPO MEDICAL ID#** (if known):

REASON LAST SEEN: _____

List All Medications Prescribed Or Taken Within The Last 12 Months

If question C 1 or 2 is answered Yes, You are not eligible for coverage. For any other Yes answer, check the applicable box & provide details in question 7.

C

		Yes	No
1.	In the last 12 months have you had COPD/Emphysema with oxygen use, or Cardiomyopathy?	☐	☐
2.	Within the last 3 MONTHS, have you had:		
	• Heart Attack (MI) or Chest Pain.	☐	☐
	• Uncontrolled Blood Pressure.	☐	☐
	• Cancer	☐	☐
	• Hip or Back Surgery	☐	☐

Please answer each question in number 3 below by checking Yes or No. Each condition should have a separate answer.

3. In the last 5 YEARS, have you been diagnosed by or received treatment from a member of the medical profession for, or had symptoms of:

Y	N		Y	N		Y	N	
☐	☐	Cancer or Any Kind of Tumor	☐	☐	Cardiomyopathy	☐	☐	Epilepsy
☐	☐	Chronic Lymphocytic Leukemia	☐	☐	Peripheral Vascular Disease	☐	☐	COPD
☐	☐	Any Disorder or Disease of the Blood	☐	☐	Congestive Heart Failure (CHF)	☐	☐	COPD (Emphysema) with Oxygen Use
☐	☐	Thyroid disease	☐	☐	Stroke	☐	☐	Dizziness
☐	☐	Anemia	☐	☐	Aneurysm	☐	☐	Disorientation
☐	☐	Macular Degeneration	☐	☐	Cerebrovascular Accident (CVA)	☐	☐	Emphysema
☐	☐	Arthritis	☐	☐	Irregular Heartbeat	☐	☐	Paralysis
☐	☐	Rheumatoid Arthritis	☐	☐	Carotid Artery Stenosis	☐	☐	Fainting
☐	☐	Osteoporosis	☐	☐	Transient Ischemic Attack (TIA)	☐	☐	Falls
☐	☐	Fractures	☐	☐	Mental or Cognitive Disorder including Memory Loss	☐	☐	Blurred Vision
☐	☐	Fibromyalgia	☐	☐	Heart Surgery	☐	☐	Loss of Balance
☐	☐	Heart Attack	☐	☐	Confusion	☐	☐	Loss of Strength
☐	☐	Joint Replacement	☐	☐	Asthma	☐	☐	Convulsions
☐	☐	Used a Straight Cane	☐	☐	Mental Retardation	☐	☐	Diabetes
☐	☐	Chest Pain	☐	☐	Depression	☐	☐	Ulcerative Colitis
☐	☐	High Blood Pressure				☐	☐	Crohn's Disease
☐	☐	Heart Murmur				☐	☐	Chronic Hepatitis
☐	☐	Heart Disease				☐	☐	Cirrhosis
						☐	☐	Sarcoidosis
						☐	☐	Systemic Lupus (SLE)
Any Disease or Disorder of the:								
☐	☐	Kidney	☐	☐	Pancreas	☐	☐	Lungs
☐	☐	Liver	☐	☐	Bone and Joint			
☐	☐	Small or Large Intestine	☐	☐	Gastrointestinal Tract			

		Yes	No
4.	Do you have a handicap sticker, handicap placard, or handicap license plate?	☐	☐
5.	In the last 24 MONTHS, have you had to or been advised by a member of the medical profession to limit, reduce, discontinue or restrict any activities or hobbies?	☐	☐
6.	In the last 12 MONTHS, have you had unplanned weight loss; or has any medical treatment, follow-up, diagnostic testing, or surgery been recommended, but not yet completed?	☐	☐

7. **Give details for all Yes answers to C 1 - 6.**

☐ Check here if more space is needed, attach a signed and dated additional sheet.

Question #	Nature of Condition/Date of Diagnosis	Date Last Treated/ Medication Taken	Name of Physician Seen/ Physician's Address

Comments:

PLAN SELECTION

Rate Class Applying For:

☐ Preferred ☐ Standard ☐ Class 1 ☐ Class 2

Daily Benefit: Facility/Home Care $_____

Policy Maximum Amount: $_____

Elimination Period: ☐ 0 ☐ 30 ☐ 60 ☐ 90 Days

Compound Inflation Coverage:

You MUST select one of the below options:

☐ Compound 5% ☐ Daily Benefit Compound 5%

Nonforfeiture Benefit:

☐ Shortened Benefit Period

If not selecting the Nonforfeiture Benefit, you must check and sign the Rejection of Nonforfeiture Benefit statement below.

☐ **Rejection of Nonforfeiture Benefit:** I understand that if I fail to pay my premium when due or prior to the end of the grace period, my policy will lapse and I will not be eligible for any future benefits because I have chosen not to purchase the Nonforfeiture Benefit. Nevertheless, I reject the option.

Signature:_____

Other Benefits:

☐ Shared Care Rider – Spouse/Partner's name:_____

☐ Full Restoration of Benefits Rider

☐ Monthly Benefit Rider

☐ Return of Premium Rider

☐ Joint Waiver of Premium Rider

BENEFICIARY NAME:	**RELATIONSHIP:**
ADDRESS (Street, City, State, Zip Code)	

PREMIUM PAYMENT (total premium cost may vary depending on mode of payment selected)

Initial Premium Payment: ☐ Check ☐ EFT ☐ Credit Card	Premium Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (available only with EFT and List Bill)
Recurring Payment Method: ☐ Direct Bill ☐ List Bill ☐ EFT ☐ Payroll Deduction	Premium Paying Period: Lifetime

Annual Premium:	Mode Premium:	Payment w/ Application:
$	$	$

DO NOT COMPLETE FOR MGI OR SI UNDERWRITING. If you are applying for Full Underwriting, your responses to the Family History Profile section below will be used during the Underwriting process.

FAMILY HISTORY PROFILE – Please answer with biological parent information, if known

Father: Age:_____ ☐ Not Applicable

☐ Living ☐ Deceased Age at Death:_____ ☐ Unknown

Did/Does your father have any of the following illnesses?

☐ Diabetes:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Heart Disease or Stroke:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Alzheimer's or other Dementia:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

Mother: Age:_____ ☐ Not Applicable

☐ Living ☐ Deceased Age at Death:_____ ☐ Unknown

Did/Does your mother have any of the following illnesses?

☐ Diabetes:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Heart Disease or Stroke:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Alzheimer's or other Dementia:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

PROTECTION AGAINST UNINTENDED LAPSE

YOU WILL RECEIVE NOTICE IF YOUR POLICY IS ABOUT TO LAPSE (TERMINATE) BECAUSE YOU HAVE NOT PAID PREMIUMS. WE WILL BE GLAD TO SEND A COPY OF THIS NOTICE TO ANOTHER PERSON, IF YOU WOULD LIKE. THAT PERSON WILL NOT BE RESPONSIBLE FOR PAYMENT OF THE PREMIUM, AND YOU WILL ALWAYS RECEIVE YOUR OWN COPY OF THE NOTICE. IF YOU WANT AN EXTRA COPY SENT TO ANOTHER PERSON, PLEASE GIVE US THAT PERSON'S NAME, ADDRESS AND PHONE NUMBER. Check the applicable box.

☐ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

FULL NAME **TELEPHONE NO.**

ADDRESS

CITY **STATE** **ZIP**

☐ I elect **NOT** to designate any person to receive such notice.

SHARED CARE BENEFIT - SEPARATE MEDICAID ASSET PROTECTION
(If the Shared Care Benefit Rider is selected, complete this section)

I acknowledge that under the Shared Care Benefit Rider, my spouse/partner and I will both draw benefits from one Policy Maximum Amount. I also acknowledge that under the Shared Care Benefit Rider, Medicaid Asset Protection is earned separately. Only those benefits paid for the spouse/partner's care will earn Medicaid Asset Protection for that spouse/partner, and only benefits paid for the other spouse/partner's care will earn Medicaid Asset Protection for the other spouse/partner. I acknowledge that Medicaid Asset Protection earned by one spouse/partner cannot be transferred to the other spouse/partner. I further acknowledge that under the Shared Care Benefit Rider it is possible that only one spouse/partner will use all the benefits of the policy. Should that happen, I acknowledge that the spouse/partner that received all the benefits will receive all the Medicaid Asset Protection, while the other spouse/partner receives no benefits and no Medicaid Asset Protection.

SIGNATURE: _____

DATE: _____

WAIVER OF INFLATION PROTECTION ON THE POLICY MAXIMUM AMOUNT
(If the Daily Benefit Compound Increase option is selected, complete this section)

You may elect to waive inflation protection coverage on your Policy Maximum Amount. This change is effective on the Policy anniversary following your 65th birthday. This means that the Policy Maximum Amount will not increase over time, while the Maximum Daily Benefits (or Monthly Benefits, if applicable) will increase in accordance with the Daily Benefit Compound Increase provision. You should be aware that if your Policy Maximum Amount does not increase over time, it might not provide all of the Medicaid Asset Protection that you need. To elect this option, you must sign below.

I have reviewed the graphs in the Outline of Coverage comparing the benefits and premiums with and without inflation protection, and I reject the inflation protection for the Policy Maximum Amount. This change is effective on the Policy anniversary following my 65th birthday. This waiver of inflation protection on the Policy Maximum Amount is most appropriate for individuals who do not expect their assets to increase after age 65.

SIGNATURE: _____

DATE: _____

RELEASE OF DATA

I hereby agree to the release of my insurance records pertaining to this long term care insurance policy by Transamerica Life Insurance Company to the state of Connecticut for the purpose of documenting a claim for Medicaid Asset Protection under the Connecticut Medicaid Program, evaluating the Connecticut Partnership for Long-Term Care, and meeting Medicaid audit requirements. I understand that my records will be used for no purpose other than those stated above, and will be kept strictly confidential by the state of Connecticut.

SIGNATURE: _____

DATE: _____

AGREEMENT: I understand that I am applying for an individual long term care insurance policy and not for coverage under a group policy. I understand and agree that no agent/insurance producer or other person except an officer of Transamerica Life Insurance Company has the authority to alter or waive any of the above conditions or any questions in the application, or to determine insurability. I understand and agree that the policy will not take effect unless it is issued by the company.

STATEMENT OF RECEIPT: I acknowledge that I have received the following when I applied for this Partnership-approved long term care insurance: (The applicant should check each box.)

- ☐ A copy of "Before You Buy", a complete description of the Connecticut Partnership for Long-Term Care, prepared by the state of Connecticut;
- ☐ I have been informed that I can request individual consumer information services from the state of Connecticut by calling the state's toll-free number, 1-800-547-3443;
- ☐ The Outline of Coverage for this long term care insurance policy;
- ☐ A Notice regarding Mandatory Inflation Protection, (found in the Outline of Coverage);
- ☐ A graphic comparison showing the differences in premium and benefits over at least a twenty (20) year period, between a policy that increases benefits and a policy that does not increase benefits, (found in the Outline of Coverage);
- ☐ A copy of "A Shopper's Guide to Long-Term Care Insurance", prepared by the National Association of Insurance Commissioners;
- ☐ A copy of the HIPAA Privacy Notice;
- ☐ A copy of the Potential Rate Increase disclosure form;
- ☐ A copy of the "Things You Should Know Before You Buy Long Term Care Insurance";
- ☐ A copy of the Disclosure Notices for the MIB and Fair Credit Reporting; and
- ☐ If eligible for Medicare, a copy of "Guide to Health Insurance for People with Medicare".

APPLICANT'S ACKNOWLEDGMENT OF SUITABILITY: I acknowledge that the agent/insurance producer identified in this application made the necessary inquiries concerning my insurance needs, and proposed a program of insurance that is suitable for my needs.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR POLICY, SUBJECT TO THE TIME LIMIT ON CERTAIN DEFENSES PROVISION IN THE POLICY.

ACKNOWLEDGMENT: I, the undersigned applicant, acknowledge and represent that I have read, or had read to me, the complete application. I, the applicant, represent to the best of my knowledge and belief, that I am competent and the answers contained in this application are true, complete and correctly recorded. This application will be part of the policy for which I am applying.

I acknowledge that I have received a copy of "Before You Buy", a complete description of the Connecticut Partnership for Long-Term Care, prepared by the state of Connecticut, including the state's toll-free number, 1-800-547-3443. I have also been advised that I can request individual consumer information assistance from the state of Connecticut. I have also received a graphic comparison of inflating vs. fixed benefits and premiums and the "Notice to Applicant Regarding Mandatory Inflation Protection" (found in the Outline of Coverage).

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

SIGNATURE: X	**DATE**
PLACE SIGNED (City/State)	
EFFECTIVE DATE (if not date of application)	

SPECIAL INSTRUCTIONS: _____

AGENT/INSURANCE PRODUCER'S ACKNOWLEDGMENT OF COMPLIANCE: I certify that I personally discussed with the applicant and followed the Company's written guidelines provided to me concerning comparisons of coverage and suitability in the marketing of this insurance coverage. I also certify, to the best of my knowledge and belief, that the answers contained in this application are true, complete, and correctly recorded.

AGENT/INSURANCE PRODUCER'S SIGNATURE X	**AGENT/INSURANCE PRODUCER'S NAME (Print Name)**	
AGENT/INSURANCE PRODUCER'S WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	

AGENT/INSURANCE PRODUCER'S SIGNATURE X	**AGENT/INSURANCE PRODUCER'S NAME (Print Name)**	
AGENT/INSURANCE PRODUCER'S WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	

AGENT/INSURANCE PRODUCER'S SIGNATURE X	**AGENT/INSURANCE PRODUCER'S NAME (Print Name)**	
AGENT/INSURANCE PRODUCER'S WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	

AGENT/INSURANCE PRODUCER'S SIGNATURE X	**AGENT/INSURANCE PRODUCER'S NAME (Print Name)**	
AGENT/INSURANCE PRODUCER'S WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	

FOR THE AGENT/INSURANCE PRODUCER

	Yes	No
1. Did you interview the applicant in person, ask all questions, and witness signatures?........	☐	☐
If No, please give details:______		
2. Did you see, hear, or were you advised of any physical or cognitive impairments of the applicant including but not limited to walking, speaking, any form of tremor, or any signs of confusion?	☐	☐
If Yes, please give details:______		
3. To the best of your knowledge, is the information provided in this application true and complete?........	☐	☐

LIST ANY OTHER HEALTH INSURANCE POLICIES YOU HAVE SOLD TO THE APPLICANT

(1) List policies sold that are still in force; and

(2) List policies sold within the last five (5) years that are no longer in force.

COMPANY	POLICY #	TYPE OF COVERAGE	IN FORCE	LAPSE DATE
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

This HIPAA authorization must be fully completed and signed as a condition of applying for insurance with Transamerica Life Insurance Company ("Transamerica"). Your application will not be accepted without a signed authorization. It is an act of fraud to intentionally withhold, or cause to be withheld, medical records or other health information material to the underwriting of an application for coverage.

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW:

(1) **Person(s) or group(s) of persons authorized to use or disclose the information:** Any physicians, medical practitioners, hospitals, clinics, laboratories, long-term care facilities, medical or medically-related facilities, pharmacies, insurance companies (including Transamerica), and insurance support organizations such as the MIB.

(2) **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** Transamerica and its authorized representatives, including affiliates, agents, business associates and insurance support organizations and/or any entity or individual, including my employer if applicable, who is designated as the owner of the policy for which I have applied.

(3) **Description of the information that may be used or disclosed:** This authorization specifically includes the release of ***all information related to my health*** (except psychotherapy notes) *and my insurance policies and claims*, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse treatment information or information regarding communicable or infectious conditions, such as AIDS.

(4) **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my application for long term care insurance with Transamerica, including providing a brief report of my personal health information to MIB, and, if a policy is issued, for evaluating contestability and eligibility for benefits and for the continuation or replacement of the policy. As applicable, in connection with the rights of any policyowner as it relates to the ownership of the policy for which I have applied.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to Transamerica is protected by federal privacy regulations and that Transamerica will only use and disclose such information as described in its Notice of Health Information Privacy Practices. However, I also understand that, upon disclosure pursuant to this authorization to any person or organization that is not covered by the federal privacy regulations, the disclosed information may no longer be protected by those regulations.

- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization, or to the extent that other law provides Transamerica with the right to contest a claim under the policy or the policy itself, by sending a written revocation to Transamerica Life Insurance Company, Underwriting Supervisor, P.O. Box 95302, Hurst, TX 76053-5302. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.

- I understand that I am entitled to receive a copy of this signed authorization.

- This authorization will expire 24 months from the date signed.

Applicant's Name: _____

Applicant's Signature: _____ Date Signed: _____

(Company Copy) A copy of this authorization will be considered as valid as the original.

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TRANSAMERICA®
LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Long Term Care Division
P.O. Box 95302
Hurst, Texas 76053-5302
1-800-227-3740

Long-Term Care Insurance
Personal Worksheet

People buy long-term care insurance for many reasons. Some don't 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 state 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 Numbers TLC 2-P CTP 0410

The premium for the coverage you are considering will be $_____ per _____.

Type of Policy (noncancellable/guaranteed renewable): _Guaranteed Renewable_____.

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

Through various related companies the Company has sold long-term care insurance products since 1987 and has sold this policy since 2011. The Company has requested nationwide rate increases for several previously sold policy forms (within the last 10 years) providing similar coverage. The increased rates on various policy forms are as shown in the table below.

Policy Form Series	Years Available	Rate History
3132 (00) 288, 6122 (00) 688, GLTC 2 1289, LTC 2 390, GLTC 3 1091, LTC 3 1091, IP-70-00-794, LTC 5 196, FLEX 2 196	1988 – 2001	Varies by state, but the largest increases in any state were 35% in 2003, 35% in 2005, 25% in 2007 and 25% in 2009.
GCC 1 387 CERT, LTC5 TQ 1096, FTQ 197	1987 – 2001	Varies by state, but the largest increases in any state were 35% in 2005, 25% in 2007 and 25% in 2009.
LTCP 889, GCPLUS 1290 and GCPLUS 2 1290, GCPRO 193	1990 – 2001	Varies by state, but the largest increases in any state were 30% in 2001, 45% in 2003, 35% in 2005, 29% in 2007 and 25% in 2009.
KLTCP 1 490, LI-LTCP 192, GCPRO-II 794	1990 – 2001	Varies by state, but the largest increases in any state were 45% in 2003, 35% in 2005, 29% in 2007 and 25% in 2009.

LI-LTCP TQ 197, GCPRO-III TQ 197, LI-LTCP TQ 898, GC001 796	1996 – 2003	Varies by state, but the largest increases in any state were 35% in 2005, 29% in 2007 and 25% in 2009.
1-811 11-190; 1-820 11-191 and 1-822 11-191; LTC-100 11-193; LTC 104-194	1991 – 1999	Varies by state, but the largest increases in any state were 45% in 2003, 35% in 2005 and 25% in 2009.
LTC 124-197; LTC 304-198 and LTC 305-198	1997 – 2004	Varies by state, but the largest increase in any state was 35% in 2005 and 25% in 2009.

This represents the largest increases that have been filed with and approved by various state insurance departments. Some states have allowed two (or more) smaller increases and some states have approved the increases in years different than those shown above.

Questions Related to Your Income

How will you pay each year's premium?

❑ 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 ❑ $10-20,000 ❑ $20-30,000 ❑ $30-50,000 ❑ Over $50,000

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.

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?

❑ From my Income ❑ From my Savings\Investments ❑ My Family will Pay

The national average annual cost of nursing home care in 2008 was $68,255, but this figure varies across the country. In ten years the national average annual cost would be about $111,180 if costs increase 5% annually. In Connecticut, the average annual cost for nursing home care in 2009 was $124,400. In ten years the average annual cost in Connecticut would be about $193,450 if costs increase 5% annually.

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

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

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

How do you expect your assets to change over the next ten 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.

Disclosure Statement

❑ The answers to the questions above describe my financial situation. OR ❑ I choose not to complete this information, but I do wish to purchase this coverage. (Check one.)
❑ I acknowledge that the carrier and/or its agent/insurance 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.** (This box must be checked.)

Signed: _____ _____
(Applicant) (Date)

❑ I explained to the applicant the importance of completing this information.

Signed: _____ _____
(Agent/Insurance Producer) (Date)

Agent's/Insurance Producer's Printed Name: _____

Note: In order for us to process your application, please return this signed statement to Transamerica Life Insurance Company, along with your application.

❑ My agent/insurance 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: _____ _____
(Applicant) (Date)

The company may contact you to verify your answers.

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Home Office: Cedar Rapids, Iowa
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Hurst, TX 76053-5302
1-800-227-3740

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

I, the undersigned, hereby authorize and request Transamerica Life Insurance Company to initiate electronic debit entries or effect a charge by any other commercially accepted practice to my account identified by the information provided below for premiums and other such payments that may become due in any amount under this policy. I request that this EFT Authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policy. I agree that this EFT Authorization in no way affects the terms of the policy, other than the mode of payment and I understand that if premiums are not paid within the grace period allowed by the policy, as in the event of withdrawals being dishonored, or for any other reason, then the policy shall terminate subject to any nonforfeiture provision of the policy, if any. No debit, check or other charge shall constitute payment until the Company actually receives payment from the financial institution within the period provided in the policy. This EFT Authorization may be terminated by either party by giving written notice to the other.

INITIAL PREMIUM PAYMENT

☐ **AUTOMATIC WITHDRAWAL:** By checking this box, I authorize Transamerica Life Insurance Company to withdraw from my account listed below, the amount indicated as the Initial Premium Payment with Application. **The Initial Premium Payment will be processed automatically on receipt of the application for insurance**. Also, at my request, I authorize an additional debit to my account for the balance of any initial premium, up to and including the balance due of the selected premium payment mode that is outstanding at the time the policy is issued.

I understand that completion of the EFT Authorization does not guarantee or otherwise indicate that any insurance coverage is in force and that any insurance coverage applied for becomes effective only as stated in the application for insurance, the Conditional Receipt or the insurance contract.

ACCOUNT INFORMATION

_____
Bank Name, Office, or Branch

_____
Bank Address City State Zip Code

_____ Check one: ☐ Checking ☐ Savings
Payor Name

_____ _____
Transit Routing Number Account Number

COMPLETE THE FOLLOWING INFORMATION FOR FUTURE RECURRING PAYMENTS

☐ Monthly
☐ Quarterly
☐ Semi-Annual
☐ Annual

☐ Withdraw on day of the month matching the policy's effective date (this will be elected if no box is checked)
☐ Withdraw on a different day of the month; choose a day between 1 and 28 _____

SIGNATURE

Payor Signature – as on financial institution's records. A copy is as valid as the original.

X_____ **Date:** _____

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Long Term Care Division
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Hurst, TX 76053-5302
1-800-227-3740

INITIAL CREDIT CARD PAYMENT AUTHORIZATION
For Long Term Care Insurance

APPLICANT NAME: _____

POLICY NUMBER (if known): _____

Authorization Agreement for Credit Card Payment

I, hereby authorize Transamerica Life Insurance Company to charge my credit card, as indicated below for the amount indicated as the Initial Premium Payment with Application. The Initial Premium Payment will be processed automatically on receipt of the application for insurance. Also, at my request, I authorize an additional credit card charge for the balance of any initial premium, up to and including the balance of the annual premium due that is outstanding at the time the policy is issued.

I understand that completion of this Initial Credit Card Payment Authorization does not guarantee or otherwise indicate that any insurance coverage is in force and that any insurance coverage applied for becomes effective only as stated in the application for insurance, the Conditional Receipt or the insurance contract.

This Initial Credit Card Payment Authorization remains valid until the earlier of the final credit card processing date or such time as I provide written notice to terminate this authorization to Transamerica Life Insurance Company, at the address stated on this form or the policy, at least 30 days in advance of the intended termination date. I agree to contact Transamerica Life Insurance Company if there are any changes to the credit card account information indicated below.

Transamerica Life Insurance Company reserves the right to terminate this method of payment at any time.

SELECTED CREDIT CARD: ☐ **Discover** ☐ **Visa** ☐ **Master Card** ☐ **American Express**

CREDIT CARD #: _____

EXPIRATION DATE: _____
(MM/YYYY)

The complete credit card number and expiration date must be included to process any payment.

Cardholder Information (exactly as shown on card or bill):

CARDHOLDER NAME: _____

BILLING ADDRESS: _____

_____

CARDHOLDER PHONE: _____

X _____ _____
CARDHOLDER SIGNATURE **DATE**

FAX THIS COMPLETED FORM TO: 866-630-7499

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Long Term Care Division
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NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with a long-term care insurance policy to be issued by Transamerica Life Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new policy carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present coverage only if, after due consideration, you find that purchase of this long-term care insurance policy is a wise decision.

STATEMENT TO THE APPLICANT BY AGENT/INSURANCE PRODUCER, BROKER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present coverage.

2. State law provides that your replacement policy may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy for similar benefits to the extent such time was spent under the original coverage.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent/insurance producer regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present coverage and replace it with this new policy, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

_____ _____

Signature of Agent/Insurance Producer, Broker or Other Representative

_____

Type or print Name & Address of Agent/Insurance Producer, Broker or Other Representative

_____ _____

Applicant's Signature

The "Notice to Applicant" was delivered to me on the above date