

SERFF Tracking Number: LFCR-125724516 State: Arkansas  
Filing Company: Assurity Life Insurance Company State Tracking Number: 39536  
Company Tracking Number: ALE-CNF-LP  
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified  
Product Name: AssurityBalance  
Project Name/Number: /

## Filing at a Glance

Company: Assurity Life Insurance Company

Product Name: AssurityBalance

TOI: LTC03I Individual Long Term Care

Sub-TOI: LTC03I.001 Qualified

Filing Type: Form

SERFF Tr Num: LFCR-125724516 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 39536

Co Tr Num: ALE-CNF-LP

State Status: Approved-Closed

Co Status:

Reviewer(s): Marie Bennett, Harris Shearer

Authors: Smith Darlene, Trudy Weigel

Disposition Date: 07/21/2008

Date Submitted: 07/08/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 02/06/2008

Requested Filing Mode: Review & Approval

Domicile Status Comments: Approved.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 07/21/2008

State Status Changed: 07/21/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

RE: ASSURITY LIFE INSURANCE COMPANY – NAIC #71439

Long Term Care filing of Arkansas required rate stabilization and partnership forms For use with AL2100P-AR et al Tax-Qualified Policy Forms

Approved February 23, 2007

<i>SERFF Tracking Number:</i>	<i>LFCR-125724516</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Assurity Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39536</i>
<i>Company Tracking Number:</i>	<i>ALE-CNF-LP</i>		
<i>TOI:</i>	<i>LTC03I Individual Long Term Care</i>	<i>Sub-TOI:</i>	<i>LTC03I.001 Qualified</i>
<i>Product Name:</i>	<i>AssurityBalance</i>		
<i>Project Name/Number:</i>	<i>/</i>		

The attached forms, as listed on the enclosed Form Filing Cover Sheet, are being filed for your review and approval as new forms and are intended for use with the above referenced previously approved individual long term care forms. The following forms are being filed to comply with Arkansas adoption of revisions to Regulation 13 and the Arkansas Long Term Care Partnership Program Regulation 94.

Forms ALE-CNF-LP, Contingent Benefit Upon Lapse Endorsement provides the required nonforfeiture if the applicant selects the 10-Pay or Paid-up at 65 premium payment option. Form ALN-LTC, Things You Should Know Before You Buy Long Term Care Insurance will be given to each prospective applicant. ALN-PRI-LP, Potential Rate Increase Disclosure Form, will be given to all prospective applicants and will advise them that the premiums may be increased in the future. Form ALE-RED, Lowering Premiums by Reducing Premiums Endorsement, allows the insured to reduce the premium on the policy by reducing the daily or maximum benefit amount.

The following forms are intended to be used in the Georgia Long Term Care Partnership program as follows. Form ALN-PRT-AR will be given to each prospective applicant applying for a partnership policy in Arkansas and Form ALD-PRT-AR will be attached to each policy that becomes a partnership policy as chosen in the Application and Outline. The certification for the policy, AL2100P-AR is attached to certify that the policies qualify as partnership policies. The following forms are revised to comply with the revised regulations and replace the original forms. Application Form AL2100A-1-AR, replacing AL2100A-AR, and Outline AL2100OC-1-AR, replacing AL2100OC-AR, are revised to include the nonforfeiture benefits in the required rate stabilization regulation and include a line and box for each applicant to choose a partnership policy and to show the ages at which inflation protection is required.

## Company and Contact

### Filing Contact Information

(This filing was made by a third party - LCA01)

Trudy Weigel, Compliance Analyst 2	trudy.weigel@lifecareassurance.com
P.O. Box 4243	(818) 867-2240 [Phone]
Woodland Hills, CA 91365-4243	(818) 867-2508[FAX]

### Filing Company Information

Assurity Life Insurance Company	CoCode: 71439	State of Domicile: Nebraska
Long Term Care Administrative Office	Group Code: 3910	Company Type:
P.O. Box 4243		
Woodland Hills, CA 91365-4243	Group Name: Assurity Security Grp	State ID Number:
(818) 867-2450 ext. [Phone]	FEIN Number: 38-1843471	

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation: Arkansas Filing Fee \$50.00 per filing  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Assurity Life Insurance Company	\$50.00	07/08/2008	21289997

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor (FM)	07/21/2008	07/21/2008

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Marie Bennett	07/21/2008	07/21/2008	Trudy Weigel	07/21/2008	07/21/2008

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## Disposition

Disposition Date: 07/21/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Sheet	Approved-Closed	Yes
Supporting Document	Issuer Certification	Approved-Closed	Yes
Supporting Document	Cover Letter July 21, 2008	Approved-Closed	Yes
Form	Contingent Benefit Upon Lapse Endorsement	Approved-Closed	Yes
Form	Potential Rate Increase Disclosure Form	Approved-Closed	Yes
Form	Reduction of Benefits Endorsement	Approved-Closed	Yes
Form	Things You Should Know Before You Buy Long Term Care Insurance	Approved-Closed	Yes
Form (revised)	Important Information About the Arkansas Long Term Care Insurance Partnership Program	Approved-Closed	Yes
Form	Important Information About the Arkansas Long Term Care Insurance Partnership Program	Withdrawn	Yes
Form	Important Notice Regarding Your Policy's Long-Term Care Insurance Partnership Status	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Application for Long Term Care Insurance Policy	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 07/21/2008  
Submitted Date 07/21/2008  
Respond By Date 08/21/2008

Dear Trudy Weigel,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Important Information About the Arkansas Long Term Care Insurance Partnership Program (Form)

Comment: The last three (3) paragraphs of the form makes reference to Minnesota Life - please correct.

### Objection 2

- Cover Sheet (Supporting Document)

Comment: The Cover Letter indicates the forms in the filing are to be used in Georgia Long Term Care Partnership program. Please correct to Arkansas.

Please feel free to contact me if you have questions.

Sincerely,

Marie Bennett

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 07/21/2008  
Submitted Date 07/21/2008

Dear Marie Bennett,

### Comments:

#### Response 1

Comments: This is in response to your objection letter of July 21, 2008.

1 – The form ALN-PRT-AR is corrected with the references to Minnesota Life revised to say Assurity Life. The originally submitted form is deleted and the corrected form attached.

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2 – Please see the attached cover letter to correct the reference to Georgia in the filing description originally submitted.

Thank you for your assistance.

**Related Objection 1**

Applies To:

- Important Information About the Arkansas Long Term Care Insurance Partnership Program (Form)

Comment:

The last three (3) paragraphs of the form makes reference to Minnesota Life - please correct.

**Related Objection 2**

Applies To:

- Cover Sheet (Supporting Document)

Comment:

The Cover Letter indicates the forms in the filing are to be used in Georgia Long Term Care Partnership program. Please correct to Arkansas.

**Changed Items:**

**Supporting Document Schedule Item Changes**

Satisfied -Name: Cover Letter July 21, 2008

Comment: Here is the cover letter with the correct state reference.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Important Information About the Arkansas Long Term Care Insurance Partnership Program	ALN-PRT-AR		Other	Initial			ALN-PRT-AR.pdf
<b>Previous Version</b>							
Important Information About the Arkansas Long Term Care	ALN-PRT-AR		Other	Initial			ALN-PRT-AR.pdf

*SERFF Tracking Number:*      *LFCR-125724516*                      *State:*                      *Arkansas*  
*Filing Company:*              *Assurity Life Insurance Company*                      *State Tracking Number:*      *39536*  
*Company Tracking Number:*      *ALE-CNF-LP*  
*TOI:*                      *LTC03I Individual Long Term Care*                      *Sub-TOI:*                      *LTC03I.001 Qualified*  
*Product Name:*              *AssurityBalance*  
*Project Name/Number:*      /  
***Insurance Partnership***  
***Program***

*SERFF Tracking Number:*      *LFCR-125724516*                      *State:*                      *Arkansas*  
*Filing Company:*              *Assurity Life Insurance Company*                      *State Tracking Number:*      *39536*  
*Company Tracking Number:*      *ALE-CNF-LP*  
*TOI:*                      *LTC03I Individual Long Term Care*                      *Sub-TOI:*                      *LTC03I.001 Qualified*  
*Product Name:*              *AssurityBalance*  
*Project Name/Number:*      /

**No Rate/Rule Schedule items changed.**

Sincerely,  
Smith Darlene, Trudy Weigel

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## Form Schedule

**Lead Form Number:** ALE-CNF-LP

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	ALE-CNF-LP	Policy/Cont	Contingent Benefit ract/Fratern Upon Lapse al Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			ALE-CNF-LP.pdf
Approved-Closed	ALN-PRI-LP	Other	Potential Rate Increase Disclosure Form	Initial			ALN-PRI-LP.pdf
Approved-Closed	ALE-RED	Policy/Cont	Reduction of Benefits ract/Fratern Endorsement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			ALE-RED.pdf
Approved-Closed	ALN-LTC	Other	Things You Should Know Before You Buy Long Term Care Insurance	Initial			ALN-LTC.pdf
Approved-Closed	ALN-PRT-AR	Other	Important Information About the Arkansas Long Term Care Insurance Partnership Program	Initial			ALN-PRT-AR.pdf
Approved-Closed	ALD-PRT-AR	Other	Important Notice Regarding Your	Initial			ALD-PRT-AR.pdf

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Policy's Long-Term  
 Care Insurance  
 Partnership Status

Approved- Closed	AL2100OC- 1-AR	Outline of Coverage Coverage	Outline of Coverage	Revised	Replaced Form #: AL2100OC-AR Previous Filing #: 35181	AL2100OC-1- AR.pdf
Approved- Closed	AL2100A- 1-AR	Application/ Enrollment Form	Application for Long Term Care Insurance Policy	Revised	Replaced Form #: AL2100A-AR Previous Filing #: 35181	AL2100A-1- AR.pdf



**Assurity Life Insurance Company**

Home Office: Lincoln, Nebraska

Long Term Care Administrative Office

Post Office Box 4243

Woodland Hills, CA 91365-4243

(888) 505-3980

**Contingent Benefit Upon Lapse Endorsement  
(Limited Premium Payment Policy)**

This endorsement is attached to and made part of the Policy as of the Policy Effective Date.

**Contingent Benefit Upon Lapse**

If we:

- (a) increase the premium rates under the Policy, which results in a cumulative increase of the annual premium equal to or exceeding the percentage of your initial annual premium, as set forth in the table below; and
- (b) the Policy lapses as described in the Grace Period and Unintentional Lapse provision of the Policy within 120 days of the due date for the payment of the increased premium; and
- (c) the ratio of the number of months you have already paid premium is 40% or more of the number of months you originally agreed to pay; then
- (d) the following options will become available under the Policy:
  - A. The Benefit Amount shown on the Benefit Schedule page of the Policy may be reduced. This may be accomplished by either reduction of the Daily Benefit or Benefit Period, to provide for a Benefit Amount that the current premium payable under the Policy will purchase. Reduction of the Benefit Amount will not be subject to evidence of insurability; or
  - B. The Policy may be converted to a paid-up status and the total lifetime Benefit Amount for your reduced paid up Policy will be determined by multiplying 90% of the lifetime Benefit Amount, available at the time the Policy becomes paid-up, by the ratio of the number of months you have already paid premiums under the Policy, to the number of months you agreed to pay them at time of application. This option may be elected at any time during the 120-day period referenced above. In addition, if the Policy lapses for nonpayment of premium during this 120-day period, this option will automatically be provided under the Policy.

The Daily Benefit Amount shown on the Benefit Schedule page of your Policy will also be adjusted by the same ratio described above.

(over)

If you purchased a Policy with a lifetime Benefit Amount, only the Daily Benefit Amount shown on the Benefit Schedule page of the Policy will be adjusted by the applicable ratio.

<b>Triggers for a Substantial Premium Increase</b>	
<b>Issue Age</b>	<b>Percent Increase Over Initial Premium</b>
Under 65	50%
65-80	30%
Over 80	10%

Executed for the Company at its Home Office in Lincoln, Nebraska.

  
President

  
Secretary

## Assurity Life Insurance Company

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# Long Term Care Insurance Potential Rate Increase Disclosure Form

1. **Premium Rate:** The premium rate that is applicable to you and the coverage you have applied for is shown on the application.
2. **The premium for the policy and any riders that are issued to you will be shown on the Benefit Schedule of your policy. This rate will be in effect unless and until the Company requests a premium rate increase and it is approved by the state in which your policy was issued.**

3. **Rate Schedule Adjustments:**

Premium rate or rate schedule adjustments will be effective on the next anniversary date following the date the state approves a rate increase.

4. **Potential Rate Revisions:**

**This policy is Guaranteed Renewable.** This means that the rates for this product may be increased in the future. Your rates 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 option.\* (This option may be available to you 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 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.

Turn the Page

**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.)

<b><u>Contingent Nonforfeiture</u></b>			
<b>Cumulative Premium Increase Over Initial Premium That Qualifies for Contingent Nonforfeiture</b>			
(Percentage Increase is cumulative from the date of original issue. It does NOT represent a one-time increase)			
<b><u>Issue Age</u></b>	<b><u>Percent Increase Over Initial Premium</u></b>	<b><u>Issue Age</u></b>	<b><u>Percent Increase Over Initial Premium</u></b>
29 and under	200%	70	40%
30-34	190%	71	38%
35-39	170%	72	36%
40-44	150%	73	34%
45-49	130%	74	32%
50-54	110%	75	30%
55-59	90%	76	28%
60	70%	77	26%
61	66%	78	24%
62	62%	79	22%
63	58%	80	20%
64	54%	81	19%
65	50%	82	18%
66	48%	83	17%
67	46%	84	16%
68	44%	85	15%
69	42%		

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

<b>Triggers for a Substantial Premium Increase</b>	
<b>Issue Age</b>	<b>Percent Increase Over Initial Premium</b>
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND
3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

- a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.
- b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

**Example:**

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

**Assurity Life Insurance Company**

Home Office: Lincoln, Nebraska

Long Term Care Administrative Office

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**Lowering Premiums by Reducing Benefits Endorsement**

This endorsement is attached to and made part of the Policy as of the Policy Effective Date.

**Lowering Premiums by Reducing Benefits**

You have the option to reduce your premiums under your current coverage, subject to benefit availability, by selecting one of the following options:

- reducing the Benefit Amount shown on the Benefit Schedule; or
- reducing the Daily Benefit shown on the Benefit Schedule.

The premium rate for your reduced coverage will be based upon your age on the date the Policy was originally issued and the premium rate in effect on the date the Benefit Amount or Daily Benefit is reduced.

In the event the Policy is about to lapse due to nonpayment of premium, we will notify you of the options described above, which will become available to you in order to reduce your coverage. This notice will be sent to you at least 30 days before the Policy is cancelled for nonpayment of premium.

**Executed for the Company at its Home Office in Lincoln, Nebraska.**



President



Secretary

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### 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 nursing home 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 agent 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.

#### Facilities

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

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# Important Consumer Information Regarding the Arkansas Long-Term Care Insurance Partnership Program

Some long-term care insurance policies sold in Arkansas may qualify for the Arkansas Long-Term Care Insurance Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies that qualify as Partnership Policies may protect the policyholder's assets through a feature known as "Asset Disregard" under Arkansas Medicaid program.

**Asset Disregard** means that an amount of the policyholder's assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply. Asset Disregard is not available under a long-term care insurance policy that is not a Partnership Policy. Therefore, you should consider whether Asset Disregard is important to you, and whether a Partnership Policy meets your needs. *The purchase of a Partnership Policy does not automatically qualify you for Medicaid.*

**What are the Requirements for a Partnership Policy.** In order for a policy to qualify as a Partnership Policy, it must, among other requirements:

- be issued to an individual after January 1, 2008;
- cover an individual who was an Arkansas resident when coverage first becomes effective under the policy;
- be a tax-qualified policy under Section 7702(B)(b) of the Internal Revenue Code of 1986;
- meet stringent consumer protection standards; and,
- must provide annual inflation protection for ages 75 and younger.

If you apply and are approved for long-term care insurance coverage, Assurity Life Insurance Company will provide you with written documentation as to whether your policy qualifies as a Partnership Policy.

**What Could Disqualify a Policy as a Partnership Policy?** Certain types of changes to a Partnership Policy could affect whether such policy continues to be a Partnership Policy. If you purchase a Partnership Policy and later decide to make *any* changes, you should first consult with Assurity Life Insurance Company to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy as a Partnership Policy, you would not receive beneficial treatment of your policy under the Medicaid program of that state. The information contained in this disclosure is based on current Arkansas and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy under Arkansas's Medicaid program.

**Additional Information.** If you have questions regarding long-term care insurance policies please contact Assurity Life Insurance Company. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Arkansas Department of Human Services.

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**Important Information Regarding Your Policy's  
Long-Term Care Insurance Partnership Status**

This disclosure notice is issued in conjunction with your long-term care policy:

Some long-term care insurance policies sold in Arkansas qualify for the Arkansas Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies that qualify as Partnership Policies may be entitled to special treatment, and in particular an "Asset Disregard," under Arkansas's Medicaid program.

**Asset Disregard** means that an amount of the policyholder's assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply. Asset Disregard is not available under a long-term care insurance policy that is not a Partnership Policy. **The purchase of a Partnership Policy does not automatically qualify you for Medicaid.**

**Partnership Policy Status.** Your long-term care insurance policy is intended to qualify as a Partnership Policy under the Arkansas Long-Term Care Partnership Program as of your Policy's effective date.

**What Could Disqualify Your Policy as a Partnership Policy?** If you make any changes to your policy, such changes could affect whether your policy continues to be a Partnership Policy. ***Before you make any changes, you should consult with Assurity Life Insurance Company to determine the effect of a proposed change.*** In addition, if you move to a State that does not maintain a Partnership Program or does not recognize your policy as a Partnership Policy, you would not receive beneficial treatment of your policy under the Medicaid program of that State. The information contained in this Notice is based on current State and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy under Arkansas's Medicaid program.

**Additional Information.** If you have questions regarding your insurance policy please contact Assurity Life Insurance Company. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Arkansas Department of Human Services.

**This form and all benefit statements received should be kept with your policy.**

**Assurity Life Insurance Company**

Home Office: Lincoln, Nebraska

Long Term Care Administrative Office

Post Office Box 4243

Woodland Hills, CA 91365-4243

(888) 505-3980

**OUTLINE OF COVERAGE FOR  
LONG TERM CARE INSURANCE POLICY FORM AL2100P-AR**

**NOTICE TO BUYER:** This policy may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

**Caution:** The issuance of this Long Term Care Insurance Policy is based upon your responses to the questions in your application. A copy of your application is enclosed. If responses are incorrect or untrue, the Company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the address shown above.

The policy is an individual policy of insurance.

**PURPOSE OF OUTLINE OF COVERAGE**

This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not the insurance contract, but only a summary of coverage. Only the individual policy contains governing contractual provisions. This means that the policy sets forth in detail the rights and obligations of both you and the Company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY CAREFULLY!**

**FEDERAL TAX CONSEQUENCES**

THE POLICY IS INTENDED TO BE A FEDERALLY TAX-QUALIFIED LONG TERM CARE INSURANCE CONTRACT AS DEFINED UNDER SECTION 7702B(b) OF THE INTERNAL REVENUE CODE OF 1986, as amended. In the event that future changes in federal law require the policy to be amended in order to maintain its status as a federally tax-qualified long term care insurance contract, you will be provided with the opportunity to accept or reject any such amendments. You should consult with your attorney, accountant, or tax advisor regarding the tax implications of purchasing this long term care insurance.

**TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED**

**RENEWABILITY: THE POLICY IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of the policy, to continue the policy as long as you pay your premiums on time. Assurity Life Insurance Company cannot change any of the terms of the policy on its own, except that, in the future, **IT MAY INCREASE THE PREMIUM YOU PAY.**

**Waiver of Premium**

Premiums for the policy and attached riders will be waived after you (either insured in the case of joint coverage) have been confined in a nursing facility or assisted living facility for a period of 90 days and you satisfy the Eligibility for the Payment of Benefits provision. The 90 days need not be consecutive, but must be satisfied during a Single Claim Period. We will return any unearned premium to you on a pro-rata basis. The premium will be waived until you no longer satisfy the Eligibility for the Payment of Benefits provision (because you have recovered and you are no longer confined in a nursing facility or assisted living facility). Premium payments will then again become due. Any new Single Claim Period will require satisfaction of a new 90-day Waiver of Premium Waiting Period, as described above.

For an additional premium payment, an optional Home and Community Based Care Waiver of Premium Benefit Rider is also available, as described below.

## **TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS**

**Premiums are subject to change. We can only change the premiums for the policy if we change premiums for everyone in your state with the same class. A class includes persons with the same benefits, issue age, and premium rate class at issue. We will give you at least 60 days written notice at your last address shown in our records before we change your premium.**

## **TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED**

If you are not satisfied with your policy, you have 30 days to return it to us or our agent for a full refund of any premium you have paid. Upon your death (last of your deaths in the case of joint coverage), we will refund any unearned premium for the policy on a pro-rata basis. We will make this refund within 30 days of our receipt of proof of your death. If you cancel your policy after 30 days, any unearned premium will be refunded to you on a pro-rata basis. If you purchase the optional Full Return of Premium Rider, all of the premiums paid for the policy and riders will be returned to your beneficiary upon your death (last of your deaths in the case of joint coverage).

## **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE**

If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from us. Neither Assurity Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

## **LONG TERM CARE COVERAGE**

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, Maintenance or Personal Care Services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

The policy provides coverage for Qualified Long Term Care Services in the form of an expense incurred benefit for covered long term care expenses, subject to policy Elimination Periods, limitations or exclusions described below.

## **BENEFITS PROVIDED BY THE POLICY**

### **Covered Services**

The policy provides benefits for Qualified Long Term Care Services performed in a nursing facility or assisted living facility and Maintenance or Personal Care Services performed in an assisted living facility. In addition, benefits are provided for Facility Bed Reservation, Respite Care and an Alternative Plan of Care. You may select coverage under the policy for Home and Community Based Care, including benefits for home health care, adult day care, hospice care and Caregiver Training.

### **Elimination Period**

This is the number of days, beginning with the day you satisfy the Eligibility for the Payment of Benefits provision and receive either Facility Care or Home and Community Based Care (if covered under the policy), as defined in the policy, before we will begin paying benefits. You may choose an Elimination Period of 0, 30, 90 or 180 days. Once you have satisfied the Elimination Period, no future Elimination Period is required. Days may be accumulated under separate claims in order to satisfy the Elimination Period. The Elimination Period applies to each insured individually in the case of joint coverage.

The Elimination Period is not applicable to Caregiver Training or Respite Care benefits. Use of these benefits does not count toward satisfaction of the Elimination Period for any other benefits payable under the policy.

### **Benefit Amount**

You may choose an unlimited Benefit Amount for Lifetime coverage, or a lesser amount determined by multiplying the Daily Benefit selected by the Benefit Period selected of 3,650 Days (10 Years), 2,190 Days (6 Years), 1,825 Days (5 Years), 1,460 Days (4 Years), 1,095 Days (3 Years) or 730 Days (2 Years). The result will be your Benefit Amount for all benefits payable under the policy. In the case of joint coverage, the policy provides for a separate Benefit Amount for each insured. For an additional premium payment, a Shared Benefit Amount Rider is also available, as described below.

### **Coverage Outside the United States**

Benefits are payable for Qualified Long Term Care Services received outside the United States or its territories, or Canada for up to 30 days per calendar year. The benefit payable under the policy will be the actual daily charges you incur for covered services, up to the Daily Benefit you select. Benefits paid are subtracted from the Benefit Amount.

### **Facility Care Benefit**

Benefits are payable for Qualified Long Term Care Services (including skilled, intermediate or custodial nursing care) provided to you in a nursing facility or assisted living facility and Maintenance or Personal Care Services performed in an assisted living facility. The benefit payable under the policy will be the actual daily Facility Care charges you incur, up to the Daily Benefit you select. You may choose a Daily Benefit of up to \$300 per day. Premium rates will vary according to the Daily Benefit you select. Benefits paid are subtracted from the Benefit Amount.

### **Facility Bed Reservation Benefit**

This benefit is payable if you are receiving Facility Care benefits under the policy, you incur a temporary absence from the nursing facility or assisted living facility and are charged by the facility to reserve your accommodations. The benefit payable will be the actual daily charges you incur for the reservation, up to the Daily Benefit selected. This benefit is payable for a maximum of 30 days per calendar year. Benefits paid are subtracted from the Benefit Amount.

### **Home and Community Based Care Benefit**

This benefit will only be covered under the policy if it is selected by you and shown on the Benefit Schedule page of the policy. Benefits are payable for home health care provided through a qualified Home Health Care Agency or Independent Home Health Caregiver, in a setting other than a hospital, nursing facility or assisted living facility. Home health care includes professional nursing care by or under the supervision of an RN or other licensed nurse; care by a qualified Home Health Aide; therapeutic care services by or under the supervision of a speech, occupational, physical, or respiratory therapist, licensed or certified under state law, if any; services provided by a registered dietician or homemaker services. Benefits are also payable for adult day care, hospice care and Caregiver Training.

The benefit payable under the policy will be the actual Home and Community Based Care charges you incur, up to the Daily Benefit you select. Premium rates will vary according to the Daily Benefit you select. Benefits paid are subtracted from the Benefit Amount.

### **Caregiver Training Benefit**

If Home and Community Based Care is covered under the policy, this benefit provides for training by a health care professional to an informal caregiver. The informal caregiver may be an unpaid member of your Family, a friend or neighbor.

The benefit payable under the policy will be the actual Caregiver Training charges incurred, up to a Maximum Lifetime Caregiver Training benefit that is equal to 3 times the Daily Benefit selected. You need not satisfy the Elimination Period to receive this benefit; however, use of the benefit does not count toward satisfaction of the Elimination Period for any other benefits payable under the policy. Benefits paid are subtracted from the Benefit Amount.

### **Respite Care Benefit**

Benefits are payable for Qualified Long Term Care Services provided on a short term basis to relieve Family or friends who are the primary caregivers in your residence. Such services may be provided in your home, a nursing facility, an assisted living facility, or through a community based program.

The benefit payable under the policy will be the actual daily Facility Care charges or, if selected, Home and Community Based Care charges incurred, up to the Daily Benefit chosen. The Respite Care Benefit is payable for a maximum of 30 days per calendar year. You need not satisfy the Elimination Period to receive this benefit; however, use of the benefit does not count toward satisfaction of the Elimination Period for any other benefits payable under the policy. Benefits paid are subtracted from the Benefit Amount.

## **Alternative Plan of Care Benefit**

If you are Chronically Ill, an Alternative Plan of Care Benefit is available if agreed to by you, your Licensed Health Care Practitioner and us. The Alternative Plan of Care benefit amount agreed upon, divided by the Daily Benefit selected, equals the number of subsequent days for which we will not pay additional benefits for Home and Community Based Care (if selected) or Facility Care under the policy. This number of subsequent days will be considered to have been paid by the Alternative Plan of Care benefit amount agreed to. An Alternative Plan of Care provides for Qualified Long Term Care Services not specifically shown as being available under the policy including: equipment purchases or rentals; permanent or temporary modifications to your residence (such as ramps or rails), or care services not normally covered under the Home and Community Based Care Benefit. The Alternative Plan of Care Benefit is not available for providing Home and Community Based Care benefits on policies providing Facility Care benefits only. We reserve the right to make the final decision on any request for the Alternative Plan of Care Benefit. Benefits paid are subtracted from the Benefit Amount.

## **Optional Personal Care Advisor**

An Optional Personal Care Advisor will be available if requested by you, to assist you with questions regarding such matters as: Eligibility for the Payment of Benefits; appropriate level of care; availability of facilities and other care and service resources in your area; or any other questions you may have about a claim for benefits. You may contact your Optional Personal Care Advisor by calling the toll-free number which will be shown on the Benefit Schedule page of the policy. You are not required to use these services in order to file a claim, there is no cost to you for their use and no benefits will be deducted from the Benefit Amount.

## **Optional Care Coordination**

At your request, if you need Optional Care Coordination assistance related to filing a claim, you may call the toll-free number which will be shown on the Benefit Schedule page of the policy and we will arrange for a care coordinator to contact you. The care coordinator will be an RN and will: assess and coordinate appropriate care and services; provide assistance in the development of a Plan of Care; if you wish, maintain a continuing role in the arrangement and monitoring of services and assist with necessary claims documentation. You are not required to use these services in order to file a claim, there is no cost to you for their use and no benefits will be deducted from the Benefit Amount.

## **Definitions**

**Activities of Daily Living** means:

- **Bathing:** washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- **Continence:** the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- **Dressing:** putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- **Eating:** feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- **Toileting:** getting to and from the toilet, getting on or off the toilet, and performing associated personal hygiene.
- **Transferring:** moving into or out of bed, a chair or wheelchair.

**Family** means you or your spouse and those related to you or your spouse; including a parent, sibling, child, grandparent or grandchild (including any of their in-laws, step or legally adopted relatives).

**Hands-On Assistance** means the physical assistance of another person without which you would be unable to perform the Activity of Daily Living.

**Home Health Aide** means a person, other than an RN or nurse, who provides Maintenance or Personal Care Services through a Home Health Care Agency. A Home Health Aide must be licensed or certified under state law, if any, and acting within the scope of his or her license or certification at the time the treatment or service is performed.

**Home Health Care Agency** means a hospital, agency, or other provider licensed under state law, if any, to provide Home Health Care.

**Independent Home Health Caregiver** means a person who is approved by us and:

- is independently employed and not associated with a Home Health Care Agency;
- provides care within the scope of his or her employment in the performance of Qualified Long Term Care Services; and
- is licensed or certified under state law, if any, and acting within the scope of his or her license at the time the treatment or service is performed.

**Licensed Health Care Practitioner** means:

- a physician;
- a registered nurse; or
- a licensed social worker.

The Licensed Health Care Practitioner must not be a member of your Family.

**Maintenance or Personal Care Services** means any care provided primarily to give needed assistance to you as a result of your being Chronically Ill (including protection of your health and safety due to a Severe Cognitive Impairment).

**Plan of Care** means a written plan prescribed by a Licensed Health Care Practitioner developed in consultation with you, based upon an assessment indicating you are Chronically Ill. The Plan of Care will recommend the necessary services to be performed. In addition, it will specifically identify the frequency and type of care most suitable to meet your needs, as well as the most appropriate providers for such care. The Plan of Care is updated as your needs change.

**Qualified Long Term Care Services** means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and Maintenance or Personal Care Services, which are required by you when you are Chronically Ill and are provided pursuant to a Plan of Care.

**Severe Cognitive Impairment** means your deterioration or loss of your intellectual capacity which requires Substantial Supervision by another person to protect yourself or others from threats to health and safety. It is measured by clinical evidence and standardized tests which reliably measure your impairment in:

- short or long term memory;
- your orientation as to person (such as who you are), place (such as your location) and time (such as day, date and year); and
- deductive or abstract reasoning.

A Severe Cognitive Impairment includes Alzheimer's disease and similar forms of irreversible dementia.

**Single Claim Period** means a claim for benefits under the policy that is not interrupted by a period of 180 consecutive days. If you do not satisfy the Eligibility for the Payment of Benefits provision under the policy (because you have recovered and you are not receiving benefits under the policy) for 180 consecutive days or longer, a new Single Claim Period will be established.

**Stand-By Assistance** means the presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, injury to you while you are performing the Activity of Daily Living.

**Substantial Assistance** means Hands-On or Stand-By Assistance.

**Substantial Supervision** means continual supervision by another person to protect you or others from threats to health or safety (such as may result from wandering) when you have a Severe Cognitive Impairment. Such supervision may include cueing by verbal prompting, gestures, or other similar demonstrations.

**Waiver of Premium Waiting Period** means the 90 days you must be confined in a nursing facility or assisted living facility and satisfy the Eligibility for the Payment of Benefits provision before we will waive premiums under the policy.

## **Eligibility for the Payment of Benefits**

You will satisfy the Eligibility for the Payment of Benefits provision if you are a Chronically Ill individual, which means that within the previous 12 months you have been certified by a Licensed Health Care Practitioner as: being unable to perform, without Substantial Assistance, at least two Activities of Daily Living for an expected period of at least 90 days due to loss of functional capacity; or having a Severe Cognitive Impairment.

The expected 90-day period for loss of functional capacity does not establish a waiting period beyond any Elimination Period selected before benefits become payable under the policy.

## **LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR THE PAYMENT OF BENEFITS**

### **Non-Eligible Facilities**

A nursing facility does not include a hospital, convalescent home, board and rest home, home for the aged, a residential care facility, domiciliary and retirement care facility, training center, government or veteran's facility or any other facility where the patient is not required to pay. An assisted living facility does not include a hospital.

No benefits will be paid under the policy for confinement in:

- non-eligible facilities; or
- an unlicensed facility (if licensing is required in your state).

### **Limitations and Exclusions**

No benefits will be paid and the Elimination Period will not be satisfied for any confinement, care, treatment or service(s):

- provided to you by a person in your Family;
- provided outside of the United States or its territories, or Canada, except as described above under Coverage Outside the United States;
- for which you have no financial liability or that is provided at no charge in the absence of insurance;
- provided in facilities operated primarily for the treatment of alcoholism or drug addiction; or
- provided in facilities operated primarily for the treatment of mental or nervous disorders. However, this shall not operate to exclude coverage for loss which results from Alzheimer's or any other demonstrable organic disease such as senile dementia.

### **Nonduplication of Benefits**

Benefits are not payable under the policy for: (a) expenses incurred to the extent that such expenses are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount; or (b) any other state or federal workers' compensation plan, or other governmental program (except Medicaid).

For purposes of satisfying the Elimination Period, days on which you satisfy the Eligibility for the Payment of Benefits provision, but coverage is excluded due to the Nonduplication of Benefits provision, will count toward satisfaction of the Elimination Period.

### **Payment of Benefits**

While the policy is in force, you will receive benefits if:

- you satisfy the Eligibility for the Payment of Benefits provision;
- you have satisfied any applicable Elimination Period shown on the Benefit Schedule page of the policy;
- you receive services covered under the policy pursuant to a Plan of Care;
- you are not receiving any other benefits covered under the policy;
- you have not been paid benefits that exceed the Benefit Amount or if shown on the Benefit Schedule page of the policy, the Maximum Benefit Amount With Restoration of Benefits or the Shared Benefit Amount;

- your claim is properly filed according to the requirements described in the policy; and
- your claim is not subject to any limitations or exclusions contained in the policy.

THE POLICY MAY NOT COVER ALL EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

#### **RELATIONSHIP OF COST OF CARE AND BENEFITS**

Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. The benefit levels of the basic policy will not increase over time. For an additional premium payment, you may purchase one of the optional Benefit Increase Riders described below.

#### **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS**

Subject to the Eligibility for the Payment of Benefits provision, the Payment of Benefits provision and any limitations or exclusions described above, the policy provides coverage if you are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses.

#### **PREMIUM**

##### **Premium Payment Options**

##### **10-Year and 20-Year Premium Payments**

These options provide that at the end of the premium payment period if each required premium has been paid, the policy will automatically be renewed for the rest of your life with no further premium payments required. During the premium payment period, premiums will be subject to change as described under "TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED" above.

**Long Term Care Insurance Policy**

\* If a PARTNERSHIP POLICY is selected below and you are age **60 or younger**, the Compound Benefit Increase Rider must be selected and will be issued with your policy. If you are age **61-75**, either the Compound or Simple Benefit Increase Rider must be selected and will be issued with your policy.

Partnership Policy     Non-Partnership Policy

Elimination Period:     0 Days     30 Days     90 Days     180 Days

Daily Benefit: \$ 150.00

Benefit Period:     Lifetime     3,650 Days (10 Years)     2,190 Days (6 Years)  
 1,825 Days (5 Years)     1,460 Days (4 Years)     1,095 Days (3 Years)  
 730 Days (2 Years)

The following are the Annual Premiums for the coverage you have applied for:

**Comprehensive coverage is Facility Care plus Home and Community Based Care (HCBC)**

	<b>Premium</b>
<b>Select only one of the following coverage combinations:</b>	
<input type="radio"/> Facility Care Only	\$ _____
<input type="radio"/> Facility Care Only with Facility Care Only Indemnity Benefit Rider (Form AL2100R-F-IND)	\$ _____
<input checked="" type="radio"/> Comprehensive	\$ <u>1,067.18</u>
<input type="radio"/> Comprehensive with Facility Care Only Indemnity Benefit Rider (Form AL2100R-F-IND)	\$ _____
<input type="radio"/> Comprehensive with Facility Care & HCBC Indemnity Benefit Rider (Form AL2100R-IND)	\$ _____
<input type="radio"/> Comprehensive with Facility Care Only Indemnity Benefit Rider (Form AL2100R-F-IND) & Monthly HCBC Benefit Rider (Form AL2100R-MTH) <b>(one of the Benefit Increase Riders must also be selected)</b>	\$ _____
<input type="radio"/> Comprehensive with Monthly HCBC Benefit Rider (Form AL2100R-MTH) <b>(one of the Benefit Increase Riders must also be selected)</b>	\$ _____
<b>Benefit Increase Riders (select only one) *:</b>	
<input checked="" type="radio"/> Compound Benefit Increase (Form AL2100R-CBI)	\$ <u>475.43</u>
<input type="radio"/> Simple Benefit Increase (Form AL2100R-SBI)	\$ _____
<b>Nonforfeiture Rider:</b>	
<input checked="" type="radio"/> Shortened Benefit Period Nonforfeiture (Form AL2100R-SBN)	\$ <u>373.51</u>
<b>Benefit Extension Riders (select only one):</b>	
<b>(not available with Lifetime Benefit Period)</b>	
<input type="radio"/> Restoration of Benefits (Form AL2100R-ROB)	\$ _____
<input type="radio"/> Shared Benefit Amount (Form AL2100R-SBA)	\$ _____
<b>Additional Benefit Riders:</b>	
<input type="radio"/> Full Return of Premium (Form AL2100R-ROP)	\$ _____
<input type="radio"/> HCBC Waiver of Premium (Form AL2100R-WOP)	\$ _____
<b>(not available with Facility Care Only coverage)</b>	
<input type="radio"/> First Day HCBC Benefit (Form AL2100R-FDC)	\$ _____
<b>(not available with Facility Care Only coverage)</b>	
<b>Premium Payment Options:</b> <input checked="" type="radio"/> Lifetime	
<input type="radio"/> 10-Year Premium	\$ _____
<input type="radio"/> 20-Year Premium	\$ _____
<b>(if Lifetime Premium and Compound Benefit Increase have been selected above, indicate the payment option):</b>	
<input type="radio"/> Standard Premium Payment Option <input checked="" type="radio"/> Step Rated Premium Payment Option	
<b>TOTAL ANNUAL PREMIUM:</b>	\$ <u>1,916.12</u>

## **Modal Premium Payments**

Premiums may be paid annually, semi-annually (additional 4.0%), quarterly (additional 8.0%), or by monthly automatic premium plan (additional 8.0%). The amount of each modal premium is calculated by multiplying the annual policy premium by the following applicable modal factors: Semi-Annual 0.52, Quarterly 0.27, Monthly 0.09.

## **ADDITIONAL FEATURES**

### **Medical Underwriting**

Your insurability for the policy will be determined by the answers given in your application and any other authorized medical information we obtain regarding your current state of health.

### **Grace Period**

Except for the first premium, you will have 31 days after each due date to pay the premium due. The policy remains in force during the Grace Period.

### **Unintentional Lapse**

If your premium is not paid by the 30th day of the Grace Period, we will provide written notice to you and any individuals designated by you to receive notice of nonpayment of premium. Notice will be sent at least 30 days before cancellation of your coverage. If your premium is not paid within 35 days after notice is sent, the policy will lapse for nonpayment of premium.

### **Nonforfeiture Benefits**

If you choose not to select the following optional nonforfeiture rider, a contingent benefit upon lapse will be available if: (a) the policy lapses as described under the Grace Period and Unintentional Lapse provisions of the policy; and (b) the premium rates for the policy are substantially increased. The benefit provided will be in the form of a Shortened Benefit Period as described below.

In addition to the contingent nonforfeiture benefit described above, if you select a limited premium payment option an additional contingent nonforfeiture benefit may also be available in the form of a reduced "paid-up" policy.

## **OPTIONAL RIDERS (available for an additional premium payment)**

### **Shortened Benefit Period Nonforfeiture**

The rider provides a benefit when the policy remains in force for at least 3 years and lapses due to nonpayment of premium. Coverage will continue and benefits will be payable based on the Daily Benefit in effect on the date of lapse. The new Benefit Amount payable under the rider will become equal to the greater of: (a) the total of premiums paid for the policy and all riders; or (b) 30 times the Daily Benefit in effect at the time of lapse. Any benefits paid after the policy lapses will be subtracted from this new Benefit Amount.

### **Full Return of Premium**

If you (both insureds in the case of joint coverage) die while the policy is in force, the total of premiums paid for the policy and any attached riders will be paid to your beneficiary.

### **Facility Care and Home and Community Based Care Indemnity Benefit**

The rider will pay the full Daily Benefit selected for Facility Care and Home and Community Based Care (if covered under the policy), regardless of the actual expenses incurred by you. Benefits paid are subtracted from the Benefit Amount.

### **Facility Care Only Indemnity Benefit**

The rider will pay the full Daily Benefit selected for Facility Care, regardless of the actual expenses incurred by you. Benefits paid are subtracted from the Benefit Amount.

### **Home and Community Based Care Waiver of Premium Benefit**

The rider will waive premiums for the policy and any attached riders after you (either insured in the case of joint coverage) have selected and are receiving Home and Community Based Care for 90 Service Days. No further premiums

will be due following the 90th Service Day. We will return any unearned premium to you on a pro-rata basis following the 90th Service Day. The premium will be waived until you no longer satisfy the Eligibility for the Payment of Benefits provision (because you have recovered and you are no longer receiving Home and Community Based Care, or you are no longer confined in a nursing facility or assisted living facility). Premium payments will then again become due. Any new Single Claim Period will require satisfaction of a new 90 Service Day Waiver of Premium Waiting Period, as described above.

The Waiver of Premium Waiting Period under the policy for confinement in a nursing facility or assisted living facility is 90 days. If you accumulate fewer than 90 Service Days of Home and Community Based Care towards your Waiver of Premium Waiting Period and do not qualify for Waiver of Premium under the rider, we will credit any Waiver of Premium Waiting Period days accumulated under the rider, during a Single Claim Period, toward satisfaction of the 90-day Waiver of Premium Waiting Period under the policy.

**Service Days** means each day on which you receive Home and Community Based Care visits, regardless of the number of visits received during that day.

### **Monthly Home and Community Based Care Benefit**

The rider will pay the actual Home and Community Based Care expenses incurred, on a monthly basis during any calendar month, up to the Daily Benefit selected for Home and Community Based Care times the actual number of days in that calendar month. Benefits paid are subtracted from the Benefit Amount.

### **First Day Home and Community Based Care Benefit**

The rider will waive any Elimination Period required for Home and Community Based Care benefits. If you otherwise satisfy the Payment of Benefits provision for Home and Community Based Care, no Elimination Period will be required and benefits will be payable on the first day you are qualified to receive Home and Community Based Care benefits.

### **Restoration of Benefits**

The rider will restore the Benefit Amount payable under the policy if, claims paid during a Single Claim Period have not exceeded the Benefit Amount, the policy remains in force and for a period of 180 consecutive days, you do not satisfy the Eligibility for the Payment of Benefits provision under the policy (because you have recovered and you are not receiving any benefits). We will restore benefits up to a Maximum Benefit Amount of twice the Benefit Amount selected. In the case of joint coverage, if only one of you has exhausted the Maximum Benefit Amount with Restoration of Benefits, coverage will continue for the remaining insured.

### **Shared Benefit Amount**

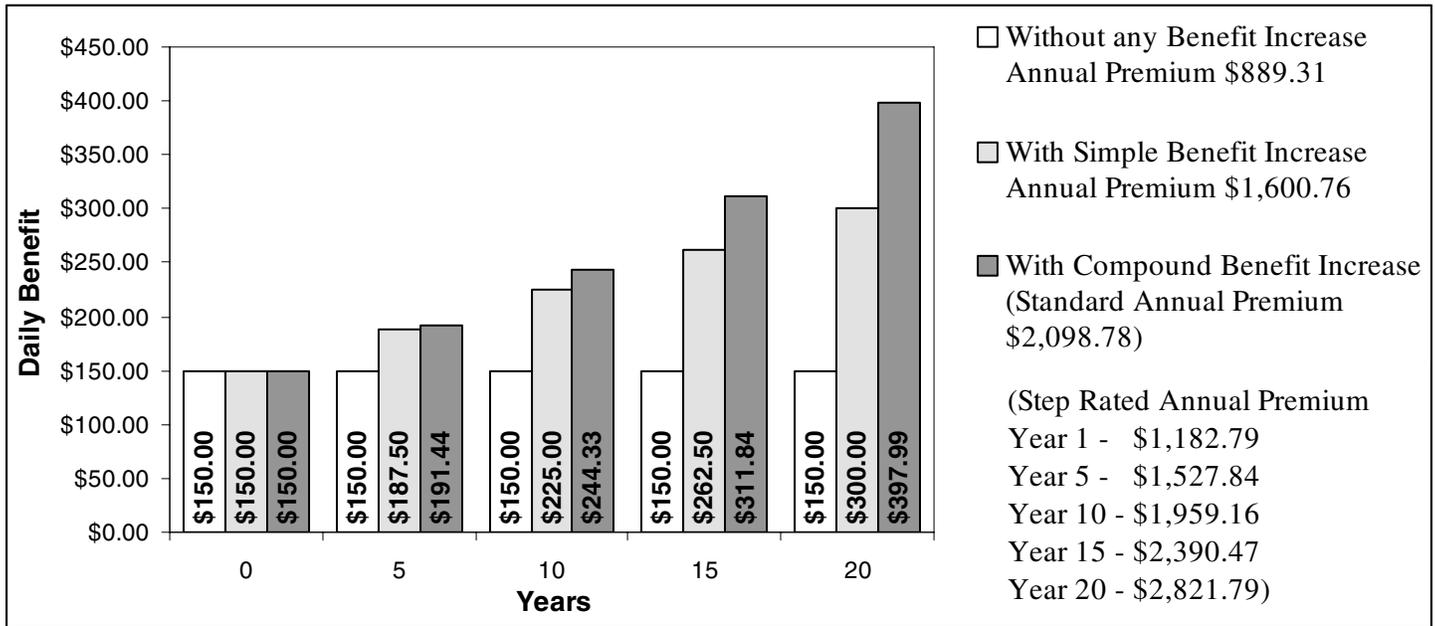
The rider provides a jointly Shared Benefit Amount in the event either or both joint insureds exhaust the Benefit Amount under the policy. The Shared Benefit Amount will be equal to the Benefit Amount shown on the Benefit Schedule page of the policy. Benefits paid are subtracted from the Shared Benefit Amount.

### **Benefit Increase**

These riders provide that on each policy anniversary, we will increase the Daily Benefit and Benefit Amount payable under the policy, as well as any applicable Maximum Lifetime Caregiver Training, Maximum Benefit Amount with Restoration of Benefits or Shared Benefit Amount benefits. The Simple Benefit Increase Rider increases the Daily Benefit by 5% of the dollar amount originally issued. The remaining Benefit Amount is increased by the same proportion as the Daily Benefit. The Compound Benefit Increase Rider increases the Daily Benefit by 5% of the previous year's dollar amount. The remaining Benefit Amount is also increased by 5%. Under both riders, the Daily Benefit and Benefit Amount will continue to increase annually while you are receiving benefits under the policy.

Premiums for the Compound Benefit Increase Rider may be paid under either the Standard Premium or the Step Rated Premium Payment Option. If the Step Rated option is selected the premium for this rider will increase by the same amount on each policy Anniversary Date, as shown on the Benefit Schedule page of the policy.

The following graph compares the benefits and premiums between a policy with the Simple Benefit Increase Rider, a policy with the Compound Benefit Increase Rider and a policy without either rider. For purposes of illustration, the sample shown is for a policy with a 1,825-day (5-year) Benefit Period for Facility Care and Home and Community Based Care, issued at age 55, a 90-day Elimination Period, and a \$150.00 Daily Benefit.



Agent \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY.

**APPLICATION FOR  
LONG TERM CARE  
INSURANCE**  
(PLEASE PRINT)  
AL2100A-1-AR

**Assurity Life Insurance Company**  
Home Office: Lincoln, Nebraska  
Long Term Care Administrative Office  
Post Office Box 4243  
Woodland Hills, CA 91365-4243  
(888) 505-3980

<b>Applicant Information</b>	Applicant (First Name, Middle Initial, Last Name) <i>John Doe</i>			Sex <input checked="" type="radio"/> M <input type="radio"/> F	Birthplace (City, State) <i>Anytown, ST</i>
	Social Security Number <i>123-45-6789</i>	Height <i>6'0"</i>	Weight <i>180</i>	Birthdate <i>1-1-53</i>	Age as of Nearest Birthday <i>55</i>
	Residence Address (Street, City, State, Zip) <i>123 Main St., Anytown, ST 12345-1234</i>			Phone Work: <i>(555) 555-1212</i> Home: <i>(555) 555-1212</i> Cell/Other: <i>(555) 555-1212</i>	
	Billing Address - If different (Name, Street, City, State, Zip)			Acceptable times to call: <input checked="" type="radio"/> Day <input type="radio"/> Evening <input type="radio"/> Sat/Sun	

<b>Health Questions</b>	<b>1. During the past 24 months, have you:</b>				
	Yes No				
	<input type="radio"/>	<input checked="" type="radio"/>	a) needed assistance or supervision with dressing, eating, bathing, toileting, transferring, or walking?		
	<input type="radio"/>	<input checked="" type="radio"/>	b) used a wheelchair, walker, brace or cane?		
	<input type="radio"/>	<input checked="" type="radio"/>	c) used oxygen equipment, received kidney dialysis or required a catheter?		
	<input type="radio"/>	<input checked="" type="radio"/>	d) received home health care services, physical or other rehabilitative therapy?		
	<input type="radio"/>	<input checked="" type="radio"/>	e) experienced amnesia, confusion, forgetfulness or memory loss?		
	<input type="radio"/>	<input checked="" type="radio"/>	f) experienced dizziness, fainting, weakness or chronic fatigue?		
	<input type="radio"/>	<input checked="" type="radio"/>	g) experienced falling, unstable gait, paralysis or loss of balance?		
	<input type="radio"/>	<input checked="" type="radio"/>	h) been confined to a nursing facility, assisted living facility, or home for the aged?		
<b>2. During the past 10 years, have you been medically diagnosed with or treated for:</b>					
Yes No		Yes No			
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	a) AIDS or positive HIV status? d) Hepatitis C?	
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	b) Alzheimer's Disease or dementia? e) Multiple Sclerosis?	
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	c) Amyotrophic Lateral Sclerosis? f) Parkinson's Disease or Parkinsonism?	
<b>3. During the past 10 years, have you been medically advised or treated for:</b>					
Yes No		Yes No			
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	a) high blood pressure? i) seizures or other neurological disorder?	
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	b) heart disorder? j) alcohol or drug dependency or abuse?	
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	c) circulatory disorder? k) arthritis or osteoporosis?	
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	d) diabetes? l) depression or other psychiatric disorder?	
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	e) emphysema or other chronic lung disorder? m) breast, prostate or other genito-urinary disorder?	
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	f) cancer; internal or melanoma? n) glaucoma or macular degeneration?	
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	g) stroke? o) liver disease or disorder?	
<input type="radio"/>	<input checked="" type="radio"/>	h) TIA (transient ischemic attack)?			
<b>If you answered "Yes" to any of Questions 1-3, provide full details below:</b>					
Ques. No.	Date From	Date To	Describe Condition and Treatment	Name of Physician or Care Facility	

Health Questions (continued)

4. Provide the name, address and phone number of your primary care physician (PCP). Additional details may be provided on page 4:

J. Doctor

145 Main St., Anytown, ST 12345-1234

Date last seen: 7-1-07 Reason for visit: Check-up

5. Provide the names of all medical specialists consulted within the last 2 years (other than your PCP). Additional details may be provided on page 4:

Name / Phone Number	Specialty	Reason for Visit	Medication / Treatment Prescribed

6. During the past 12 months have you:

Yes No

- a) smoked cigarettes?
- b) received disability benefits? If "Yes," details: \_\_\_\_\_
- c) been advised to have any surgery that has not yet been performed? If "Yes," details: \_\_\_\_\_
- d) been declined by another company for a policy providing nursing home or home health care coverage? If "Yes," details: \_\_\_\_\_
- e) taken prescription medication? If "Yes," list all medications: \_\_\_\_\_

Additional Information

Yes No

- 7. Due to any mental or physical disability that you now have or have had in the past, is any person or institution authorized to act on your behalf? Additional details may be provided on page 4.
- 8. Are you actively at work? If "Yes," hours per week: \_\_\_\_\_
- 9. Occupation: \_\_\_\_\_ If retired, date of retirement: \_\_\_\_\_
- 10. With whom do you currently live?  Spouse  Family  Alone  Other: \_\_\_\_\_
- 11. Type of residence?  House or Condo  Apartment  Retirement Community  Other

Information About Your Insurance Coverage

Yes No

- 12. Are you covered by Medicaid? (This does not mean Medicare)
- 13. Do you have a policy, certificate or application with this or any other company providing long term care insurance (including a health care service contract or health maintenance organization contract)?
- 14. Did you have another long term care insurance policy or certificate in force during the last twelve (12) months?  
If that policy lapsed, when did it lapse? \_\_\_\_\_
- 15. Do you intend to replace any of your long term care, medical or health insurance coverage with this policy?

If you answered "Yes" to any of Questions 13-15, provide full details below and complete required replacement forms:

Ques. No.	Company	Issue Date	Type of Policy	Daily Benefit	Renewal Date

**COMPLETE THIS PAGE FOR JOINT COVERAGE APPLICANT ONLY**

**Applicant Information**

Applicant (First Name, Middle Initial, Last Name) <i>Mary Doe</i>			Sex ○ M <input checked="" type="radio"/> F	Birthplace (City, State) <i>Anytown, ST</i>
Social Security Number <i>234-56-7891</i>	Height <i>5' 5"</i>	Weight <i>130 lbs.</i>	Birthdate <i>1-1-58</i>	Age as of Nearest Birthday <i>50</i>
Phone Work: <i>(555) 555-1212</i> Home: <i>(555) 555-1212</i> Cell/Other: <i>(555) 555-1212</i> Acceptable times to call: <input checked="" type="radio"/> Day <input type="radio"/> Evening <input type="radio"/> Sat/Sun			Relationship to Primary Applicant <i>Wife</i>	

**Health Questions**

**1. During the past 24 months, have you:**

**Yes No**

- a) needed assistance or supervision with dressing, eating, bathing, toileting, transferring, or walking?
- b) used a wheelchair, walker, brace or cane?
- c) used oxygen equipment, received kidney dialysis or required a catheter?
- d) received home health care services, physical or other rehabilitative therapy?
- e) experienced amnesia, confusion, forgetfulness or memory loss?
- f) experienced dizziness, fainting, weakness or chronic fatigue?
- g) experienced falling, unstable gait, paralysis or loss of balance?
- h) been confined to a nursing facility, assisted living facility, or home for the aged?

**2. During the past 10 years, have you been medically diagnosed with or treated for:**

**Yes No**

**Yes No**

- |  |  |
|--|--|
| <input type="radio"/> <input checked="" type="radio"/> a) AIDS or positive HIV status?     | <input type="radio"/> <input checked="" type="radio"/> d) Hepatitis C?                         |
| <input type="radio"/> <input checked="" type="radio"/> b) Alzheimer's Disease or dementia? | <input type="radio"/> <input checked="" type="radio"/> e) Multiple Sclerosis?                  |
| <input type="radio"/> <input checked="" type="radio"/> c) Amyotrophic Lateral Sclerosis?   | <input type="radio"/> <input checked="" type="radio"/> f) Parkinson's Disease or Parkinsonism? |

**3. During the past 10 years, have you been medically advised or treated for:**

**Yes No**

**Yes No**

- |   |  |
|---|--|
| <input type="radio"/> <input checked="" type="radio"/> a) high blood pressure?                      | <input type="radio"/> <input checked="" type="radio"/> i) seizures or other neurological disorder?           |
| <input type="radio"/> <input checked="" type="radio"/> b) heart disorder?                           | <input type="radio"/> <input checked="" type="radio"/> j) alcohol or drug dependency or abuse?               |
| <input type="radio"/> <input checked="" type="radio"/> c) circulatory disorder?                     | <input type="radio"/> <input checked="" type="radio"/> k) arthritis or osteoporosis?                         |
| <input type="radio"/> <input checked="" type="radio"/> d) diabetes?                                 | <input type="radio"/> <input checked="" type="radio"/> l) depression or other psychiatric disorder?          |
| <input type="radio"/> <input checked="" type="radio"/> e) emphysema or other chronic lung disorder? | <input type="radio"/> <input checked="" type="radio"/> m) breast, prostate or other genito-urinary disorder? |
| <input type="radio"/> <input checked="" type="radio"/> f) cancer; internal or melanoma?             | <input type="radio"/> <input checked="" type="radio"/> n) glaucoma or macular degeneration?                  |
| <input type="radio"/> <input checked="" type="radio"/> g) stroke?                                   | <input type="radio"/> <input checked="" type="radio"/> o) liver disease or disorder?                         |
| <input type="radio"/> <input checked="" type="radio"/> h) TIA (transient ischemic attack)?          |  |

**If you answered "Yes" to any of Questions 1-3, provide full details below:**

Ques. No.	Date From	Date To	Describe Condition and Treatment	Name of Physician or Care Facility

**COMPLETE THIS PAGE FOR JOINT COVERAGE APPLICANT ONLY**

Health Questions (continued)

**4. Provide the name, address and phone number of your primary care physician (PCP). Additional details may be provided on page 4:**

*J. Doctor*

*145 Main St., Anytown, ST 12345-1234*

Date last seen: *7-1-07* Reason for visit: *Check-up*

**5. Provide the names of all medical specialists consulted within the last 2 years (other than your PCP). Additional details may be provided on page 4:**

Name / Phone Number	Specialty	Reason for Visit	Medication / Treatment Prescribed

**6. During the past 12 months have you:**

Yes No

- a) smoked cigarettes?
- b) received disability benefits? If "Yes," details: \_\_\_\_\_
- c) been advised to have any surgery that has not yet been performed? If "Yes," details: \_\_\_\_\_
- d) been declined by another company for a policy providing nursing home or home health care coverage? If "Yes," details: \_\_\_\_\_
- e) taken prescription medication? If "Yes," list all medications: \_\_\_\_\_

Additional Information

Yes No

- 7. Due to any mental or physical disability that you now have or have had in the past, is any person or institution authorized to act on your behalf? Additional details may be provided on page 4.
- 8. Are you actively at work? If "Yes," hours per week: \_\_\_\_\_
- 9. Occupation: \_\_\_\_\_ If retired, date of retirement: \_\_\_\_\_
- 10. With whom do you currently live?  Spouse  Family  Alone  Other: \_\_\_\_\_
- 11. Type of residence?  House or Condo  Apartment  Retirement Community  Other

Information About Your Insurance Coverage

Yes No

- 12. Are you covered by Medicaid? (This does not mean Medicare)
- 13. Do you have a policy, certificate or application with this or any other company providing long term care insurance (including a health care service contract or health maintenance organization contract)?
- 14. Did you have another long term care insurance policy or certificate in force during the last twelve (12) months? If that policy lapsed, when did it lapse? \_\_\_\_\_
- 15. Do you intend to replace any of your long term care, medical or health insurance coverage with this policy?

**If you answered "Yes" to any of Questions 13-15, provide full details below and complete required replacement forms:**

Ques. No.	Company	Issue Date	Type of Policy	Daily Benefit	Renewal Date

\* If a PARTNERSHIP POLICY is selected below and you are age **60 or younger**, the Compound Benefit Increase Rider must be selected and will be issued with your policy. If you are age **61-75**, either the Compound or Simple Benefit Increase Rider must be selected and will be issued with your policy.

Partnership Policy       Non-Partnership Policy

**Comprehensive coverage is Facility Care plus Home and Community Based Care (HCBC)**

**Select only one of the following coverage combinations:**

- Facility Care Only
- Facility Care Only with Facility Care Only Indemnity Benefit Rider
- Comprehensive
- Comprehensive with Facility Care Only Indemnity Benefit Rider
- Comprehensive with Facility Care & HCBC Indemnity Benefit Rider
- Comprehensive with Facility Care Only Indemnity Benefit Rider & Monthly HCBC Benefit Rider **(one of the Benefit Increase Riders must also be selected)**
- Comprehensive with Monthly HCBC Benefit Rider **(one of the Benefit Increase Riders must also be selected)**

**Elimination Period:**

- 0 Days
- 30 Days
- 90 Days
- 180 Days

**Daily Benefit Applied For:** \$ 150.00

**Benefit Period:**

- Lifetime
- 3,650 Days (10 Years)
- 2,190 Days (6 Years)
- 1,825 Days (5 Years)
- 1,460 Days (4 Years)
- 1,095 Days (3 Years)
- 730 Days (2 Years)

\* Please refer to Partnership Policy requirements above.

**Benefit Increase Riders (select only one):**

- Compound Benefit Increase
- Simple Benefit Increase

**Nonforfeiture Benefit Rider:**

- Shortened Benefit Period Nonforfeiture

**Benefit Extension Riders (select only one):**  
**(not available with Lifetime Benefit Period)**

- Restoration of Benefits
- Shared Benefit Amount

**Additional Benefit Riders:**

- Full Return of Premium
- HCBC Waiver of Premium **(not available with Facility Care Only coverage)**
- First Day HCBC Benefit **(not available with Facility Care Only coverage)**

**Required Benefit Rejection**

**IF INFLATION PROTECTION OR NONFORFEITURE BENEFITS ARE NOT SELECTED YOU MUST INITIAL IN BOXES BELOW:**

\* See Benefit Increase Rider requirements related to *Partnership Policies* above.

**REJECTION OF BENEFIT INCREASE RIDERS** - I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of this policy with and without the Benefit Increase Riders and I have chosen to **reject** these riders.

**Initial here:**              
                          Primary Applicant      Joint Applicant

**REJECTION OF NONFORFEITURE RIDER** - I have reviewed the Outline of Coverage that describes the Shortened Benefit Period Nonforfeiture Rider and I have chosen to **reject** this rider.

**Initial here:**              
                          Primary Applicant      Joint Applicant

**Premium Information**

**Primary Applicant Rate Class:**

- Preferred       Select       Standard

**Joint Applicant Rate Class:**

- Preferred       Select       Standard

**Payment Mode (select only one):**

- Annual       Quarterly
- Semi-Annual       Monthly Automatic Payment Plan
- List Billing (select mode as shown below):**  
 Annual       Semi-Annual       Quarterly       Monthly

**Approved Employer or Association Group?**

Yes       No      If "Yes," Group Identification Code or Name: \_\_\_\_\_

**Premium Payment Options (select only one):**

- 10-Year Premium
- 20-Year Premium
- Lifetime Premium **(if Lifetime Premium and Compound Benefit Increase are selected, you must also select one of the following):**  
 Standard Premium Payment Option  
 Step Rated Premium Payment Option

<b>Paid with Application</b> \$ <u>1,916.12</u>	<b>Beneficiary Name and Relationship</b> <u>Jane Doe Sister</u>
<b>Special Request / Requested Effective Date</b> 	

**PROTECTION AGAINST UNINTENTIONAL LAPSE**

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. **Check applicable box:**

- I elect NOT to designate any person to receive such notice.
- I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

Name: Paul Doe Telephone Number: (555) 555-1414

Address: 123 First St. Anytown ST 12345-1234  
Street City State Zip Code

Relationship: Brother

Unintentional Lapse

**ADDITIONAL DETAILS**

Provide additional details for any "yes" answers, or for questions 4 and 5. Include the question number and indicate whether details pertain to **Primary** or **Joint** Applicant.

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Additional Details

**AGREEMENT** - The answers given are complete and true to the best of my knowledge and belief. I understand that the Company will rely on my written answers to the questions in this application and that if my answers are not complete and true, my policy may not be valid. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy.

**ACKNOWLEDGMENT** - I acknowledge receipt of an Outline of Coverage, NAIC Shopper's Guide, Potential Rate Increase Disclosure Form, Disclosure Statement (which includes the Notice of Insurance Information Practices) and Notice of Privacy Practices.

**"I" means the applicant and if applicable, the joint applicant applying for coverage under this application.**

**CAUTION: If your answers on this application are incorrect or untrue, Assurity Life Insurance Company has the right to deny benefits or rescind your policy.**

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

Signed at: Anytown, ST  
City, State

<b>x</b>	<u>John Doe</u>	<u>1-1-08</u>
	Applicant's Signature	Date

<b>x</b>	<u>Mary Doe</u>	<u>1-1-08</u>
	Joint Applicant's Signature	Date

Applicant Statements

Agent Must Complete Statement on Next Page

**AGENT'S STATEMENT**

**1. How well do you know the applicant(s)?**

- Known well for \_\_\_\_ years                       Met very recently  
 Known slightly for \_\_\_\_ years                       Relative? \_\_\_\_\_

Yes No

**2a. To the best of your knowledge, is the insurance applied for intended to replace any long term care, medical or health insurance in force with this or any other company?**

**2b. List any other health insurance policies that you have sold to the applicant(s):**

(i) Which of the policies listed above are still in force, if any?

(ii) Which of the policies listed above sold in the past five (5) years are no longer in force, if any?

**3. Did you ask the applicant(s) all the questions face to face and witness their signature(s)?**

If "No," provide details: \_\_\_\_\_

**4. Did you deliver to the applicant(s) the Outline of Coverage, the required Disclosures, including the Notice of Insurance Information Practices, the NAIC Shopper's Guide and the Notice of Privacy Practices?**

I certify that the answers to the questions provided by the applicant(s) were fully and accurately recorded in the application, that the questions in the Agent's Statement have been answered accurately and that the Outline of Coverage, the required Disclosures, the NAIC Shopper's Guide and the Notice of Privacy Practices have been given to the applicant(s). I have reviewed the current health insurance coverage of the applicant(s) and find that the coverage of the type and amount applied for is appropriate for the needs of the applicant(s). Further, if this is a replacement, I have reviewed the current health insurance coverage of the applicant(s) and find that this replacement is appropriate for the needs of the applicant(s).

John Q. Porter

Licensed Agent's Name (Please Print)

**x**

John Q. Porter

Licensed Agent's Signature

1234

Ident. Code

100

Split %

(555) 555-1515

Agent Phone

(555) 555-1414

Agent Fax

5678

Agency Number

1-1-08

Date

\_\_\_\_\_  
Second Agent's Name (Please Print)

\_\_\_\_\_  
Ident. Code

\_\_\_\_\_  
Split %

\_\_\_\_\_  
Third Agent's Name (Please Print)

\_\_\_\_\_  
Ident. Code

\_\_\_\_\_  
Split %

Agent's Statement

SERFF Tracking Number: LFCR-125724516 State: Arkansas  
Filing Company: Assurity Life Insurance Company State Tracking Number: 39536  
Company Tracking Number: ALE-CNF-LP  
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified  
Product Name: AssurityBalance  
Project Name/Number: /

## Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: LFCR-125724516

State: Arkansas

Filing Company: Assurity Life Insurance Company

State Tracking Number: 39536

Company Tracking Number: ALE-CNF-LP

TOI: LTC03I Individual Long Term Care

Sub-TOI: LTC03I.001 Qualified

Product Name: AssurityBalance

Project Name/Number: /

## Supporting Document Schedules

<b>Satisfied -Name:</b> Certification/Notice	<b>Review Status:</b> Approved-Closed	07/21/2008
<b>Comments:</b>		
<b>Attachment:</b> AR CERTIFICATION OF COMPLIANCE.pdf		
<b>Bypassed -Name:</b> Application	<b>Review Status:</b> Approved-Closed	07/21/2008
<b>Bypass Reason:</b> See Form Schedule		
<b>Comments:</b>		
<b>Bypassed -Name:</b> Health - Actuarial Justification	<b>Review Status:</b> Approved-Closed	07/21/2008
<b>Bypass Reason:</b> NA		
<b>Comments:</b>		
<b>Bypassed -Name:</b> Outline of Coverage	<b>Review Status:</b> Approved-Closed	07/21/2008
<b>Bypass Reason:</b> See Form Schedule		
<b>Comments:</b>		
<b>Satisfied -Name:</b> Cover Sheet	<b>Review Status:</b> Approved-Closed	07/21/2008
<b>Comments:</b>		
<b>Attachment:</b> AR AL2100 updates Cover Sheet.pdf		
<b>Satisfied -Name:</b> Issuer Certification	<b>Review Status:</b> Approved-Closed	07/21/2008
<b>Comments:</b>		
<b>Attachment:</b> AR Partnership Issuer Certification.pdf		

SERFF Tracking Number: LFCR-125724516 State: Arkansas  
Filing Company: Assurity Life Insurance Company State Tracking Number: 39536  
Company Tracking Number: ALE-CNF-LP  
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified  
Product Name: AssurityBalance  
Project Name/Number: /

**Satisfied -Name:** Cover Letter July 21, 2008 **Review Status:** Approved-Closed 07/21/2008

**Comments:**  
Here is the cover letter with the correct state reference.

**Attachment:**  
AR AL rs and partnership filing letter correction.pdf

**CERTIFICATION OF COMPLIANCE**

**Insurer:** \_\_\_\_\_

**The company has reviewed the enclosed policy form(s) and certified that they comply with the provision of Regulation 19 as well as all applicable requirements of the Arkansas Department of Insurance.**

**Signature:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**FORM FILING COVER SHEET – AR**

**RATE STABILIZATION AND PARTNERSHIP FORMS**

**POLICY FORMS FILED FOR USE AS QUALIFIED TAX STATUS:**

Rate Stabilization forms:

ALE-CNF-LP Contingent Benefit Upon Lapse Endorsement for Limited Pay Policy

ALN-PRI-LP Potential Rate Increase Disclosure Form

ALE-RED Reduction of Benefits Endorsement

ALN-LTC Things You Should Know before You Buy Long Term Care Insurance

Partnership forms:

ALN-PRT-AR Partnership Program Notice

ALD-PRT-AR Important Notice Regarding Your Policy's Long-Term Care Insurance Partnership Status

Revised Forms:

AL2100OC-1-AR Outline of Coverage revised and replacing AL2100OC-AR

AL2100A-1-AR Application for Long Term Care revised and replacing AL2100-A-AR

**APPENDIX C**  
**ISSUER CERTIFICATION FORM**  
(relating to Qualified State Long-Term Care Insurance Partnership)

In order to provide the Insurance Commissioner with information necessary to provide a certification for policies, this Issuer Certification Form requires information and a certification from issuers of long-term care insurance policies with respect to policy forms that may be covered under the Qualified Partnership of the State.

An insurance company may request certification of policies from time to time and, accordingly, may supplement this issuer certification form, *e.g.*, as it introduces new long-term care insurance policy forms for issuance.

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**I. GENERAL INFORMATION**

**A. Name, address and telephone number of issuer:**

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**B. Name, address, telephone number, and email address (if available) of an employee of issuer who will be the contact person for information relating to this form:**

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**C. Policy form number(s) (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form (expand the space below as required):**

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Specimen copies of each of the above policy forms, including any riders and endorsements, shall be provided upon request.

**II. CERTIFICATIONS**

- A.** I hereby certify that the policy forms listed above are in compliance with Rule 13 and Rule 94 and all other Arkansas statutes and rules regarding long-term care insurance.
- B.** I hereby certify to the best of my knowledge and belief that all producers who sell, solicit or negotiate long-term care insurance products on {insert issuer name's} behalf have received the training required for Partnership policies and that they demonstrate an understanding of the policies and their relationship to public and private long-term care coverage.
- C.** I hereby certify that the answers, accompanying documents, and other information set forth herein are, to the best of my knowledge and belief, true, correct, and complete.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name and title of officer of the Issuer

\_\_\_\_\_  
Signature of officer of the Issuer



Long Term Care Administrative Office  
21600 Oxnard Street, Suite 1500  
Mailing Address: Post Office Box 4243  
Woodland Hills, CA 91365-4243

An Assurity Security Group Inc. Company  
(888) 505-3980 • Fax (818) 887-4595

July 21, 2008

Marie Bennett  
Arkansas Department of Insurance  
**VIA SERFF**

**RE: ASSURITY LIFE INSURANCE COMPANY – NAIC #71439**  
Long Term Care filing of Arkansas required rate stabilization and partnership forms For use with AL2100P-AR et al **Tax-Qualified Policy Forms**  
**Approved February 23, 2007**

The attached forms, as listed on the enclosed Form Filing Cover Sheet, are being filed for your review and approval as new forms and are intended for use with the above referenced previously approved individual long term care forms.

The following forms are being filed to comply with Arkansas adoption of revisions to Regulation 13 and the Arkansas Long Term Care Partnership Program Regulation 94.

Forms ALE-CNF-LP, Contingent Benefit Upon Lapse Endorsement provides the required nonforfeiture if the applicant selects the 10-Pay or Paid-up at 65 premium payment option. Form ALN-LTC, Things You Should Know Before You Buy Long Term Care Insurance will be given to each prospective applicant. ALN-PRI-LP, Potential Rate Increase Disclosure Form, will be given to all prospective applicants and will advise them that the premiums may be increased in the future. Form ALE-RED, Lowering Premiums by Reducing Premiums Endorsement, allows the insured to reduce the premium on the policy by reducing the daily or maximum benefit amount.

The following forms are intended to be used in the **Arkansas** Long Term Care Partnership program as follows.

Form ALN-PRT-AR will be given to each prospective applicant applying for a partnership policy in Arkansas and Form ALD-PRT-AR will be attached to each policy that becomes a partnership policy as chosen in the Application and Outline. The certification for the policy, AL2100P-AR is attached to certify that the policies qualify as partnership policies.

The following forms are revised to comply with the revised regulations and replace the original forms.

Application Form AL2100A-1-AR, replacing AL2100A-AR, and Outline AL2100OC-1-AR, replacing AL2100OC-AR, are revised to include the nonforfeiture benefits in the required rate stabilization regulation and include a line and box for each applicant to choose a partnership policy and to show the ages at which inflation protection is required.

Thank you for your assistance.

Trudy Weigel, LTCP  
Compliance Analyst  
800-366-5463 Ext. 2240

SERFF Tracking Number: LFCR-125724516 State: Arkansas  
 Filing Company: Assurity Life Insurance Company State Tracking Number: 39536  
 Company Tracking Number: ALE-CNF-LP  
 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified  
 Product Name: AssurityBalance  
 Project Name/Number: /

## Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Important Information About the Arkansas Long Term Care Insurance Partnership Program	07/07/2008	ALN-PRT-AR.pdf

## Assurity Life Insurance Company

Home Office: Lincoln, Nebraska

Long Term Care Administrative Office

Post Office Box 4243

Woodland Hills, CA 91365-4243

(888) 505-3980

# Important Consumer Information Regarding the Arkansas Long-Term Care Insurance Partnership Program

Some long-term care insurance policies sold in Arkansas may qualify for the Arkansas Long-Term Care Insurance Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies that qualify as Partnership Policies may protect the policyholder's assets through a feature known as "Asset Disregard" under Arkansas Medicaid program.

**Asset Disregard** means that an amount of the policyholder's assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply. Asset Disregard is not available under a long-term care insurance policy that is not a Partnership Policy. Therefore, you should consider whether Asset Disregard is important to you, and whether a Partnership Policy meets your needs. *The purchase of a Partnership Policy does not automatically qualify you for Medicaid.*

**What are the Requirements for a Partnership Policy.** In order for a policy to qualify as a Partnership Policy, it must, among other requirements:

- be issued to an individual after January 1, 2008;
- cover an individual who was an Arkansas resident when coverage first becomes effective under the policy;
- be a tax-qualified policy under Section 7702(B)(b) of the Internal Revenue Code of 1986;
- meet stringent consumer protection standards; and,
- must provide annual inflation protection for ages 75 and younger.

If you apply and are approved for long-term care insurance coverage, Minnesota Life Insurance Company will provide you with written documentation as to whether your policy qualifies as a Partnership Policy.

**What Could Disqualify a Policy as a Partnership Policy?** Certain types of changes to a Partnership Policy could affect whether such policy continues to be a Partnership Policy. If you purchase a Partnership Policy and later decide to make *any* changes, you should first consult with Minnesota Life Insurance Company to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy as a Partnership Policy, you would not receive beneficial treatment of your policy under the Medicaid program of that state. The information contained in this disclosure is based on current Arkansas and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy under Arkansas's Medicaid program.

**Additional Information.** If you have questions regarding long-term care insurance policies please contact Minnesota Life Insurance Company. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Arkansas Department of Human Services.