

SERFF Tracking Number: NWST-125547151 State: Arkansas
Filing Company: Northwestern Long-Term Care Insurance State Tracking Number: 38435
Company
Company Tracking Number: 90-1973 LTC (1008)
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: 90-1973 LTC (1008)
Project Name/Number: 90-1973 LTC (1008)/90-1973 LTC (1008)

Filing at a Glance

Company: Northwestern Long-Term Care Insurance Company

Product Name: 90-1973 LTC (1008)

TOI: LTC03I Individual Long Term Care

Sub-TOI: LTC03I.001 Qualified

Filing Type: Form

SERFF Tr Num: NWST-125547151 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 38435

Co Tr Num: 90-1973 LTC (1008)

State Status: Approved-Closed

Co Status:

Reviewer(s): Harris Shearer

Authors: Addie Croeker, Laine

Disposition Date: 07/02/2008

Ebert-loff, Julie Lewandowski

Date Submitted: 03/17/2008

Disposition Status: Approved

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: 90-1973 LTC (1008)

Project Number: 90-1973 LTC (1008)

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 07/02/2008

State Status Changed: 07/02/2008

Corresponding Filing Tracking Number: 90-1973 LTC (1008)

Filing Description:

We are submitting Medical Questionnaire application form 90-1973 LTC (1008) for your review and approval. It will be introduced in the fourth quarter of 2008, pending state insurance department approval. It will replace application form 90-1973 LTC (1101), which was previously approved by your state. It will be used in conjunction with our previously approved policy forms.

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

This form has been updated. In particular, the sequencing of questions has been modified to facilitate simplified

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underwriting.

Based on this information, your review and approval of the above referenced form is respectfully requested. If you have any questions, please call me at (414) 665-4114.

Laine-Ebert-Loff
 Product Compliance Specialist

Company and Contact

Filing Contact Information

Laine Ebert-Loff, Product Compliance Specialist laineebertloff@northwesternmutual.com
 720 East Wisconsin Avenue (414) 665-4114 [Phone]
 Milwaukee, WI 53202 (414) 665-5006[FAX]

Filing Company Information

Northwestern Long-Term Care Insurance CoCode: 69000 State of Domicile: Wisconsin
 Company
 720 East Wisconsin Avenue Group Code: 860 Company Type: Long Term Care
 Rm S845
 Milwaukee, WI 53202 Group Name: State ID Number:
 (414) 665-4224 ext. [Phone] FEIN Number: 36-2258318

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Northwestern Long-Term Care Insurance Company	\$0.00	03/17/2008	

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Harris Shearer	07/02/2008	07/02/2008

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Filing Fee returned	Note To Reviewer	Addie Croeker	06/12/2008	06/12/2008
Filing Fee	Note To Reviewer	Addie Croeker	05/27/2008	05/27/2008

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Readability Certification		Yes
Form	Medical Questionnaire		Yes

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Form Schedule

Lead Form Number: 90-1973 LTC (1008)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	90-1973 LTC (1008)	Application/Medical Enrollment	Questionnaire Form	Revised	Replaced Form #: 90-1973 LTC (1101) Previous Filing #:	53	STD 90-1973 LTC (1008).pdf

MEDICAL QUESTIONNAIRE – Each question must be individually asked and answered.

Policy Number: _____
 (For NLTC Administration Office Use Only)

INSURED'S NAME: (First, MI, Last) *please print* _____

FORMER NAME (If changed within 5 years) _____

GENERAL INFORMATION

1. Who is your regular physician or other health care provider? None

 ()-
 PHYSICIAN NAME TELEPHONE NUMBER

 ADDRESS CITY STATE ZIP CODE

 DATE LAST SEEN (MM/DD/YYYY) REASON

2. a. Are you currently employed on a full time basis? (If yes, please continue to 2b. and 2c.)..... b. Are you employed inside or outside of the home?..... c. Have your hours been limited in the past 24 months for health reasons?.....	YES NO <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> <input type="checkbox"/>	Provide Full details for all "Yes" responses: <ul style="list-style-type: none"> Identify question numbers. State signs, symptoms, and diagnosis of each illness or injury. List the details and results of tests and treatment. For each health care provider consulted, list the name, full address, telephone number, and dates. 	
	GENERAL PROFILE		DETAILS
	3. Do you currently, or in the past 12 months did you require human assistance or receive help in any way with:		YES NO

a. Moving into or out of a bed or a chair?..... b. Bathing?..... c. Eating?..... d. Dressing?..... e. Using the toilet? f. Controlling bowel or bladder? g. Taking your medications?	YES NO <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
4. Do you currently receive, or in the past 12 months have you received:	YES NO	
a. Care in a nursing home or extended care unit of a hospital?..... b. Home health care (including visiting nurse, therapist, and home health aid)?..... c. Adult day care services?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
5. Do you currently use, or in the past 12 months have you used:	YES NO	
a. Oxygen equipment? b. Cane or quad cane? c. Walker?..... d. Wheelchair? e. Motorized scooter?..... f. A hospital bed in your home?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

6. Have you had, been told you had, or been treated or tested for:	YES	NO	DETAILS
a. Metastatic cancer (cancer that has spread from the original site)?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Alzheimer's Disease, dementia or memory loss?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Parkinson's disease?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Stroke, mini-stroke, or transient ischemic attack (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>	
e. Multiple sclerosis?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Kidney dialysis or chronic kidney failure?	<input type="checkbox"/>	<input type="checkbox"/>	
g. Amputation due to diabetes or peripheral vascular disease?	<input type="checkbox"/>	<input type="checkbox"/>	

MEDICAL HISTORY

7. a. What is your current height? ft. ____ in.
 b. What is your current weight? lbs.
 c. Have you lost weight in the past 6 months?.....
 If yes, indicate how many pounds and the reason for the weight loss.
 ____ lbs. Reason: _____

8. Have you used tobacco or nicotine in any form in the past 10 years including cigarette, pipe, snuff, chewing tobacco, cigar, nicotine gum, or nicotine patch?	YES	NO
If "Yes," date last used (MM/DD/YYYY) _____	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past 5 years, have you requested or received payments, benefits, or a pension because of an injury, accident, sickness, or disability?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you plan to retire due to health reasons, or have you been advised to retire, change jobs or limit your hours due to health reasons?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever tested positive for the Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you currently take, or have you in the past 12 months taken, any prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>

If "Yes," list each medication, why it is needed, and the name and address of prescribing physician.
 If more space is needed, please attach an additional sheet of paper.

Name of Medication	Dosage	Frequency	Reason Prescribed	Physician Name

13. In the last 10 years have you had, been told you had, or been treated or tested for:

		YES	NO	DETAILS
	a. Any problems with balance or coordination?	<input type="checkbox"/>	<input type="checkbox"/>	
	b. Huntington's chorea?	<input type="checkbox"/>	<input type="checkbox"/>	
	c. Any muscle weakness or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>	
	d. Muscular dystrophy?	<input type="checkbox"/>	<input type="checkbox"/>	
	e. Myasthenia gravis?	<input type="checkbox"/>	<input type="checkbox"/>	
	f. Amyotrophic lateral sclerosis (ALS)?	<input type="checkbox"/>	<input type="checkbox"/>	
	g. Seizures?	<input type="checkbox"/>	<input type="checkbox"/>	
	h. Tremor?	<input type="checkbox"/>	<input type="checkbox"/>	
	i. Macular degeneration or other disorder of the eye?	<input type="checkbox"/>	<input type="checkbox"/>	
	j. Any problem, disease, or disorder of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Vessels	k. Angina?	<input type="checkbox"/>	<input type="checkbox"/>	
	l. Congestive heart failure?	<input type="checkbox"/>	<input type="checkbox"/>	
	m. Heart attack or myocardial infarction (MI)?	<input type="checkbox"/>	<input type="checkbox"/>	
	n. Irregular heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	
	o. Any other disorder or disease of the heart?	<input type="checkbox"/>	<input type="checkbox"/>	
Blood	p. High blood pressure or hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
	q. Peripheral vascular disease?	<input type="checkbox"/>	<input type="checkbox"/>	
	r. Any other disorder or disease of the blood vessels, including problems with circulation?	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	s. Osteopenia or Osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>	
	t. Falls?	<input type="checkbox"/>	<input type="checkbox"/>	
	u. Fractures?	<input type="checkbox"/>	<input type="checkbox"/>	
	v. Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	
	w. Any disorder or disease of the neck, back or spine?	<input type="checkbox"/>	<input type="checkbox"/>	
General Medical Conditions	x. Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	
	y. Enlarged lymph node?	<input type="checkbox"/>	<input type="checkbox"/>	
	z. Any disorder or disease of the blood?	<input type="checkbox"/>	<input type="checkbox"/>	
	aa. Diabetes or elevated blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>	
	bb. Any disorder or disease of the kidney or urinary bladder?	<input type="checkbox"/>	<input type="checkbox"/>	
	cc. Asthma, wheezing or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	
	dd. Emphysema or chronic obstructive lung disease (COPD)?	<input type="checkbox"/>	<input type="checkbox"/>	
	ee. Cystic Fibrosis?	<input type="checkbox"/>	<input type="checkbox"/>	
	ff. Any disorder or disease of the liver?	<input type="checkbox"/>	<input type="checkbox"/>	
	gg. Any disorder or disease of the stomach or bowels?	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health	hh. Anxiety?	<input type="checkbox"/>	<input type="checkbox"/>	
	ii. Depression?	<input type="checkbox"/>	<input type="checkbox"/>	
	jj. Psychosis?	<input type="checkbox"/>	<input type="checkbox"/>	
	kk. Alcohol abuse?	<input type="checkbox"/>	<input type="checkbox"/>	
	ll. Illegal drug use or excess use of prescription medication?	<input type="checkbox"/>	<input type="checkbox"/>	

14. Other than as previously provided on this form, in the *past 5 years*:

	YES	NO	DETAILS
a. have you seen or consulted with any other health care provider, including a psychologist, chiropractor, counselor, therapist, or other health care provider?	<input type="checkbox"/>	<input type="checkbox"/>	
b. have you had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
c. have you been a patient at a hospital, clinic, or other health care facility?	<input type="checkbox"/>	<input type="checkbox"/>	
d. have you been advised to have any tests, consultations, hospitalizations, surgery or diagnostic studies that have not been completed?	<input type="checkbox"/>	<input type="checkbox"/>	

15. Family History

- a. Do you have a family history of heart or kidney disease, stroke, diabetes, cancer, melanoma, or any hereditary disease?
- b. Always complete the first three columns. Complete the last two columns if 15a is answered "Yes".

	Age if Living	Age at Death	Cause of Death	Condition	Age at Onset/Event
Father					
Mother					
Brothers					
Sisters					

The Insured declares that the answers and statements are correctly recorded, complete, and true to the best of the Insured's knowledge and belief. Statements in this application are representations and not warranties.

<p>➡ <input type="text"/></p> <p>Print Name of INSURED</p> <p>➡ <input type="text"/></p> <p>Date Signed by INSURED (MM/DD/YYYY)</p>	<p>➡ <input type="text"/></p> <p>Signature of INSURED</p> <p>➡ <input type="text"/></p> <p>(City, County & State) Signed by INSURED</p> <p>➡ <input type="text"/></p> <p>Signature of LICENSED AGENT</p>
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Supporting Document Schedules

Review Status:
Satisfied -Name: Certification/Notice 03/14/2008
Comments:
Attachment:
AR Certification.pdf

Review Status:
Bypassed -Name: Application 03/14/2008
Bypass Reason: not applicable to this filing
Comments:

Review Status:
Bypassed -Name: Outline of Coverage 03/14/2008
Bypass Reason: not applicable to this filing
Comments:

Review Status:
Satisfied -Name: Readability Certification 03/14/2008
Comments:
Attachment:
Std. Readability Cert.pdf

NORTHWESTERN LONG TERM CARE INSURANCE COMPANY

Re: 90-1973 LTC (1008)

We hereby certify that we have carefully reviewed the form(s) submitted herewith and to the best of our knowledge and ability find:

- a. That said form(s) conform(s) to Regulation 19s10B and all applicable Arkansas Insurance Statutes and Department requirements.
- b. That said form(s) contain(s) no provision previously disapproved by the Insurance Department of Arkansas.



Ted A. Matchulat
Product Compliance Officer

03/14/2008

Date

READABILITY OF LTC MEDICAL QUESTIONNAIRE

I certify to the best of my knowledge and belief that the following form meets the readability, legibility, and format requirements of any applicable laws and regulations of your state, and that the Flesch Readability Score is as follows:

<u>Form</u>	<u>Flesch Readability Score</u>
90-1973 LTC (1008)	52.9

NORTHWESTERN LONG TERM
CARE INSURANCE COMPANY



Ted A. Matchulat
Product Compliance Officer

March 14, 2008
Date