

<i>SERFF Tracking Number:</i>	<i>LFSC-126051299</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>LifeSecure Insurance Company</i>	<i>State Tracking Number:</i>	<i>41870</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>LTC03I Individual Long Term Care</i>	<i>Sub-TOI:</i>	<i>LTC03I.004 Partnership</i>
<i>Product Name:</i>	<i>Partnership & New Regulations</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Filing at a Glance

Company: LifeSecure Insurance Company

Product Name: Partnership & New Regulations SERFF Tr Num: LFSC-126051299 State: ArkansasLH

TOI: LTC03I Individual Long Term Care SERFF Status: Closed State Tr Num: 41870

Sub-TOI: LTC03I.004 Partnership Co Tr Num: State Status: Under Review

Filing Type: Form Co Status: Reviewer(s): Marie Bennett, Stephanie Fowler

Authors: Sue Howard, Judy Lucas Disposition Date: 05/13/2009

Date Submitted: 03/19/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Partnership qualification has not been approved in our domicile

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 05/13/2009

Explanation for Other Group Market Type:

State Status Changed: 04/06/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

See cover letter

Company and Contact

SERFF Tracking Number: LFSC-126051299 State: Arkansas
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Company Tracking Number:
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.004 Partnership
Product Name: Partnership & New Regulations
Project Name/Number: /

Filing Contact Information

Judy Lucas, Senior Compliance Analyst jllucas@lifeseecureltc.com
10559 Citation Drive (810) 220-4610 [Phone]
Brighton, MI 48116 (810) 220-4690[FAX]

Filing Company Information

LifeSecure Insurance Company CoCode: 77720 State of Domicile: Michigan
10559 Citation Drive Group Code: 572 Company Type: Life, A & H
Suite 300
Brighton, MI 48116 Group Name: BCBS of MI GRP State ID Number:
(810) 220-8774 ext. [Phone] FEIN Number: 75-0956156

Filing Fees

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

SERFF Tracking Number: LFSC-126051299

State: Arkansas

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State Tracking Number: 41870

Company Tracking Number:

TOI: LTC03I Individual Long Term Care

Sub-TOI: LTC03I.004 Partnership

Product Name: Partnership & New Regulations

Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	05/13/2009	05/13/2009

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	03/25/2009	03/25/2009	Judy Lucas	03/26/2009	03/26/2009

SERFF Tracking Number: *LFSC-126051299* *State:* *Arkansas*
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Product Name: *Partnership & New Regulations*
Project Name/Number: /

Disposition

Disposition Date: 05/13/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: LFSC-126051299 State: Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Cover Letter	Accepted for Informational Purposes	Yes
Supporting Document	Issuer Certification for Partnership Qualification	Approved	Yes
Form	Individual Long Term Care Policy	Approved	Yes
Form	Outline of Coverage	Approved	Yes
Form	Partnership Policy- Solitation Notice	Approved	Yes
Form	Partnership Policy Disclosure Notice	Approved	Yes
Form	Potential Rate Dislcosure Form	Approved	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 03/25/2009
Submitted Date 03/25/2009
Respond By Date 04/10/2009

Dear Judy Lucas,

This will acknowledge receipt of the captioned filing.

Objection 1

- Flesch Certification (Supporting Document)
- Application (Supporting Document)
- Health - Actuarial Justification (Supporting Document)
- Outline of Coverage (Supporting Document)
- Individual Long Term Care Policy (Form)
- Outline of Coverage (Form)
- Partnership Policy- Solitation Notice (Form)
- Partnership Policy Disclosure Notice (Form)
- Potential Rate Dislcosure Form (Form)
- Cover Letter (Supporting Document)
- Issuer Certification for Partnership Qualification (Supporting Document)

Comment:

Please submit \$50.00 filing fee as required by Rule 57, Section 5, Subsection II - See below:

CATEGORY "B" – MAXIMUM \$50
(Per Covered Entity, Filing or Transaction)

ADMINISTRATIVE AND REGULATORY FEES FEE AMOUNTS

(a) Compliance.

(1) Filing or review of policy/contract, endorsements or certificates, riders, applications, or annuity forms, per submission (not per form)-----\$ 50

Please feel free to contact me if you have questions.

Sincerely,

Marie Bennett

SERFF Tracking Number: LFSC-126051299 State: Arkansas
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Company Tracking Number:
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.004 Partnership
Product Name: Partnership & New Regulations
Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
Response Letter Date 03/26/2009
Submitted Date 03/26/2009

Dear Marie Bennett,

Comments:

Thank you so much for your continued review

Response 1

Comments: Filing fee information has been updated and check is mailed

Related Objection 1

Applies To:

- Flesch Certification (Supporting Document)
- Application (Supporting Document)
- Health - Actuarial Justification (Supporting Document)
- Outline of Coverage (Supporting Document)
- Individual Long Term Care Policy (Form)
- Outline of Coverage (Form)
- Partnership Policy- Solitation Notice (Form)
- Partnership Policy Disclosure Notice (Form)
- Potential Rate Dislcosure Form (Form)
- Cover Letter (Supporting Document)
- Issuer Certification for Partnership Qualification (Supporting Document)

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per submission (not per form)-----\$ 50

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank You!

Sincerely,
Judy Lucas, Sue Howard

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	LS-0002 AR 03/09	Policy/Cont	Individual Long Term Initial ract/Fratern Care Policy al Certificate	Initial		43	LS 0002 AR 03.09 - Arkansas Policy.doc.pdf
Approved	LS-0052 AR 03/09	Outline of	Outline of Coverage Coverage	Initial		41	LS-0052 AR 03.09 - Outline of Coverage.pdf
Approved	LS-0127A AR 02/09	Other	Partnership Policy- Solitation Notice	Initial			LS-0127A AR 02.09- Partnership Soliciation Notice.pdf
Approved	LS-0127B AR 02/09	Other	Partnership Policy Disclosure Notice	Initial			LS-0127B AR 02.09- Partnership Policy Disclosure Form.pdf
Approved	LS-0101 ST 02/09	Other	Potential Rate Dislcosure Form	Initial			LS 0101 ST 02 09 - Potential Rate Disclosure Form.pdf



**Long Term Care
Insurance Policy**

LifeSecure Insurance Company
LifeSecure Administrative Office
411 N. Baylen Street
Pensicola, FL 32501
1-888-575-8246

LONG TERM CARE INSURANCE POLICY

Welcome! We thank you for choosing LifeSecure Insurance Company to be your long term care insurance carrier. We encourage you to contact us anytime – not just at time of claim – with any questions, concerns or comments you might have. Your long term care insurance policy has many important features. Please read it carefully. We look forward to serving you today and in the future.

NOTICE TO BUYER. This Policy may not cover all of the costs associated with long term care incurred by You during the period of coverage. We advise You to carefully review all Policy limitations.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. It is not intended to replace your present health insurance. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us.

THIS IS A TAX-QUALIFIED CONTRACT. This Policy is intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 and as amended by the Health Insurance Portability and Accountability Act of 1996 - Public Law 104-191.

GUARANTEED RENEWABLE FOR LIFE. You have the right, subject to the terms of this Policy, to continue this coverage as long as You pay the required premiums on time. We cannot change any of the terms of Your coverage or benefits without Your consent.

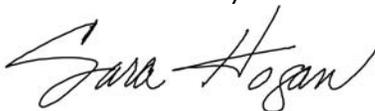
PREMIUM CHANGES. You cannot be singled out for a rate increase due to a change in Your age or health status. We can, however, change premiums, but only if We change the premiums for all similar policies issued in the same state and on the same form as Your Policy. Any premium changes will be effective on the next Premium Due Date following Our notice to You. We must give You at least 45 days written notice before the effective date of a premium change. If we ever increase Your premium, You will have the option to reduce coverage in order to preserve the premium amount You had previously been paying.

30-DAY FREE LOOK. If for any reason You decide not to keep this Policy, simply return it to Us within thirty (30) days after You receive it. We will treat the Policy as though it had never been issued. We will refund the full amount of any premium paid.

CAUTION: The issuance of this long term care insurance Policy is based upon the responses to questions on Your Application. A copy of Your Application is enclosed. If Your answers are incorrect or untrue, We have the right to deny benefits or rescind the 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.

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
1-800-282-9134

Secretary



President



TABLE OF CONTENTS

Schedule of Benefits Enclosed

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A copy of Your Application for this Policy Enclosed

Any appropriate Riders, Endorsements or Notices Enclosed

Refer to the Schedule of Benefits to determine Your benefits, options and applicable coverage details.

Note: *This Policy contains terms that have a special meaning when applied to Your coverage. To help You recognize these terms, the first letter of each word is capitalized wherever it appears throughout the Policy. These terms either: 1) appear in the Glossary (Section 6) with a corresponding definition; and/or 2) appear in a heading or sub-heading within the Policy with accompanying text providing further explanation.*

SECTION 1: DESCRIPTION OF BENEFITS AND FEATURES

Benefit Bank

Your Schedule of Benefits shows the Benefit Bank amount You have elected. Your Benefit Bank represents the lifetime dollar benefit amount available to You under this Policy. Your Benefit Bank balance is reduced by all benefit amounts paid to You whether based on reimbursement for Covered Expenses for Qualified Long Term Care Services or payments related to the Flexible Benefit.

Monthly Benefit Access Limit

Your Schedule of Benefits shows the Monthly Benefit Access Limit You have elected. Your Monthly Benefit Access Limit represents the dollar benefit amount available to You on a monthly basis during a claim period. The original dollar amount, as shown on Your Schedule of Benefits, is calculated as a percentage of Your Benefit Bank.

Note: *The percentage of Benefit Bank calculation is used only to determine the dollar amount of Your Monthly Benefit Access Limit at the Policy Effective Date. Thereafter, the percentage calculation no longer applies so that Your Monthly Benefit Access Limit (dollar amount) will not shrink as Your Benefit Bank balance decreases during time of claim.*

If You are eligible for benefits for fewer than 31 days in any one calendar month period, we will calculate the Monthly Benefit Access Limit based on a pro rata amount reflecting the actual number of days You were eligible.

Benefit Payout Structure

Covered Expense

When You are eligible for benefits, as described in Section 2 of this Policy, We will reimburse You for Covered Expenses for Qualified Long Term Care Services, up to Your Monthly Benefit Access Limit each calendar month. If You are eligible for benefits and You have not incurred Covered Expenses for Qualified Long Term Care Services up to the full Monthly Benefit Access Limit for a given calendar month, 50% of Your unused Monthly Benefit Access Limit will be available to You as a Flexible Benefit.

Qualified Long Term Care Services

The Flexible Benefit is not restricted by the definition of Covered Expenses. It is designed to provide You greater flexibility in the types of care or services You receive under this Policy, such as: care provided by an informal caregiver or family member, installation of a wheelchair access ramp to Your home, or rental of durable medical equipment for Your home.

Flexible Benefit

All benefits, both Covered Expenses and Flexible Benefits, payable to You under this Policy must be pursuant to a written Plan of Care.

Note: *The definitions of the terms Covered Expenses, Qualified Long Term Care Services and Flexible Benefit are especially important for You to understand. Together, these definitions clarify the differences between Your reimbursable expenses and Your Flexible Benefit allowances. You will find the definitions of each of these terms in the Glossary (Section 6 of this Policy).*

**LifeSecure
Care Advisor
Services**

LifeSecure Care Advisor Services are provided through Our LifeSecure Care Advisors. You may use the LifeSecure Care Advisor Services anytime while Your Policy is in force. The services are provided at no cost to You.

A LifeSecure Care Advisor is available to:

- assist in identifying Your specific personal care needs and the long term care services in Your area which may appropriately meet those needs;
- assist in developing a Plan of Care that meets Your needs; and
- help You arrange for care or services.

**Guaranteed Future
Purchase Offers**

Note: *This feature is included in Your coverage as a standard feature unless You have elected one of the optional inflation protection benefits: Automatic 3% Compound Inflation Protection Benefit or Automatic 5% Compound Inflation Protection Benefit, described later in this Section.*

Under the Guaranteed Future Purchase Offers, You will be offered the opportunity to increase Your Monthly Benefit Access Limit and Benefit Bank every three years, subject to the conditions listed below.

Each offer to increase will be for 15% of the dollar amount of Your current Monthly Benefit Access Limit and the remaining dollar amount of Your Benefit Bank. This offer will be made beginning on the third anniversary of Your Policy Effective Date and every three years thereafter. You may elect to increase Your coverage by the amount offered under this feature without submitting evidence of insurability. All increased amounts will be rounded to the nearest whole dollar.

The premium for the additional amount of coverage will be based on Your attained age, Your original rate class and Our premium rate schedule as of the date the benefit increase offer is made to You.

We will notify You in writing or electronically of the offer at least 60 days prior to the anniversary of the Policy Effective Date. You may accept or decline the offer within 60 days after We send the notification. If We do not receive Your acceptance of Our offer within 60 days, We will deem this to be a declination of the offer. You may accept or decline ongoing offers to increase coverage each time an offer is made.

No further offers will be made if Your Policy is terminated, or if coverage is continuing in effect under:

- the Extension of Benefits;
- the Lapse Protection Benefit, if any; or
- the Contingent Non-Forfeiture Benefit, if any.

**Guaranteed Future
Purchase Offers**
(continued)

No further offers will be made:

- once You have attained age 80;
- during the Benefit Wait Period; or
- if You meet the Eligibility Requirements for benefits, as described in Section 2 of this Policy.

If You recover so that You no longer meet the Eligibility Requirements for benefits, You will again be eligible for Guaranteed Future Purchase Offers when they occur, subject to the above restrictions.

**Contingent
Non-Forfeiture
Benefit**

Note: *This benefit is automatically included in Your coverage as a standard benefit unless You have elected the optional Lapse Protection Benefit, described later in this Section.*

This Contingent Non-Forfeiture Benefit will apply to You if, and only if, there is a substantial increase in the premium rates for Your coverage, as described here.

If there is an increase in premium rates so that the cumulative amount of all premium rate increases is considered to be a substantial increase in premium rates, as determined by the schedule below, We will do the following:

We will offer to reduce Your current level of coverage without evidence of insurability so that the required premium for Your coverage is not increased.

We will offer to convert Your coverage to a paid-up status with a lesser Benefit Bank. Under this conversion option, the amount of Your revised Benefit Bank will be equal to the greater of: (a) one hundred percent (100%) of the sum of all premiums paid, excluding any waived premiums; or (b) one times (1x) Your Monthly Benefit Access Limit in effect at the time of conversion. The revised Benefit Bank is reduced by the sum of all benefits previously paid to You. Your Monthly Benefit Access Limit will remain at the dollar amount in effect at the time of conversion, restricted only by the amount of Your revised Benefit Bank. This conversion option may be elected at any time during the 120-day period following the effective date of the premium increase.

We will notify You that a premium lapse at any time during the 120-day period following the effective date of the premium increase will be deemed to be the election of the preceding offer to convert Your coverage to a paid-up status. A premium lapse is Your failure to pay the required premiums within the 31-day Grace Period.

If You convert Your coverage to the paid-up status in accordance with the provisions above, We will continue to provide coverage, subject to all of the terms and conditions of the Policy in effect at the time of conversion.

**Contingent
Non-Forfeiture
Benefit**
(continued)

Your coverage under this Contingent Non-Forfeiture Benefit ends when Your Benefit Bank has been exhausted.

The following table determines what constitutes a substantial premium increase.

Substantial Premium Increase Schedule

Cumulative premium increase over original premium that will allow the Contingent Non-Forfeiture to be triggered. (Percentage increase is cumulative from the Policy Effective Date. It does NOT represent a one time increase.)

Issue Age	Percentage of Increase Over Initial Annual Premium	Issue Age	Percentage of Increase Over Initial Annual Premium
29 and under	200%	72	36%
30 – 34	190%	73	34%
35 – 39	170%	74	32%
40 – 44	150%	75	30%
45 – 49	130%	76	28%
50 – 54	110%	77	26%
55 – 59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and older	10%

OPTIONAL BENEFITS

You must refer to Your Schedule of Benefits to see which of these optional benefits, if any, are included in Your coverage.

**Money-Back
Promise Option**

Your Schedule of Benefits shows whether or not You have elected this optional Policy benefit.

This benefit provides for reimbursement of a portion of Your premiums paid, less any benefits paid, to a Beneficiary upon Your death. If We receive a certified death certificate as proof of Your death while Your Policy was in force for five or more years, We will refund the amount shown in the table below:

Years Since Policy Effective Date	Percentage of Premium Reimbursable (less any benefits paid)
Less than 5	0%
5 – 9	25%
10 – 14	50%
15 or more	75%

This benefit will be paid in one lump sum to Your Beneficiary as shown on Your Application, unless later changed by You. If there is no named or living Beneficiary on the date of Your death, the benefits will be paid to Your estate.

The Money-Back Promise Option is not payable if Your coverage is not in force at the time of Your death or if Your coverage is continuing in effect under the Lapse Protection Benefit at the time of Your death.

Important Notice Regarding Federal Income Tax Law – Please note that the payment of the Money-Back Promise Option may have federal income tax implications for Your estate or Beneficiary. You are advised to review this benefit with a qualified tax professional or attorney to determine any such tax impact.

**Automatic 3%
Compound
Inflation Protection
Benefit**

Your Schedule of Benefits shows whether or not You have elected this optional Policy benefit.

If You elected this option, We will increase Your Monthly Benefit Access Limit and the amount remaining in Your Benefit Bank. The dollar amount of Your current Monthly Benefit Access Limit will be increased each year by 3%. The remaining dollar amount of Your Benefit Bank will be increased each year by 3%. All increased amounts will be rounded to the nearest whole dollar.

The increase will be effective on each anniversary of the Policy Effective Date, even if You are receiving benefits. Your premium rate will not change as a result of these annual benefit increases. However, Your premium may change subject to the other terms of the Policy.

Annual compound inflation protection increases will terminate if Your coverage is continuing in effect under:

- the Extension of Benefits;
- the Lapse Protection Benefit, if any; or
- the Contingent Non-Forfeiture Benefit, if any.

**Automatic 5%
Compound
Inflation Protection
Benefit**

Your Schedule of Benefits shows whether or not You have elected this optional Policy benefit.

If You elected this option, We will increase Your Monthly Benefit Access Limit and the amount remaining in Your Benefit Bank. The dollar amount of Your current Monthly Benefit Access Limit will be increased each year by 5%. The remaining dollar amount of Your Benefit Bank will be increased each year by 5%. All increased amounts will be rounded to the nearest whole dollar.

The increase will be effective on each anniversary of the Policy Effective Date, even if You are receiving benefits. Your premium rate will not change as a result of these annual benefit increases. However, Your premium may change subject to the other terms of the Policy.

Annual compound inflation protection increases will terminate if Your coverage is continuing in effect under:

- the Extension of Benefits;
- the Lapse Protection Benefit, if any; or
- the Contingent Non-Forfeiture Benefit, if any.

Lapse Protection Benefit

Your Schedule of Benefits shows whether or not You have elected this optional Policy benefit.

If Your coverage terminates due to non-payment of premium on or after the third anniversary of this option and before Your Benefit Bank has been exhausted, the Lapse Protection Benefit will provide a paid-up continuation of Your coverage with a lesser Benefit Bank. The amount of Your revised Benefit Bank will be equal to the greater of: (a) one hundred percent (100%) of the sum of all premiums paid, excluding any waived premiums; or (b) one times (1x) Your Monthly Benefit Access Limit in effect at the time of lapse. The revised Benefit Bank is reduced by the sum of all benefits previously paid to You. Your Monthly Benefit Access Limit will remain at the dollar amount in effect at the time of lapse, restricted only by the amount of Your revised Benefit Bank.

We will continue to provide coverage, subject to all of the terms and conditions of the Policy in effect at the time of lapse. Your coverage under this option ends when the Benefit Bank has been exhausted.

Note: *If you lapse coverage before Your Policy has been in effect for three full years, this Lapse Protection Benefit cannot be triggered.*

SECTION 2: ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Eligibility Requirements

We will pay benefits described in this Policy when We verify that You meet all of the following conditions:

- You are Chronically Ill;
- You receive any service covered under the Policy and provided pursuant to a written Plan of Care;
- Coverage under this Policy is in force on the date(s) the care is received;
- You have satisfied the applicable Benefit Wait Period, as shown in Your Schedule of Benefits;
- You have not exhausted Your Benefit Bank or Your applicable Monthly Benefit Access Limit; and
- You meet the additional Policy requirements for the specific Policy benefits You claim.

Your Role / Claim Requests (Notice of Claim)

We recommend You tell Us immediately, or as soon as reasonably possible, when You first become disabled or when You think You are eligible for benefits under this Policy. We urge You to notify Us even if You are unsure, and We can help You determine whether or not You are eligible for benefits. Except in the absence of legal capacity, Your initial notice of claim must be provided to Us no later than 12 months from the date you are deemed Chronically Ill.

To submit a claim request, You or Your Representative must notify Us or any authorized agent of Us. You can notify Us by using the mailing address, phone number or e-mail address as follows:

LifeSecure Administrative Office
ATTN: LTC Claims Department
3050 Universal Blvd., Suite 150
Weston, FL 33331

1.888.575.8246

E-mail: claims@YourLifeSecure.com

**Claims Notification
and Decision**
(Proof of Loss)

When a claim request is received, We will provide a claim form to You. In some cases, We may also arrange for an in-home Assessment.

We will collect the information We need to determine Your eligibility for benefits. We may need to contact Your Physician or other care provider(s). We may also need to review Your medical records or arrange for an Assessment which will be performed at no cost to You. We will review all such information to determine Your eligibility for benefits as defined in the Eligibility Requirements paragraph at the beginning of this Section.

We will notify You if We determine that You are eligible for benefits. We will also arrange for a Plan of Care to be developed by a LifeSecure Care Advisor or another Licensed Health Care Practitioner.

Note: *Future Assessments may also be required at reasonable intervals to determine Your continued eligibility for benefits. Such Assessments will be at no cost to You.*

We will notify You within ten business days of receiving all the required information if Your claim request is denied. If You want to receive information related to the denial, We will provide a written explanation of the reasons and make available all information directly related to the denial within 30 days of receipt of Your written or electronic request, unless such disclosure is prohibited under state or federal law.

**Benefits Availability
and Payments**

Once You have met the Benefit Wait Period, benefit payments will be made on a monthly basis following receipt of Your claim requests, or receipt of invoices submitted by You or submitted from providers to whom You have assigned benefits. Your claim requests may relate to Covered Expenses for Qualified Long Term Care Services, or to Flexible Benefits, or to a combination of both. All benefits payable by this Policy are pursuant to the written Plan of Care prepared for You.

For claim requests related to Covered Expenses for Qualified Long Term Care Services, written or electronic proof of expense must be given to Us, or to any authorized agent of Us, within 90 days after which such Covered Expense is incurred. However, a claim request will still be considered if it was not possible for You to furnish proof within this time and the proof was furnished as soon as reasonably possible. Except in the absence of legal capacity, in no event will an expense be considered if proof for that expense is furnished more than 12 months after the date of service.

Covered Expenses for Qualified Long Term Care Services are always applied against the Monthly Benefit Access Limit for the month when such expenses are incurred – not when the claim is actually paid by Us.

**Benefits Availability
and Payments**
(continued)

The Flexible Benefit, if any, will be calculated on the final day of each calendar month. The Flexible Benefit amount is a function of the actual, expected or known Covered Expenses incurred during a calendar month – specifically, 50% of the difference between the Monthly Benefit Access Limit and the dollar amount of Covered Expenses incurred. The Flexible Benefit amount, as calculated at the end of the current calendar month, will be available to You until the last day of the following calendar month. As such, the available Flexible Benefit amount is always calculated one month in arrears.

Note: *If You do not incur any Covered Expenses during a given month, the available Flexible Benefit amount will equal the full 50% of Your Monthly Benefit Access Limit.*

Note: *In some situations, the exact amount of an invoice for a Covered Expense submitted to Us in a future month (from the actual date of service) may not precisely match what was expected when We calculated Your Flexible Benefit for a given month. In these situations, the Flexible Benefit amount applicable to that period will be re-calculated. If the Flexible Benefit had not yet been paid to You, the applicable invoice for the Covered Expense will simply be reimbursed up to the Monthly Benefit Access Limit for the respective month of the incurred expense. If the Flexible Benefit had already been paid to You, the reimbursable Covered Expense will first be offset by any Flexible Benefit amount that was overpaid, if any. The remainder of the reimbursable Covered Expense, if any, will be paid accordingly.*

Benefit amounts payable under the Flexible Benefit for care provided by a family member or other informal care provider will be determined based on Usual and Customary charges the geographic region where Your care is received. Such amounts payable will also be based on the skill level for the care or services required by You.

Unused Monthly Benefit Access Limit amounts do not roll over or accumulate month to month; however, all un-used benefit amounts will remain in Your overall Benefit Bank balance.

All claims are payable in United State dollars only.

**To Whom Benefits
Are Payable**

All benefits will be payable to You unless otherwise assigned by You or Your Representative, except such benefits as might be payable under the Money-Back Promise Option (if elected) to a Beneficiary named by You. Any other benefits unpaid at Your death will be payable to Your estate. However, We reserve the right to pay up to \$5,000 of such benefits otherwise payable to Your estate directly to someone related to You by blood or marriage who is deemed by Us to be justly entitled to the benefits. We will be discharged to the extent of any such payment in good faith.

Appeal Process

If You disagree with Our decision regarding Your claim, You can appeal. You may request in writing or electronically within 60 days of the decision that We reconsider Your claim. You should submit any additional information that You feel We need to review Our decision. You should include the names, addresses, and phone numbers of any care providers You think We should contact to learn more about Your loss. You are responsible for the expense of securing additional information, if applicable, for each instance of reconsideration. We will reconsider Our decision and send You written or electronic notification of the results. If We deny Your appeal request and You want to receive written or electronic information related to such denial, that information will be sent to You within 30 days of receipt of Your appeal request.

Assignment of Benefits

You may instruct Us to pay benefits due You under this coverage directly to a Nursing Home, Assisted Living Facility, Adult Day Care Center or Home Care Agency providing the care for which We are reimbursing expenses. You must notify Us in writing or electronically. The care provider must also agree to the assignment of benefits. No assignment shall be binding upon Us unless a copy is on file at Our office. We do not assume any responsibility for the validity or effect of an assignment.

SECTION 3: LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Exclusions

No benefits, including the Flexible Benefit, will be payable under this Policy for:

- a loss that occurs while this Policy is not in force; or
- an illness, treatment or medical condition that is due to war or act of war, whether declared or not; or
- an illness, treatment or medical condition that results from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury; or
- expenses for treatment or rehabilitation related to alcoholism or drug addictions; or
- expenses for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act (Medicare), or would be so reimbursable but for the application of a deductible or coinsurance amount; or
- care or services, unless otherwise required by law, for which benefits are duplicated or provided under a governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
- care or services provided outside the United States of America, its territories or possessions, or Canada.

Charges for the following types of care or services are excluded under the reimbursable Covered Expenses for Qualified Long Term Care Services portion of Your Policy; however, the following types of care or services may be covered under the Flexible Benefit portion of Your Policy:

- care or services provided by a family member unless:
 - he or she is a regular employee of an organization which is providing the treatment, service or care; and
 - the organization receives the payment for the treatment, service or care; and
 - he or she receives no compensation other than the normal compensation for employees in his or her job category; or
- care or services for which no charge is made in the absence of insurance.

SECTION 4: PREMIUM AND RENEWAL PROVISIONS

Premium Payments	You will pay premiums to Us or to one of Our agents. Your first premium is due on the Policy Effective Date as shown on Your Schedule of Benefits.
Grace Period	There is a 31 day Grace Period. This means that if a premium is not paid on or before the date it is due, it may be paid during the following 31 days. Your insurance under the Policy will remain in force during the Grace Period, unless We have been advised in writing by You or Your Representatives that You want to cancel Your coverage prior to the end of the Grace Period.
Protection Against Unintentional Lapse	You have the right, at the time of application, to designate at least one person who is to receive notice of termination for non-payment of premium in addition to Yourself. You may change this designation at any time. To do so, You must notify Us in writing or electronically. We will remind You in writing or electronically every two years of this opportunity.
Notification of Termination Due to Non-Payment	If Your premium is due and unpaid at the end of the Grace Period, We will give notice of termination to You and to the person(s) You have designated to receive notice. The notice of termination will be sent at the end of the Grace Period and at least 35 days in advance of termination. This notice will state the amount of unpaid premium, the date by which premium must be paid, and the date the coverage is to terminate. Our notice will be sent prepaid by United States first class mail. We will consider You and Your designee(s) notified as of five calendar days after the date the notice is mailed by Us. If Your premium remains unpaid on the termination date stated in the notice, Your coverage will terminate as of the end of the Grace Period. Any benefits payable after the last date for which Your premium was paid will be reduced by the premium due from the date the last premium was paid to the date Your coverage under the Policy terminated.
Waiver of Premium	We will waive the payment of premium beginning on the first day You begin receiving benefits. As long as You continue to receive benefits, additional premiums will not be required. Premium payments will again be required after 30 days of not receiving benefits. We will credit or refund, on a pro rata basis, any premiums paid for periods in which Waiver of Premium is in effect. Any such credit will be applied to reduce future premiums that may become due. Any such refund will be made as described in the Refund of Premiums in Certain Cases paragraph below.
Unpaid Premium	When a claim is paid, any premium due and unpaid will be deducted from the claim payment.

Refund of Premiums in Certain Cases

If You die while covered under the Policy or choose to cancel Your Policy, We will refund the pro rata part of any premiums paid for periods beyond Your death or cancellation. In addition, if You become eligible for Waiver of Premium, We will refund any outstanding credit with respect to the Waiver of Premium as described above. In the event of death, any refund will be made within 30 days of Our receipt of Your certified death certificate and will be paid to Your Beneficiary. If there is no named or living Beneficiary on the date of Your death, any refund will be paid to Your estate. In the event of Your cancellation of the Policy, any refund will be paid to You. In the event of an outstanding credit applicable to Waiver of Premium, any such refund will be paid upon the earlier of Your death or Your cancellation of the Policy and will be paid to Your Beneficiary, Your estate or to You in the manner described above. The aggregate amount of all refunds paid upon Your death or cancellation of the Policy cannot exceed the total premiums You paid for Your Policy.

Reinstatement

If Your coverage is terminated due to non-payment of premiums, You may apply for Reinstatement by notifying Us. We have the right to require evidence of insurability. You will be asked to complete an Application. A completed Application must be received by Us within one year after the end of the Grace Period. The Application for Reinstatement will be contestable for two years from the date of its approval. You will be required to pay the cost of any records that may be necessary to provide this evidence. If approved, the premium due from the date of the first unpaid premium must be paid, and coverage will be reinstated retroactive to the date of termination of coverage. We have the right to decline a request for Reinstatement of coverage. Any premium accepted in connection with a Reinstatement will be applied to the period for which premium was not previously paid. Acceptance of premium by Our agent does not mean Your request for Reinstatement has been accepted. In all other respects, upon Reinstatement You will have the same rights under the Policy as You had prior to the Premium Due Date of the defaulted premium.

Added Protection Against Lapse

If Your coverage is terminated due to non-payment of premiums because You were Chronically Ill before the Grace Period expired, We will provide a reinstatement of coverage based on the conditions specified below. To be eligible for this reinstatement, You must provide Us proof that You were Chronically Ill before the Grace Period expired.

The proof must be in the form of a certification and Assessment from a Licensed Health Care Practitioner which demonstrates that You were Chronically Ill. The proof must be provided to Us within five months of the termination date. You must pay all past due premiums for the coverage that was in force immediately prior to the date of termination. In that event, Your insurance will be reinstated as of the date of that termination without interruption of insurance for that period.

SECTION 5: GENERAL PROVISIONS

Coverage Effective Date	You will become covered under the Policy on the Policy Effective Date shown on Your Schedule of Benefits, subject to payment of the required premium.
Coverage Termination Date	Your coverage terminates on the first to occur of: <ul style="list-style-type: none">• the date of Your death; or• the date coverage is cancelled pursuant to Your request; or• the date Your Benefit Bank is exhausted; or• the last day of the Grace Period; or• if You are covered under the Lapse Protection Benefit or the Contingent Non-Forfeiture Benefit, the date Your revised Benefit Bank has been exhausted.
Right to Reduce Coverage	If You wish to lower Your premiums in the future, You have the right to reduce Your coverage by requesting a lesser Benefit Bank amount. To request a reduction in coverage, You simply notify Us in writing or electronically. Your revised premium will be based on Your original issue age, Your original rate class and Our premium rate schedule as of the date the coverage change is made.
Change of Beneficiary	You may change your Beneficiary at any time by giving written or electronic notice to Us. The effective date of the Beneficiary change will be the date the change is received and recorded by Us.
Extension of Benefits	If Your Policy terminates due to failure to pay premium, We will recognize Your basis for a claim for Your Confinement in a Nursing Home or an Assisted Living Facility before the date Your Policy ended in the same manner as if Your insurance was in force. Extension of Benefits stops on the earlier of the date when You no longer meet the Eligibility Requirements for benefits, the date You are no longer Confined in a Nursing Home or an Assisted Living Facility, or the date Your Benefit Bank is exhausted.
Entire Contract	The entire contract consists of: the Policy, the Schedule of Benefits, any riders or endorsements to the Policy that are issued by Us, and Your Application.
Contract Changes	Any contract change made by Us must be signed by one of Our executive officers. No agent may modify or waive any of the terms of the contract. No change in the contract is effective until You accept the change in writing or electronically, with the following exceptions: a change in the premiums; a change which is required by law or regulation; or a change which does not reduce or eliminate benefits or coverage. These exceptions do not include an increase in benefits or coverage with a like increase in premium. Any change will be without prejudice to any claim incurred for benefits prior to the date of the change.

**Misstatements /
Incontestability**

In issuing this Policy, We have relied upon information presented by You in Your Application. If Your Policy has been in force for less than six months, We may rescind Your Policy or deny a claim due to a misrepresentation in Your Application that is material to the acceptance for coverage.

If Your Policy has been in force for at least six months, but less than two years, We may rescind Your Policy or deny a claim due to a misrepresentation in Your Application that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

After Your Policy has been in force for two years, We cannot rescind Your Policy or deny a claim due to misrepresentation alone, except in cases where We can show that You knowingly and intentionally misrepresented relevant facts relating to Your health in Your Application.

**Misstatement
of Age**

If Your age was misstated in Your application, We will adjust Your premium to the correct amount for Your insurance at Your correct age as of the Policy Effective Date. The amount of the insurance shall not be affected, provided that any necessary adjustment in premium is made and collected. If based on Your correct age Your Application would not have been accepted and a Policy not issued, We will only be liable for the refund of all premiums paid for the Policy.

**Conformity With
State Statutes /
Severability**

Any provision of Your Policy which, on the Policy Effective Date, is contrary to the applicable laws of the state where the Policy is delivered is amended to conform to the minimum requirements of such state laws.

If one or more provisions of this Policy are deemed invalid, the remaining provisions of this Policy remain intact.

**Conformity
With Internal
Revenue Code**

If on the Policy Effective Date, the Policy does not comply with the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, it will be treated as if it had been changed to comply with those requirements. Because the Policy is guaranteed renewable, We will inform You in writing or electronically of any required change in the provisions of this Policy; and You will be given the choice of accepting the change, or retaining the Policy without that change.

Time Periods

All time periods start and end at 12:01 a.m. in the time zone in which You reside.

Clerical Error

Clerical error or delays in making entries on the records by Us or Our designees will not void Your coverage if Your coverage would otherwise have been in effect. Such clerical error will not cause You to become insured if You are otherwise not eligible. Such clerical error will also not extend Your coverage if Your coverage would otherwise have ended or been reduced as provided by the Policy. If a clerical error is found, premiums and benefits will be adjusted based on the true facts and the provisions of the Policy.

Legal Actions

No action may be brought to recover under this Policy until 60 days after proof of loss has been given to Us. No action can be brought more than three years from the date written or electronic proof of loss was required to be given.

SECTION 6: GLOSSARY

This Section provides the definitions of words and terms used in the Policy that have a special meaning when applied to Your coverage. To help You recognize these special words and terms, the first letter of each word is capitalized wherever it appears throughout the Policy.

Activities of Daily Living (ADLs)

Each of the following functions is an **Activity of Daily Living**:

- **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.
- **Dressing:** Putting on and taking off all items of clothing and any necessary braces; fasteners or artificial limbs.
- **Toileting:** Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- **Transferring:** Moving into or out of a bed, chair or wheelchair.
- **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 catheter or colostomy bag).
- **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.

Adult Day Care

A program for six or more individuals of social and health-related services provided during the day in a community group setting. The purpose is to support frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Adult Day Care Center

A facility that is licensed registered or certified to provide a planned program of Adult Day Care services by the state in which it operates. If the state does not license such facilities, then it must be operated pursuant to law and meet all of the following standards:

- it provides Adult Day Care services in a protective setting and related supportive services that are designed to meet the needs of functionally or cognitively impaired adults through an individualized service plan;
- it operates on less than a 24 hour basis;
- it keeps written record of services for each person; and
- it has established procedures for obtaining appropriate aid in the event of a medical emergency.

Application

The written or electronic application form provided by Us and completed by You when You apply for coverage.

Assessment An evaluation done by a Licensed Health Care Practitioner to determine or verify that You are Chronically Ill. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

Assisted Living Facility A facility that is engaged primarily in providing ongoing care and related services that: (a) has the appropriate state licensure or certification as an Assisted Living Facility where required; and (b) meets all of the following requirements:

- it provides services and care on a continuous 24-hour basis sufficient to support the needs resulting from the inability to perform Activities of Daily Living or from a Severe Cognitive Impairment;
- it has trained and ready-to-respond personnel actively on duty in the facility at all times to provide the services and care;
- it makes and keeps records of all care and services provided to each resident;
- it provides at least three meals a day and accommodates special dietary needs;
- it provides residential services and Maintenance or Personal Care Services for at least six inpatients in one location;
- it has formal arrangements with a Physician or Nurse to furnish medical care in case of an emergency; and
- it has appropriate procedures to provide onsite assistance with prescription medications.

Assisted Living Facility also means a facility that is licensed as a specialized Alzheimer's unit in a state where such licensure exists.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as an Assisted Living Facility only if it is engaged primarily in providing care and services that meet all of the above criteria.

An Assisted Living Facility is not a hospital or clinic, a place that operates primarily for the treatment of alcoholism, drug addiction or Mental Disorder, a Nursing Home, an individual residence or an independent living unit.

Beneficiary The person designated by You to receive benefits, if any are payable, under this Policy after your death, or to receive a Refund of Premiums in Certain Cases, if applicable.

Benefit Bank The overall maximum benefit amount payable under Your Policy. This amount decreases for benefits paid and increases for applicable optional inflation protection benefits (if elected by You), Guaranteed Future Purchase Offers that are accepted, and underwritten coverage amount increases.

Benefit Wait Period

The total number of days that You remain Chronically Ill before benefits are payable. The Benefit Wait Period begins on the first day that We verify You are Chronically Ill. Days more than 12 months prior to the date You submit Your initial claim request will not count towards meeting the Benefit Wait Period, even if it can be established that You were Chronically Ill at that time. The Benefit Wait Period need only be met once during your lifetime.

You do not have to be receiving Qualified Long Term Care Services in order to satisfy the Benefit Wait Period. Any day on which We verify that You are Chronically Ill will count toward the Benefit Wait Period.

Chronically Ill

You are Chronically Ill when You have been certified by a Licensed Health Care Practitioner as:

- being unable to perform, without Substantial Assistance from another person, at least two Activities of Daily Living for a period that is expected to last at least 90 consecutive days due to a loss of functional capacity; or
- requiring Substantial Supervision to protect Yourself from threats to health and safety due to a Severe Cognitive Impairment.

You will not meet the definition of Chronically Ill unless within the preceding 12-month period a Licensed Health Care Practitioner has certified that You meet such requirements.

Substantial Assistance means either Hands-on Assistance or Standby Assistance. **Hands-on Assistance** means the physical assistance of another person without which You would be unable to perform the Activities of Daily Living. **Standby Assistance** means the presence of another person, within Your arm's reach, that is necessary to prevent by physical intervention, Your injury while You are performing the Activity of Daily Living.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures or other demonstrations) by another person that is necessary to protect You from threats to Your health or safety (including, but not limited to, such threats as may result from wandering.)

Confinement or Confined

A period of time You are a resident in a Nursing Home or an Assisted Living Facility during which a room and board charge is made.

Covered Expenses

Costs for Qualified Long Term Care Services received in a Nursing Home, Assisted Living Facility, Adult Day Care Center, Hospice Care facility, or through a Home Care Agency, or by an Independent Provider or at-home Hospice Care provider.

Covered Expenses for Nursing Home care, Assisted Living Facility care or facility-based Hospice Care include expenses You incur for Qualified Long Term Care Services during Your confinement in a Nursing Home, Assisted Living Facility or Hospice Care facility for:

- room and board (including charges to reserve Your bed when You are absent for any reason except discharge);
- ancillary services;
- patient supplies provided by the Nursing Home, Assisted Living Facility or Hospice Care facility for care of its residents; and
- Hospice Care services.

Covered Expenses for Home Care Agency or Independent Provider care or at-home Hospice Care include expenses You incur for Qualified Long Term Care Services provided to You by a Home Care Agency, an Independent Provider or at-home Hospice Care provider for:

- Home Care Services;
- Maintenance or Personal Care Services; and
- Hospice Care Services.

Covered Expenses for any type of provider do not include the cost of drugs.

Flexible Benefit

The benefit available to You if You meet the Eligibility Requirements for benefits and have not depleted the full amount of your Monthly Benefit Access Limit for Covered Expenses for Qualified Long Term Care Services incurred in a given calendar month. This benefit is designed to address various forms of care, services and/or products which are recognized to effectively support or serve special needs of a Chronically Ill individual, but which are not formally defined within this Policy under the term Covered Expenses. This benefit is further described in Section 1 in the Benefit Payout Structure paragraphs and in Section 2 in the Benefits Availability and Payments paragraphs.

Home Care Agency

An entity that is regularly engaged in providing Home Care Services, or Maintenance or Personal Care Services for compensation and employs staff who are qualified by training or experienced to provide such care. The entity must:

- be supervised by a qualified professional such as a Registered Nurse (RN), a licensed social worker, or a Physician;
- keep clinical records or care plans on all patients;
- provide ongoing supervision and training to its employees appropriate to the services to be provided; and
- have the appropriate state licensure or certification, where required.

Home Care Services

The following services provided in Your home:

- part-time or intermittent skilled services provided by licensed nursing personnel;
- physical therapy, respiratory therapy, occupational therapy, speech therapy, or medical social services;
- home health aide or personal care attendant services, including assistance with or performance of personal hygiene, Activities of Daily Living, medication management or other related supportive services; and
- homemaker services, such as meal preparation, laundry, housekeeping, transportation and shopping *when provided in conjunction with any other Home Care Services specified above.*

Hospice Care

Services designed to provide palliative care to someone diagnosed with a Terminal Illness in order to help alleviate that person's physical emotional and/or spiritual discomforts during the last phases of life. Hospice Care can be provided in Your home, or in a separate facility. The provider of Hospice Care services must be licensed or certified to provide Hospice Care by the state in which it is located.

Terminal Illness means an illness or injury which a Physician certifies is likely to result in a person's death within six months.

Independent Provider

A home health aide, certified nursing assistant, Nurse, or physical, occupational respiratory or speech therapist who is working independently and is not affiliated with a Home Care Agency. Such person must be licensed, registered or certified to provide Home Care Services and Maintenance or Personal Care Services by the state in which he or she is providing the services.

Licensed Health Care Practitioner

Any of the following who is not a family member: a Physician (as defined in section 1861(r)(1) of the Social Security Act); a registered professional nurse; a licensed social worker; or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

LifeSecure Care Advisor

A Licensed Health Care Practitioner designated by Us who is qualified by training and experience to assist in identifying and coordinating the overall care needs of a person who is Chronically Ill.

Maintenance or Personal Care Services

Any care the primary purpose of which is the provision of needed assistance with helping You conduct Your Activities of Daily Living while You are Chronically Ill. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Medicare	Title XVIII of the Social Security Act as amended.
Mental Disorder	Any neurosis, psychoneurosis, psychopathology, psychosis, or mental or emotional disease or disorder, as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. If the DSM is discontinued or replaced, the diagnostic manual in use by the American Psychiatric Association as of the date of Your illness will be used.
Monthly Benefit Access Limit	The dollar amount of benefits available to You on a monthly basis during a claim period. The original dollar amount is calculated as a percentage of the Benefit Bank (either 1%, 2% or 3%). Your Schedule of Benefits shows the Monthly Benefit Access Limit You have elected. The dollar amount of Your Monthly Benefit Access Limit increases for applicable optional inflation protection benefits (if elected by You), Guaranteed Future Purchase Offers that are accepted and underwritten coverage amount increases.
Nurse	Someone who is licensed as a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) and is operating within the scope of that license.
Nursing Home	<p>A facility or distinctly separate part of a hospital or other institution that is appropriately licensed or certified, or complies with the state's facility licensing requirements to engage primarily in providing nursing care to inpatients under a planned program supervised by a Physician. It also:</p> <ul style="list-style-type: none"> • provides twenty-four (24) hour-a-day nursing care by a Nurse under the supervision of a Registered Nurse (RN) or a Physician; • maintains a daily medical record of each inpatient; and • provides nursing care at skilled, intermediate, or custodial levels. <p>Nursing Home also means a facility that is licensed as a specialized Alzheimer's unit in a state where such licensure exists.</p> <p>A Nursing Home is not: a hospital or clinic; a place which operates primarily for the treatment of alcoholism, drug addiction, or Mental Disorder; an Assisted Living Facility; an adult residential care home; a domiciliary care facility; or Your primary place of residence in an area used principally for independent residential living; or a similar establishment. If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as a Nursing Home only if it meets all of the above criteria; is authorized to provide nursing care to inpatients; and is engaged principally in providing such nursing care in accordance with that license.</p>

Physician	A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.
Plan of Care	A written individualized plan of services prescribed by a LifeSecure Care Advisor or another Licensed Health Care Practitioner. The Plan of Care specifies Your long term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services. The Plan of Care will be modified as required to reflect changes in: Your functional or cognitive abilities, Your social situation, and Your care service needs.
Policy	The contract between You and Us.
Premium Due Date	Each date a premium is due, after the initial premium, in accordance with the terms of this Policy.
Qualified Long Term Care Services	Necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are: <ol style="list-style-type: none"> 1. required by a Chronically Ill individual; and 2. are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.
Representative	A person or entity legally empowered to represent You.
Severe Cognitive Impairment	A loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in the person's: <ul style="list-style-type: none"> • short-term or long-term memory; • orientation as to people, places or time; or • deductive or abstract reasoning; and • judgment as it relates to safety awareness
Usual and Customary	Amounts customarily charged in a given geographic region for similar forms of care, services and/or products which are recognized to effectively support the long term care needs of a Chronically Ill individual, as recommended by a Licensed Health Care Practitioner.
We, Us, Our	LifeSecure Insurance Company or the administrator it designates.
You, Your or Yourself	The Policyholder named on Your Schedule of Benefits.



LifeSecure Insurance Company

10559 Citation Drive, Suite 300

Brighton, Michigan 48116

1-866-582-7701

LONG TERM CARE INSURANCE - OUTLINE OF COVERAGE

For Policy Form Series LS-0002

Name of Applicant: _____ Date of Application: _____

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 on your Application. A copy of your Application will be attached to your policy if one is issued to you. If your answers are incorrect or untrue, we have the right to deny benefits or rescind the 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.

1. POLICY DESIGNATION

This is an individual policy of insurance.

2. PURPOSE OF THE 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 an insurance contract, but only a summary of coverage. Only the policy contains governing contractual provisions. This means that the policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY CAREFULLY!**

3. FEDERAL TAX CONSEQUENCES

The policy is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B (b) of the Internal Revenue Code of 1986 and as amended by the Health Insurance Portability and Accountability Act of 1996 - Public Law 104-191.

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

Renewability – THIS POLICY IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of the policy, to continue the policy as long as premiums for your coverage are paid on time. LifeSecure Insurance Company cannot change any of the terms of your policy on its own, except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY.

Waiver of Premium – We will waive the payment of premium beginning on the first day you begin receiving benefits. As long as you continue to receive benefits, additional premiums will not be required. Premium payments will again be required after 30 days of not receiving benefits. We will credit or refund, on a pro rata basis, any premiums paid for periods in which Waiver of Premium is in effect. Any such refund will be made as described in the Refund of Premiums in Certain Cases paragraph of Section 6 below.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

You cannot be singled out for a rate increase due to a change in your age or health status. We can, however, change premiums, but only if we change premiums for all similar policies issued in the same state and on the same form as your policy. Any premium changes will be effective on the next premium due date following our notice to you. If we ever increase your premium, you will have the option to reduce coverage in order to preserve the premium amount you had previously been paying.

6. TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED

30-Day Free Look – You may cancel your policy for any reason within 30 days after you receive it. Simply return the policy to us. We will treat the policy as though it had never been issued. We will refund the full amount of any premium paid.

Partial Refund of Premium Upon Death – This policy contains an optional benefit called the **Money-Back Promise Option** for the refund of premium in the event of death. The Money-Back Promise Option provides for reimbursement of a portion of your premiums paid, less any benefits paid, to a Beneficiary upon your death. If we receive a death certificate as proof of your death while your policy was in force for five or more years, and continues in force until death, we will refund the amount shown in the table below:

Years Since Policy Effective Date	Percentage of Premium Reimbursable (less any benefits paid)
Less than 5	0%
5 – 9	25%
10 – 14	50%
15 or more	75%

Refund of Premiums in Certain Cases – If you die while covered under the policy or choose to cancel your policy, we will refund the pro rata part of any premiums paid for periods beyond your death or cancellation. In addition, if you become eligible for Waiver of Premium, We will refund any outstanding credit with respect to the Waiver of Premium as described above in Section 4. In the event of death, any refund will be made within 30 days of our receipt of your death certificate and will be paid to your Beneficiary. If there is no named or living Beneficiary on the date of your death, any refund will be paid to your estate. In the event of your cancellation of the policy, any refund will be paid to you. In the event of an outstanding credit applicable to Waiver of Premium, any such refund will be paid upon the earlier of your death or your cancellation of the policy and will be paid to your Beneficiary, your estate or to you in the manner described above. The aggregate amount of all refunds paid upon your death or cancellation of the policy cannot exceed the total premiums you paid for your policy.

7. 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 LifeSecure Insurance Company nor its agents represent Medicare, the federal government, or any state government.

8. 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. This policy reimburses you incurred Covered Expenses for Qualified Long Term Care Services. In addition, the policy includes a Flexible Benefit that is not restricted by the definitions of Covered Expenses and Qualified Long Term Care Services.

9. BENEFITS PROVIDED BY THIS POLICY / BENEFIT ELIGIBILITY

Benefit Descriptions and Coverage Amounts

Benefit Bank – Your Benefit Bank represents the lifetime dollar benefit amount available to you under the policy. Your Benefit Bank balance is reduced by all benefit amounts paid to you, whether based on reimbursement for Covered Expenses for Qualified Long Term Care Services or payments related to the Flexible Benefit.

The Benefit Bank amounts available to you range from: \$75,000 to \$1,000,000.

Monthly Benefit Access Limit – Your Monthly Benefit Access Limit represents the dollar benefit amount available to you on a monthly basis during a claim period. The original dollar amount is calculated as a percentage of your Benefit Bank.

The Monthly Benefit Access Limit percentages available to you are: 1%, 2% or 3% of the Benefit Bank. (*Note: The 3% choice is not available for Benefit Bank amounts greater than \$500,000.*)

Example Illustration – Monthly Benefit Access Limit (MBAL) Calculation

$$\begin{array}{r} \text{Benefit Bank} \\ \$300,000 \end{array} \times \begin{array}{r} \text{MBAL (\%)} \\ 1\% \end{array} = \begin{array}{r} \text{MBAL (\$)} \\ \$3,000 \end{array}$$

Benefit Payout Structure – When you are eligible for benefits, we will reimburse you for Covered Expenses for Qualified Long Term Care Services, up to your Monthly Benefit Access Limit each calendar month. If you are eligible for benefits and you have not incurred Covered Expenses for Qualified Long Term Care Services up to the full Monthly Benefit Access Limit for a given calendar month, 50% of your unused Monthly Benefit Access Limit will be available to you as a Flexible Benefit. All benefits, both Covered Expenses and Flexible Benefits, payable to you under the policy must be pursuant to a written Plan of Care.

Example Illustration – Benefit Payout Structure

In this example, assume a claimant has a Monthly Benefit Access Limit of \$3,000. This claimant uses \$2,000 for qualified home health care during a one-month period. The unused monthly benefit = \$1,000. Claimant may receive a Flexible Benefit of up to \$500.

$$\begin{array}{r} \text{Home Health Cost} \\ \$2,000 \end{array} \quad \begin{array}{r} \text{Flexible Benefit} \\ \$500 \end{array} \quad \Rightarrow \quad \begin{array}{r} \text{Remaining Amount} \\ \text{Stays in Benefit Bank} \end{array}$$

Flexible Benefit – The Flexible Benefit is not restricted by the definition of Covered Expenses. It is designed to provide you greater flexibility in the types of care or services you receive under the policy, such as: care provided by an informal caregiver or family member; installation of a wheelchair access ramp to your home; or rental of durable medical equipment for your home. This benefit is calculated as defined in the previous paragraph.

Benefit Wait Period – You must satisfy a Benefit Wait Period of 90 days before benefits are payable. The Benefit Wait Period is the total number of days that you remain Chronically Ill before benefits are payable. It begins on the first day that we verify that you are Chronically Ill. The Benefit Wait Period need be met only once during your lifetime. You do not need to be receiving Qualified Long Term Care Services in order to satisfy the Benefit Wait Period. Any day on which we verify that you are Chronically Ill will count toward the Benefit Wait Period.

LifeSecure Care Advisor Services – LifeSecure Care Advisor Services are provided through our LifeSecure Care Advisors. You may use the LifeSecure Care Advisor Services anytime while your policy is in force. The services are optional and provided at no cost to you. A LifeSecure Care Advisor is available to: assist in identifying your specific personal care needs and the long term care

services in your area which may appropriately meet those needs; assist in developing a Plan of Care that meets your needs; and help you arrange for care or services.

Guaranteed Future Purchase Offers – *This is a standard feature unless you elect one of the optional inflation protection benefits: Automatic 3% Compound Inflation Protection Benefit or Automatic 5% Compound Inflation Protection Benefit, as described in Section 11 below.*

Under the Guaranteed Future Purchase Offers, you will be offered the opportunity to increase your Monthly Benefit Access Limit and Benefit Bank every three years, subject to the conditions listed below.

Each offer to increase will be for 15% of the dollar amount of your current Monthly Benefit Access Limit and the remaining dollar amount of your Benefit Bank. This offer will be made beginning on the third anniversary of your policy effective date and every three years thereafter. You may elect to increase your coverage by the amount offered under this feature without submitting evidence of insurability. The premium for the amount of increased coverage will be based on your attained age, your original rate class, and our premium rate schedule as of the date the benefit increase offer is made to you.

We will notify you by mail or e-mail of the offer at least 60 days prior to the anniversary of the policy effective date. You may accept or decline the offer within 60 days after we send the notification. If we do not receive your acceptance of our offer within 60 days, we will deem this to be a declination of the offer. You may accept or decline ongoing offers to increase coverage each time an offer is made.

No further offers will be made if your policy is terminated, or if coverage is continuing in effect under: the Extension of Benefits; the Lapse Protection Benefit, if any; or the Contingent Non-Forfeiture Benefit, if any. No further offers will be made: once you have attained age 80; during the Benefit Wait Period; or if you meet the Eligibility Requirements for benefits.

Contingent Non-Forfeiture Benefit – *This is a standard feature unless you elect the optional Lapse Protection Benefit as described below under Optional Benefits and Features.*

This benefit provides protection in the event of a substantial rate increase. If there is an increase in premium rates so that the cumulative amount of all premium rate increases is considered to be substantial, as determined by the schedule below, we will do all of the following:

- We will offer to reduce your current level of coverage without evidence of insurability so that the required premium for your coverage is not increased.
- We will offer to convert your coverage to a paid-up status with a lesser Benefit Bank. This option may be elected at any time during the 120-day period following the date of the premium rate increase. Under this conversion option, the amount of your revised Benefit Bank will be equal to the greater of: (a) one hundred percent (100%) of the sum of all premiums paid, excluding any waived premiums; or (b) one times your Monthly Benefit Access Limit in effect at the time of conversion. The revised Benefit Bank is reduced by the sum of all benefits previously paid to you. Your Monthly Benefit Access Limit will remain at the dollar amount in effect at the time of conversion, restricted only by the size of your revised Benefit Bank. This conversion option may be elected at any time during the 120-day period following the effective date of the premium rate increase.
- We will notify you that a premium lapse at any time during the 120-day period following the effective date of the premium increase will be deemed to be the election of the preceding offer to convert your coverage to a paid-up status. A premium lapse is your failure to pay the required premiums within the 31-day grace period.

Please refer to the schedule below to determine whether or not a change in premiums constitutes a Substantial Premium Increase. Cumulative premium increases over original premium that will allow

the Contingent Non-Forfeiture Benefit to be initiated appear in the chart. (Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Triggers for a Substantial Premium Increase

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

Optional Benefits and Features

The following benefits and features are available to you as options under this policy.

Money-Back Promise Option – (defined previously in Section 6 above.)

Lapse Protection Benefit – If you elect the optional Lapse Protection Benefit, it will provide a continuation of your policy up to a specified dollar amount. If you elect it and your coverage terminates due to non-payment of premium on or after the third anniversary of this option and before your Benefit Bank has been exhausted, the Lapse Protection Benefit provides a paid-up continuation of your coverage with a lesser Benefit Bank. The amount of your revised Benefit Bank will be equal to the greater of: (a) one hundred percent (100%) of the sum of all premiums paid, excluding any waived premiums; or (b) one times your Monthly Benefit Access Limit in effect at the time of lapse. The revised Benefit Bank is reduced by the sum of all benefits previously paid to you. Your Monthly Benefit Access Limit will remain at the dollar amount in effect at the time of lapse, restricted only by the size of your revised Benefit Bank. Your coverage under this option ends when the revised Benefit Bank has been exhausted.

Automatic Inflation Protection Choices – You have *two* optional automatic inflation protection benefit choices: Automatic 3% Compound Inflation Protection Benefit and Automatic 5% Compound Inflation Protection Benefit. These two benefits are described in Section 11 below.

Optional Premium Payment Modes

You may elect any one of the following limited-pay options to pay the premiums for your policy. (*Note:* Limited-pay options can only be elected with plan designs that include either the Automatic 3% Compound Inflation Protection Benefit or the Automatic 5% Compound Inflation Protection Benefit.)

10-Year Premium Payment Option – This option provides that your policy premiums may be paid over a ten-year period, after which no additional premiums will be due. Prior to the end of your tenth policy year, we have the right to change your premiums in accordance with the terms described in Section 5 above. In the event of a future benefit increase, a separate 10-year premium payment period will be applied for the increased benefit portion only, beginning on the effective date of the benefit increase.

To-Age-65 Premium Payment Option (*allowed only for issue ages 55 and under*) – This option provides that your policy premiums may be paid as due until the anniversary of the policy effective date following your 65th birthday, after which no additional premiums will be due. Prior to the policy anniversary date following your 65th birthday, we have the right to change your premiums in accordance with the terms described in Section 5 above. In the event of a future benefit increase, a separate 10-year premium payment period will be applied for the increased benefit portion only, beginning on the effective date of the benefit increase.

Eligibility Requirements For The Payment of Benefits

We will pay benefits under the policy when we verify that you meet all of the following conditions:

- You are Chronically Ill (refer to full definition in Section 16 below);
- You receive any service covered under the policy and provided pursuant to a written Plan of Care;
- Coverage under the policy is in force on the date(s) the care is received;
- You have satisfied the applicable Benefit Wait Period;
- You have not exhausted your Benefit Bank or your applicable Monthly Benefit Access Limit; and
- You meet the additional policy requirements for the specific policy benefits you claim.

10. LIMITATIONS AND EXCLUSIONS

No benefits, including the Flexible Benefit, will be payable under the policy for:

- a loss that occurs while the policy is not in force; or
- an illness, treatment or medical condition that is due to war or act of war, whether declared or not; or
- an illness, treatment or medical condition that results from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury; or
- expenses for treatment or rehabilitation related to alcoholism or drug addictions; or
- expenses for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act (Medicare), or would be so reimbursable but for the application of a deductible or coinsurance amount; or
- care or services, unless otherwise required by law, for which benefits are duplicated or provided under a governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
- care or services provided outside the United States of America, its territories or possessions, or Canada.

Charges for the following types of care or services are excluded under the reimbursable Covered Expenses for Qualified Long Term Care Services portion of the policy; however, the following types of care or services may be covered under the Flexible Benefit portion of the policy:

- care or services provided by a Family Member unless:
 - ✓ he or she is a regular employee of an organization which is providing the treatment, service or care; and
 - ✓ the organization receives the payment for the treatment, service or care; and
 - ✓ he or she receives no compensation other than the normal compensation for employees in his or her job category; or
- care or services for which no charge is made in the absence of insurance.

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

11. 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. You may elect one of the automatic inflation protection options to increase your coverage. If you do not elect one of the automatic inflation protection options, your coverage will include Guaranteed Future Purchase Offers by default. Only increases taken in accordance with one of the options listed below do not require evidence of insurability. Increases taken in accordance with one of the inflation protection features listed below do not require future evidence of insurability.

Benefit Adjustment Provisions

Automatic 3% Compound Inflation Protection Benefit – If you elect the optional Automatic 3% Compound Inflation Protection Benefit, we will increase your Monthly Benefit Access Limit and the amount remaining in your Benefit Bank. The dollar amount of your current Monthly Benefit Access Limit will be increased each year by 3%. The remaining dollar amount of your Benefit Bank will be increased each year by 3%. The increase will be effective on each anniversary of the Policy Effective Date, even if you are receiving benefits. Annual compound inflation protection increases will terminate if your coverage is continuing in effect under: the Extension of Benefits; the Lapse Protection Benefit, if any; or the Contingent Non-Forfeiture Benefit, if any.

Automatic 5% Compound Inflation Protection Benefit – If you elect the optional Automatic 5% Compound Inflation Protection Benefit, we will increase your Monthly Benefit Access Limit and the amount remaining in your Benefit Bank. The dollar amount of your current Monthly Benefit Access Limit will be increased each year by 5%. The remaining dollar amount of your Benefit Bank will be increased each year by 5%. The increase will be effective on each anniversary of the Policy Effective Date, even if you are receiving benefits. Annual compound inflation protection increases will terminate if your coverage is continuing in effect under: the Extension of Benefits; the Lapse Protection Benefit, if any; or the Contingent Non-Forfeiture Benefit, if any.

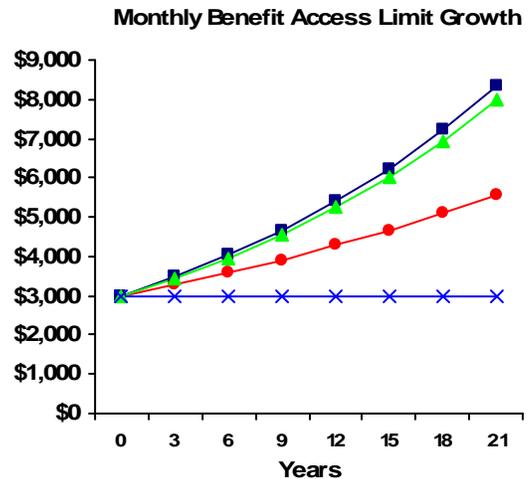
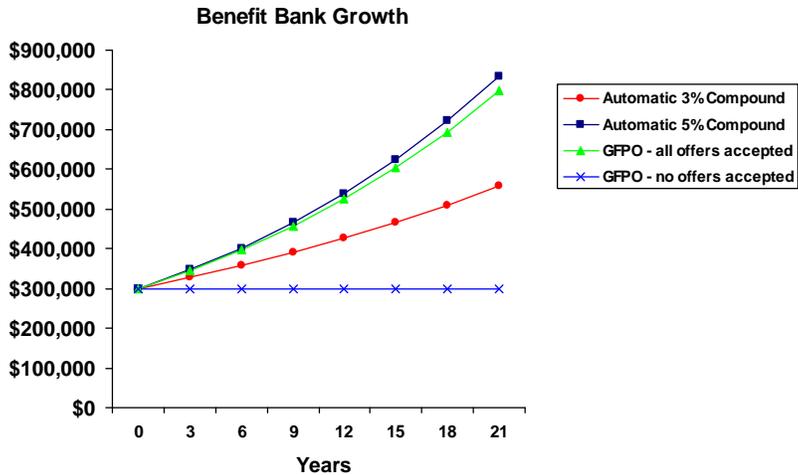
Guaranteed Future Purchase Offers – If you do not elect one of the optional automatic inflation protection benefits described above, your coverage will include the Guaranteed Future Purchase Offers feature, as described in Section 9 above.

Inflation Protection – Graphic Comparisons

The charts below compare and contrast the growth of an initial Benefit Bank amount of \$300,000 and a 1% Monthly Benefit Access Limit (\$3,000 initially) over a 21-year period, considering four variations:

- 1) a plan with the Automatic 3% Compound Inflation Protection Benefit;
- 2) a plan with the Automatic 5% Compound Inflation Protection Benefit;
- 3) a plan with Guaranteed Future Purchase Offers where *all* such offers are accepted; and
- 4) a plan with Guaranteed Future Purchase Offers where *no* such offers are accepted.

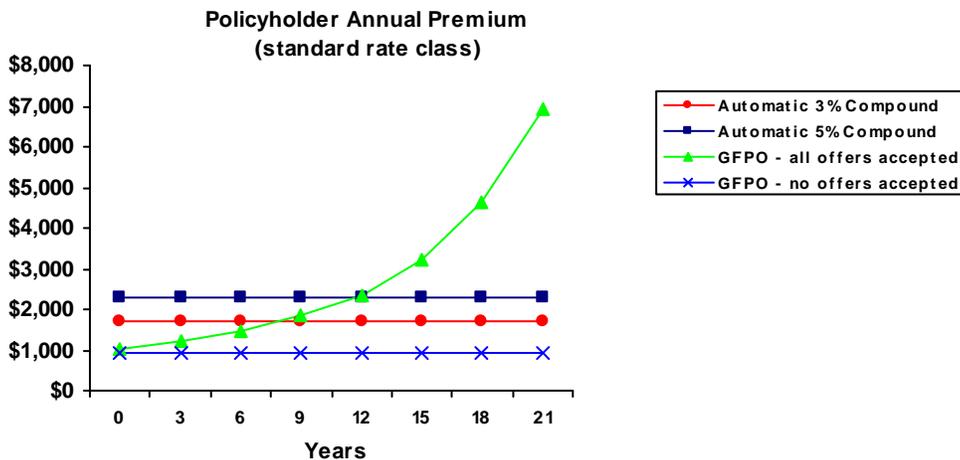
Example



The chart below compares and contrasts the annual premium applicable to a person who purchases a policy at 55 years of age with an initial Benefit Bank amount of \$300,000 and a 1% Monthly Benefit Access Limit over a 21-year period, considering four variations:

- 1) a plan with the Automatic 3% Compound Inflation Protection Benefit;
- 2) a plan with the Automatic 5% Compound Inflation Protection Benefit;
- 3) a plan with Guaranteed Future Purchase Offers where *all* such offers are accepted; and
- 4) a plan with Guaranteed Future Purchase Offers where *no* such offers are accepted.

Example



12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Once your Application for coverage under the policy is approved, the policy provides coverage for treatment of Alzheimer's disease, Parkinson's disease, senile dementia, and other forms of organic brain disease.

13. PREMIUM

Refer to the table below to find the premium applicable to the coverage amounts and policy design of your choice.

PREMIUM	Benefit Bank: \$ _____ Monthly Benefit Access Limit: ____ %	
Premium Payment Mode	Base Policy Coverage Premium:	\$ _____
Ⓒ Annual	Money-Back Promise Option:	\$ _____
Ⓒ Semi-Annual	Lapse Protection Benefit:	\$ _____
Ⓒ Quarterly	Automatic 3% Compound Inflation Protection Benefit:	\$ _____
Ⓒ Monthly EFT	Automatic 5% Compound Inflation Protection Benefit:	\$ _____
Ⓒ Monthly Credit Card	Total Annual Premium:	\$ _____
Ⓒ Bi-Weekly		
Ⓒ Other Payroll Cycle		
Premium Payment Time Period		
Ⓒ Lifetime		
Ⓒ 10-years		
Ⓒ To-Age-65		
	Modal Premium (based on Mode & Time Period elected):	\$ _____

14. ADDITIONAL FEATURES

Underwriting – Medical underwriting is required. We will underwrite your Application by reviewing one or more of the following: the information submitted on your Application; an attending Physician's report; copies of your medical records; a medical evaluation; a telephone interview; and an in-person interview.

Extension of Benefits – If your policy terminates due to failure to pay premium, we will recognize your basis for a claim for your Confinement in a Nursing Home or an Assisted Living Facility before the date your policy ended in the same manner as if your policy was in force. Extension of Benefits stops on the earlier of the date when you no longer meet the Eligibility for the Payment of Benefits requirements; the date you are no longer Confined in a Nursing Home or an Assisted Living Facility; or the date your Benefit Bank is exhausted.

Reinstatement Provision – If your coverage is terminated due to non-payment of premiums, you may apply for reinstatement by notifying us. We have the right to require evidence of insurability. If approved, the premium due from the date of the first unpaid premium must be paid, and coverage will be reinstated retroactive to the date of termination of coverage. We have the right to decline a request for reinstatement of coverage.

Added Protection Against Lapse – If your coverage terminates due to non-payment of premiums because you were Chronically Ill before the Grace Period expired, your coverage will be reinstated if we receive proof from a Licensed Health Care Practitioner (or other proof approved by us) that you were Chronically Ill. Such proof must be provided within 5 months of the termination date. You must pay all past due premiums for the coverage that was in force immediately prior to the date of termination.

15. CONTACT THE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. SEE ATTACHMENT 1 FOR CONTACT INFORMATION IN YOUR STATE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY.

Senior Health Insurance Information Program
Arkansas State Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Phone: 800-224-6330

http://www.accessarkansas.org/insurance/srinsnetwork/seniorshlth_p1.html

16. DEFINITIONS

Activities of Daily Living: Each of the following functions is an Activity of Daily Living:

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.

Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring: Moving into or out of a bed, chair or wheelchair.

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 catheter or colostomy bag.)

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.

Adult Day Care: A program for six or more individuals of social and health-related services provided during the day in a community group setting. The purpose is to support frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Adult Day Care Center: A facility that is licensed, registered or certified to provide a planned program of Adult Day Care services by the state in which it operates. If the state does not license such facilities, then it must be operated pursuant to law and meet certain standards.

Application: The written or electronic application form provided by us and completed by you when you apply for coverage.

Assisted Living Facility: A facility that is engaged primarily in providing ongoing care and related services that: (a) has the appropriate state licensure or certification as an Assisted Living Facility where required; and (b) meets certain requirements.

Beneficiary: The person designated by you to receive benefits, if any are payable, under the policy after your death, or to receive a refund of premiums paid beyond your death, if applicable.

Benefit Bank: The overall maximum benefit amount payable under the policy. This amount decreases for benefits paid and increases for applicable optional inflation protection benefits (if elected by you), Guaranteed Future Purchase Offers that are accepted, and underwritten coverage amount increases.

Benefit Wait Period: The total number of days that you remain Chronically Ill before benefits are payable. The Benefit Wait Period begins on the first day that we verify you are Chronically Ill. Days more than 12 months prior to the date you submit your initial claim request will not count towards meeting the Benefit Wait Period, even if it can be established that you were Chronically Ill at that time. The Benefit Wait Period need only be met once during your lifetime. You do not have to be receiving Qualified Long Term Care Services in order to satisfy the Benefit Wait Period. Any day on which we verify that you are Chronically Ill will count toward the Benefit Wait Period.

Chronically III: You are Chronically III when you have been certified by a Licensed Health Care Practitioner as: a) being unable to perform, without Substantial Assistance from another person, at least two Activities of Daily Living for a period that is expected to last at least 90 consecutive days due to a loss of functional capacity; or b) requiring Substantial Supervision to protect yourself from threats to health and safety due to a Severe Cognitive Impairment. You will not meet the definition of Chronically III unless within the preceding 12-month period a Licensed Health Care Practitioner has certified that you meet such requirements.

Substantial Assistance means either Hands-on Assistance or Standby Assistance.

Hands-on Assistance means the physical assistance of another person without which you would be unable to perform the Activity of Daily Living. **Standby Assistance** means the presence of another person, within your arm's reach, that is necessary to prevent, by physical intervention, your injury while you are performing the Activity of Daily Living.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect you from threats to your health or safety (including, but not limited to, such threats as may result from wandering.)

Confinement or Confined: A period of time you are a resident in a Nursing Home or an Assisted Living Facility during which a room and board charge is made.

Covered Expenses: Costs for Qualified Long Term Care Services received in a Nursing Home, Assisted Living Facility, Adult Day Care Center, Hospice Care facility, or through a Home Care Agency, or by an Independent Provider or at-home Hospice Care provider.

Covered Expenses for Nursing Home care, Assisted Living Facility care or facility-based Hospice Care include expenses you incur for Qualified Long Term Care Services during your Confinement in a Nursing Home, Assisted Living Facility or Hospice Care facility for:

- Room and board (including charges to reserve your bed when you are absent for any reason except discharge);
- Ancillary services;
- Patient supplies provided by the Nursing Home, Assisted Living Facility or Hospice Care facility for care of its residents; and
- Hospice Care services.

Covered Expenses for Home Care Agency or Independent Provider care or at-home Hospice care include expenses you incur for Qualified Long Term Care Services provided to you by a Home Care Agency, an Independent Provider or at-home Hospice Care provider:

- Home Care Services;
- Maintenance or Personal Care Services; and
- Hospice Care services.

Covered Expenses for any type of provider do not include the cost of drugs.

Flexible Benefit: The benefit available to you if you meet the Eligibility for the Payment of Benefits requirements and have not depleted the full amount of your Monthly Benefit Access Limit for Covered Expenses for Qualified Long Term Care Services incurred in a given calendar month. This benefit is designed to address various forms of care, services and/or products which are recognized to effectively support or serve special needs of a Chronically III individual, but which are not formally defined within the policy under the term Covered Expenses.

Home Care Agency: An entity that is regularly engaged in providing Home Care Services, or Maintenance or Personal Care Services for compensation and employs staff who are qualified by training or experience to provide such care. The entity must: be supervised by a qualified professional such as a Registered Nurse (RN), a licensed social worker, or a Physician; keep clinical records or care plans on all patients; provide ongoing supervision and training to its employees appropriate to the services to be provided; and have the appropriate state licensure, accreditation or certification, where required.

Home Care Services: The following services provided in your home: part-time or intermittent skilled services provided by licensed nursing personnel; home health aide or personal care attendant services, including assistance with or performance of personal hygiene, Activities of Daily Living, medication management or other related supportive services; and homemaker services, such as meal preparation, laundry, housekeeping, transportation and shopping *when provided in conjunction with any other Home Care Services specified above.*

Hospice Care: Services designed to provide palliative care to someone diagnosed with a Terminal Illness in order to help alleviate that person's physical, emotional and/or spiritual discomforts during the last phases of life. Hospice Care can be provided in your home, or in a separate facility. The provider of Hospice Care services must be licensed or certified to provide Hospice Care by the state in which it is located.

Terminal Illness means an illness or injury which a Physician certifies is likely to result in a person's death within six months.

Independent Provider: A home health aide, certified nursing assistant, Nurse, or physical, occupational, respiratory or speech therapist who is working independently and is not affiliated with a Home Care Agency. Such person must be licensed, registered or certified to provide Home Care Services and Maintenance or Personal Care Services by the state in which he or she is providing the services.

Licensed Health Care Practitioner: Any of the following who is not a family member: a Physician (as defined in Section 1861(r)(1) of the Social Security Act); a registered professional nurse; a licensed social worker; or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

LifeSecure Care Advisor: A Licensed Health Care Practitioner designated by us who is qualified by training and experience to assist in identifying and coordinating the overall care needs of a person who is Chronically Ill.

Maintenance or Personal Care Services: Any care the primary purpose of which is the provision of needed assistance with helping you conduct your Activities of Daily Living while you are Chronically Ill. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Medicare: Title XVIII of the Social Security Act as amended.

Nursing Home: A facility or distinctly separate part of a hospital or other institution that is appropriately licensed or certified, or complies with the state's facility licensing requirements to engage primarily in providing nursing care to inpatients under a planned program supervised by a Physician. A Nursing Home provides 24-hour-a-day nursing care at skilled, intermediate, and/or custodial levels.

Physician: A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

Plan of Care: A written individualized plan of services prescribed by a LifeSecure Care Advisor or another Licensed Health Care Practitioner. The Plan of Care specifies your long term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services. The Plan of Care will be modified as required to reflect changes in: your functional or cognitive abilities, your social situation, and your care service needs.

Qualified Long Term Care Services: Necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are required by a Chronically Ill individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Severe Cognitive Impairment: A loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in your: short-term or long-term memory; orientation as to people, places or time; deductive or abstract reasoning; and judgment as it relates to safety awareness.

Usual and Customary Charges: amounts customarily charged in a given geographic region for similar forms of care, services and/or products which are recognized to effectively support the long term care needs of a Chronically Ill individual, as recommended by a Licensed Health Care Practitioner.



LifeSecure Insurance Company
10559 Citation Drive, Suite 300
Brighton, MI 48116
1-866-582-7702

**SOLICITATION DISCLOSURE FORM
IMPORTANT CONSUMER INFORMATION REGARDING 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 and special rules may apply to persons whose home equity exceeds \$500,000. Asset Disregard is not available under a long-term care insurance policy that is not a Partnership Policy. Therefore, you should consider if 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 compound annual inflation protection for ages 75 and younger.

If you apply and are approved for long-term care insurance coverage, LifeSecure Insurance Company will provide you with written documentation as to whether or not 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 or not 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 LifeSecure 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 LifeSecure Insurance Company. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Arkansas Department of Human Services



LifeSecure Insurance Company
10559 Citation Drive, Suite 300
Brighton, MI 48116
1-866-582-7702

Policy Disclosure Form

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 and special rules may apply to persons whose home equity exceeds \$500,000. 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 LifeSecure 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 LifeSecure 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.



LifeSecure Insurance Company
10559 Citation Drive, Suite 300
Brighton, MI 48116

Long Term Care Insurance Potential Rate Increase Disclosure Form

1. Premium Rate:

Premium rate that is applicable to you and that will be in effect until a request is made and approved for an increase is _____.

2. The premium for this policy will be shown on the Schedule of Benefits page of your Policy.

3. Rate Schedule Adjustments:

The premium rates for this coverage may change. Any change will be effective on the next billing date after LifeSecure Insurance Company has provided you at least 45 days written notice before we change premiums.

4. Potential Rate Revisions:

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your 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 Non-Forfeiture Benefit Rider if purchased. (This rider is available for purchase for an additional premium.)
- Exercise your contingent non-forfeiture rights*. (This feature is provided if you do not purchase the Non-Forfeiture Benefit Rider.)

***Contingent Non-Forfeiture**

If the premium rate for your policy goes up in the future and you didn't buy the optional Non-Forfeiture Benefit Rider, you may be eligible for contingent non-forfeiture. Here's how to tell if you are eligible:

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

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

The amount of coverage (i.e., new Benefit Bank 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 Benefit Bank 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 Non-Forfeiture option, your policy, with this reduced Benefit Bank amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your “paid-up” policy benefits are \$10,000 (provided you have at least \$10,000 of benefits remaining under your policy).

**Contingent Non-Forfeiture
Cumulative Premium Increase over Initial Premium
That Qualifies for Contingent Non-Forfeiture**

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

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

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;

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
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 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 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.

SERFF Tracking Number: LFSC-126051299

State: Arkansas

Filing Company: LifeSecure Insurance Company

State Tracking Number: 41870

Company Tracking Number:

TOI: LTC03I Individual Long Term Care

Sub-TOI: LTC03I.004 Partnership

Product Name: Partnership & New Regulations

Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: LFSC-126051299

State: Arkansas

Filing Company: LifeSecure Insurance Company

State Tracking Number: 41870

Company Tracking Number:

TOI: LTC03I Individual Long Term Care

Sub-TOI: LTC03I.004 Partnership

Product Name: Partnership & New Regulations

Project Name/Number: /

Supporting Document Schedules

Satisfied -Name: Flesch Certification

Review Status:

Accepted for Informational Purposes 05/13/2009

Comments:

Attachment:

Readability Certification 03.09.pdf

Bypassed -Name: Application

Review Status:

05/13/2009

Bypass Reason: The applications used with this policy were previously approved by your Department on 9/10/2007 .

The form numbers are: LS-0202A ST 07/07, LS-0202 ST 07/07, LS-0203 ST 07/07.

Comments:

Bypassed -Name: Health - Actuarial Justification

Review Status:

05/13/2009

Bypass Reason: no rate changes from previously filed form

Comments:

Satisfied -Name: Outline of Coverage

Review Status:

Approved 05/13/2009

Comments:

Attachment:

LS-0052 AR 03.09 - Outline of Coverage.pdf

Satisfied -Name: Cover Letter

Review Status:

Accepted for Informational Purposes 05/13/2009

Comments:

Attachment:

Cover Letter 3.19.09.pdf

SERFF Tracking Number: LFSC-126051299 State: Arkansas
Filing Company: LifeSecure Insurance Company State Tracking Number: 41870
Company Tracking Number:
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.004 Partnership
Product Name: Partnership & New Regulations
Project Name/Number: /

Satisfied -Name: Issuer Certification for Partnership
Qualification **Review Status:** Approved 05/13/2009

Comments:

Attachment:

Issuer Certification Form - AR.pdf



Readability Certification

This is to certify the policy forms listed below have achieved a Flesch Reading East Test Score (shown below) and complies with the requirements of ARK. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>Form Number</u>	<u>Description</u>	<u>Flesch</u>
LS-0002 AR 03/09	Individual Long Term Care Policy	43.1
LS-0052 AR 03/09	Outline of Coverage	41.3
LS-0101 ST 02/09	Potential Rate Increase Disclosure	46.0

A handwritten signature in black ink, appearing to read "Stephen H. Kellar".

Stephen H. Kellar, Vice President
Chief Financial Officer

03/19/2009

Date



LifeSecure Insurance Company

10559 Citation Drive, Suite 300

Brighton, Michigan 48116

1-866-582-7701

LONG TERM CARE INSURANCE - OUTLINE OF COVERAGE

For Policy Form Series LS-0002

Name of Applicant: _____ Date of Application: _____

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 on your Application. A copy of your Application will be attached to your policy if one is issued to you. If your answers are incorrect or untrue, we have the right to deny benefits or rescind the 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.

1. POLICY DESIGNATION

This is an individual policy of insurance.

2. PURPOSE OF THE 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 an insurance contract, but only a summary of coverage. Only the policy contains governing contractual provisions. This means that the policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY CAREFULLY!**

3. FEDERAL TAX CONSEQUENCES

The policy is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B (b) of the Internal Revenue Code of 1986 and as amended by the Health Insurance Portability and Accountability Act of 1996 - Public Law 104-191.

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

Renewability – THIS POLICY IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of the policy, to continue the policy as long as premiums for your coverage are paid on time. LifeSecure Insurance Company cannot change any of the terms of your policy on its own, except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY.

Waiver of Premium – We will waive the payment of premium beginning on the first day you begin receiving benefits. As long as you continue to receive benefits, additional premiums will not be required. Premium payments will again be required after 30 days of not receiving benefits. We will credit or refund, on a pro rata basis, any premiums paid for periods in which Waiver of Premium is in effect. Any such refund will be made as described in the Refund of Premiums in Certain Cases paragraph of Section 6 below.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

You cannot be singled out for a rate increase due to a change in your age or health status. We can, however, change premiums, but only if we change premiums for all similar policies issued in the same state and on the same form as your policy. Any premium changes will be effective on the next premium due date following our notice to you. If we ever increase your premium, you will have the option to reduce coverage in order to preserve the premium amount you had previously been paying.

6. TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED

30-Day Free Look – You may cancel your policy for any reason within 30 days after you receive it. Simply return the policy to us. We will treat the policy as though it had never been issued. We will refund the full amount of any premium paid.

Partial Refund of Premium Upon Death – This policy contains an optional benefit called the **Money-Back Promise Option** for the refund of premium in the event of death. The Money-Back Promise Option provides for reimbursement of a portion of your premiums paid, less any benefits paid, to a Beneficiary upon your death. If we receive a death certificate as proof of your death while your policy was in force for five or more years, and continues in force until death, we will refund the amount shown in the table below:

Years Since Policy Effective Date	Percentage of Premium Reimbursable (less any benefits paid)
Less than 5	0%
5 – 9	25%
10 – 14	50%
15 or more	75%

Refund of Premiums in Certain Cases – If you die while covered under the policy or choose to cancel your policy, we will refund the pro rata part of any premiums paid for periods beyond your death or cancellation. In addition, if you become eligible for Waiver of Premium, We will refund any outstanding credit with respect to the Waiver of Premium as described above in Section 4. In the event of death, any refund will be made within 30 days of our receipt of your death certificate and will be paid to your Beneficiary. If there is no named or living Beneficiary on the date of your death, any refund will be paid to your estate. In the event of your cancellation of the policy, any refund will be paid to you. In the event of an outstanding credit applicable to Waiver of Premium, any such refund will be paid upon the earlier of your death or your cancellation of the policy and will be paid to your Beneficiary, your estate or to you in the manner described above. The aggregate amount of all refunds paid upon your death or cancellation of the policy cannot exceed the total premiums you paid for your policy.

7. 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 LifeSecure Insurance Company nor its agents represent Medicare, the federal government, or any state government.

8. 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. This policy reimburses you incurred Covered Expenses for Qualified Long Term Care Services. In addition, the policy includes a Flexible Benefit that is not restricted by the definitions of Covered Expenses and Qualified Long Term Care Services.

9. BENEFITS PROVIDED BY THIS POLICY / BENEFIT ELIGIBILITY

Benefit Descriptions and Coverage Amounts

Benefit Bank – Your Benefit Bank represents the lifetime dollar benefit amount available to you under the policy. Your Benefit Bank balance is reduced by all benefit amounts paid to you, whether based on reimbursement for Covered Expenses for Qualified Long Term Care Services or payments related to the Flexible Benefit.

The Benefit Bank amounts available to you range from: \$75,000 to \$1,000,000.

Monthly Benefit Access Limit – Your Monthly Benefit Access Limit represents the dollar benefit amount available to you on a monthly basis during a claim period. The original dollar amount is calculated as a percentage of your Benefit Bank.

The Monthly Benefit Access Limit percentages available to you are: 1%, 2% or 3% of the Benefit Bank. (*Note: The 3% choice is not available for Benefit Bank amounts greater than \$500,000.*)

Example Illustration – Monthly Benefit Access Limit (MBAL) Calculation

$$\begin{array}{r} \text{Benefit Bank} \\ \$300,000 \end{array} \times \begin{array}{r} \text{MBAL (\%)} \\ 1\% \end{array} = \begin{array}{r} \text{MBAL (\$)} \\ \$3,000 \end{array}$$

Benefit Payout Structure – When you are eligible for benefits, we will reimburse you for Covered Expenses for Qualified Long Term Care Services, up to your Monthly Benefit Access Limit each calendar month. If you are eligible for benefits and you have not incurred Covered Expenses for Qualified Long Term Care Services up to the full Monthly Benefit Access Limit for a given calendar month, 50% of your unused Monthly Benefit Access Limit will be available to you as a Flexible Benefit. All benefits, both Covered Expenses and Flexible Benefits, payable to you under the policy must be pursuant to a written Plan of Care.

Example Illustration – Benefit Payout Structure

In this example, assume a claimant has a Monthly Benefit Access Limit of \$3,000. This claimant uses \$2,000 for qualified home health care during a one-month period. The unused monthly benefit = \$1,000. Claimant may receive a Flexible Benefit of up to \$500.

$$\begin{array}{r} \text{Home Health Cost} \\ \$2,000 \end{array} \quad \begin{array}{r} \text{Flexible Benefit} \\ \$500 \end{array} \quad \Rightarrow \quad \begin{array}{r} \text{Remaining Amount} \\ \text{Stays in Benefit Bank} \end{array}$$

Flexible Benefit – The Flexible Benefit is not restricted by the definition of Covered Expenses. It is designed to provide you greater flexibility in the types of care or services you receive under the policy, such as: care provided by an informal caregiver or family member; installation of a wheelchair access ramp to your home; or rental of durable medical equipment for your home. This benefit is calculated as defined in the previous paragraph.

Benefit Wait Period – You must satisfy a Benefit Wait Period of 90 days before benefits are payable. The Benefit Wait Period is the total number of days that you remain Chronically Ill before benefits are payable. It begins on the first day that we verify that you are Chronically Ill. The Benefit Wait Period need be met only once during your lifetime. You do not need to be receiving Qualified Long Term Care Services in order to satisfy the Benefit Wait Period. Any day on which we verify that you are Chronically Ill will count toward the Benefit Wait Period.

LifeSecure Care Advisor Services – LifeSecure Care Advisor Services are provided through our LifeSecure Care Advisors. You may use the LifeSecure Care Advisor Services anytime while your policy is in force. The services are optional and provided at no cost to you. A LifeSecure Care Advisor is available to: assist in identifying your specific personal care needs and the long term care

services in your area which may appropriately meet those needs; assist in developing a Plan of Care that meets your needs; and help you arrange for care or services.

Guaranteed Future Purchase Offers – *This is a standard feature unless you elect one of the optional inflation protection benefits: Automatic 3% Compound Inflation Protection Benefit or Automatic 5% Compound Inflation Protection Benefit, as described in Section 11 below.*

Under the Guaranteed Future Purchase Offers, you will be offered the opportunity to increase your Monthly Benefit Access Limit and Benefit Bank every three years, subject to the conditions listed below.

Each offer to increase will be for 15% of the dollar amount of your current Monthly Benefit Access Limit and the remaining dollar amount of your Benefit Bank. This offer will be made beginning on the third anniversary of your policy effective date and every three years thereafter. You may elect to increase your coverage by the amount offered under this feature without submitting evidence of insurability. The premium for the amount of increased coverage will be based on your attained age, your original rate class, and our premium rate schedule as of the date the benefit increase offer is made to you.

We will notify you by mail or e-mail of the offer at least 60 days prior to the anniversary of the policy effective date. You may accept or decline the offer within 60 days after we send the notification. If we do not receive your acceptance of our offer within 60 days, we will deem this to be a declination of the offer. You may accept or decline ongoing offers to increase coverage each time an offer is made.

No further offers will be made if your policy is terminated, or if coverage is continuing in effect under: the Extension of Benefits; the Lapse Protection Benefit, if any; or the Contingent Non-Forfeiture Benefit, if any. No further offers will be made: once you have attained age 80; during the Benefit Wait Period; or if you meet the Eligibility Requirements for benefits.

Contingent Non-Forfeiture Benefit – *This is a standard feature unless you elect the optional Lapse Protection Benefit as described below under Optional Benefits and Features.*

This benefit provides protection in the event of a substantial rate increase. If there is an increase in premium rates so that the cumulative amount of all premium rate increases is considered to be substantial, as determined by the schedule below, we will do all of the following:

- We will offer to reduce your current level of coverage without evidence of insurability so that the required premium for your coverage is not increased.
- We will offer to convert your coverage to a paid-up status with a lesser Benefit Bank. This option may be elected at any time during the 120-day period following the date of the premium rate increase. Under this conversion option, the amount of your revised Benefit Bank will be equal to the greater of: (a) one hundred percent (100%) of the sum of all premiums paid, excluding any waived premiums; or (b) one times your Monthly Benefit Access Limit in effect at the time of conversion. The revised Benefit Bank is reduced by the sum of all benefits previously paid to you. Your Monthly Benefit Access Limit will remain at the dollar amount in effect at the time of conversion, restricted only by the size of your revised Benefit Bank. This conversion option may be elected at any time during the 120-day period following the effective date of the premium rate increase.
- We will notify you that a premium lapse at any time during the 120-day period following the effective date of the premium increase will be deemed to be the election of the preceding offer to convert your coverage to a paid-up status. A premium lapse is your failure to pay the required premiums within the 31-day grace period.

Please refer to the schedule below to determine whether or not a change in premiums constitutes a Substantial Premium Increase. Cumulative premium increases over original premium that will allow

the Contingent Non-Forfeiture Benefit to be initiated appear in the chart. (Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Triggers for a Substantial Premium Increase

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

Optional Benefits and Features

The following benefits and features are available to you as options under this policy.

Money-Back Promise Option – (defined previously in Section 6 above.)

Lapse Protection Benefit – If you elect the optional Lapse Protection Benefit, it will provide a continuation of your policy up to a specified dollar amount. If you elect it and your coverage terminates due to non-payment of premium on or after the third anniversary of this option and before your Benefit Bank has been exhausted, the Lapse Protection Benefit provides a paid-up continuation of your coverage with a lesser Benefit Bank. The amount of your revised Benefit Bank will be equal to the greater of: (a) one hundred percent (100%) of the sum of all premiums paid, excluding any waived premiums; or (b) one times your Monthly Benefit Access Limit in effect at the time of lapse. The revised Benefit Bank is reduced by the sum of all benefits previously paid to you. Your Monthly Benefit Access Limit will remain at the dollar amount in effect at the time of lapse, restricted only by the size of your revised Benefit Bank. Your coverage under this option ends when the revised Benefit Bank has been exhausted.

Automatic Inflation Protection Choices – You have *two* optional automatic inflation protection benefit choices: Automatic 3% Compound Inflation Protection Benefit and Automatic 5% Compound Inflation Protection Benefit. These two benefits are described in Section 11 below.

Optional Premium Payment Modes

You may elect any one of the following limited-pay options to pay the premiums for your policy. (*Note:* Limited-pay options can only be elected with plan designs that include either the Automatic 3% Compound Inflation Protection Benefit or the Automatic 5% Compound Inflation Protection Benefit.)

10-Year Premium Payment Option – This option provides that your policy premiums may be paid over a ten-year period, after which no additional premiums will be due. Prior to the end of your tenth policy year, we have the right to change your premiums in accordance with the terms described in Section 5 above. In the event of a future benefit increase, a separate 10-year premium payment period will be applied for the increased benefit portion only, beginning on the effective date of the benefit increase.

To-Age-65 Premium Payment Option (*allowed only for issue ages 55 and under*) – This option provides that your policy premiums may be paid as due until the anniversary of the policy effective date following your 65th birthday, after which no additional premiums will be due. Prior to the policy anniversary date following your 65th birthday, we have the right to change your premiums in accordance with the terms described in Section 5 above. In the event of a future benefit increase, a separate 10-year premium payment period will be applied for the increased benefit portion only, beginning on the effective date of the benefit increase.

Eligibility Requirements For The Payment of Benefits

We will pay benefits under the policy when we verify that you meet all of the following conditions:

- You are Chronically Ill (refer to full definition in Section 16 below);
- You receive any service covered under the policy and provided pursuant to a written Plan of Care;
- Coverage under the policy is in force on the date(s) the care is received;
- You have satisfied the applicable Benefit Wait Period;
- You have not exhausted your Benefit Bank or your applicable Monthly Benefit Access Limit; and
- You meet the additional policy requirements for the specific policy benefits you claim.

10. LIMITATIONS AND EXCLUSIONS

No benefits, including the Flexible Benefit, will be payable under the policy for:

- a loss that occurs while the policy is not in force; or
- an illness, treatment or medical condition that is due to war or act of war, whether declared or not; or
- an illness, treatment or medical condition that results from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury; or
- expenses for treatment or rehabilitation related to alcoholism or drug addictions; or
- expenses for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act (Medicare), or would be so reimbursable but for the application of a deductible or coinsurance amount; or
- care or services, unless otherwise required by law, for which benefits are duplicated or provided under a governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
- care or services provided outside the United States of America, its territories or possessions, or Canada.

Charges for the following types of care or services are excluded under the reimbursable Covered Expenses for Qualified Long Term Care Services portion of the policy; however, the following types of care or services may be covered under the Flexible Benefit portion of the policy:

- care or services provided by a Family Member unless:
 - ✓ he or she is a regular employee of an organization which is providing the treatment, service or care; and
 - ✓ the organization receives the payment for the treatment, service or care; and
 - ✓ he or she receives no compensation other than the normal compensation for employees in his or her job category; or
- care or services for which no charge is made in the absence of insurance.

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

11. 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. You may elect one of the automatic inflation protection options to increase your coverage. If you do not elect one of the automatic inflation protection options, your coverage will include Guaranteed Future Purchase Offers by default. Only increases taken in accordance with one of the options listed below do not require evidence of insurability. Increases taken in accordance with one of the inflation protection features listed below do not require future evidence of insurability.

Benefit Adjustment Provisions

Automatic 3% Compound Inflation Protection Benefit – If you elect the optional Automatic 3% Compound Inflation Protection Benefit, we will increase your Monthly Benefit Access Limit and the amount remaining in your Benefit Bank. The dollar amount of your current Monthly Benefit Access Limit will be increased each year by 3%. The remaining dollar amount of your Benefit Bank will be increased each year by 3%. The increase will be effective on each anniversary of the Policy Effective Date, even if you are receiving benefits. Annual compound inflation protection increases will terminate if your coverage is continuing in effect under: the Extension of Benefits; the Lapse Protection Benefit, if any; or the Contingent Non-Forfeiture Benefit, if any.

Automatic 5% Compound Inflation Protection Benefit – If you elect the optional Automatic 5% Compound Inflation Protection Benefit, we will increase your Monthly Benefit Access Limit and the amount remaining in your Benefit Bank. The dollar amount of your current Monthly Benefit Access Limit will be increased each year by 5%. The remaining dollar amount of your Benefit Bank will be increased each year by 5%. The increase will be effective on each anniversary of the Policy Effective Date, even if you are receiving benefits. Annual compound inflation protection increases will terminate if your coverage is continuing in effect under: the Extension of Benefits; the Lapse Protection Benefit, if any; or the Contingent Non-Forfeiture Benefit, if any.

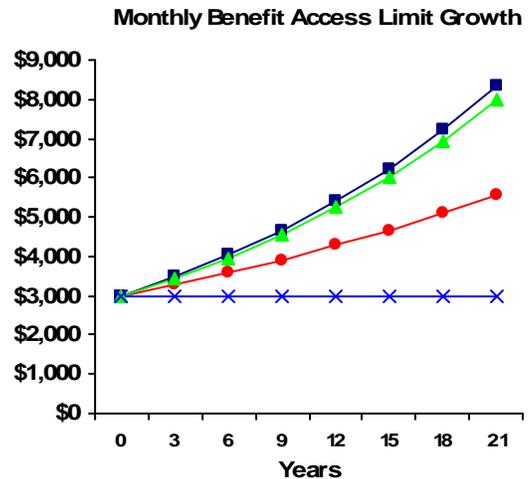
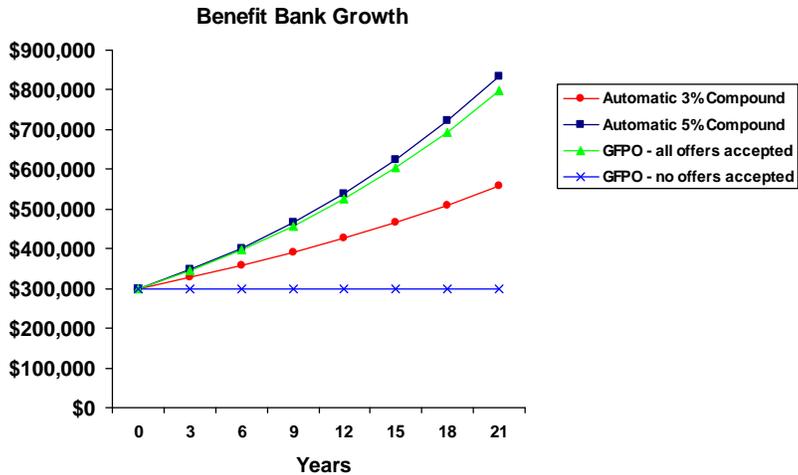
Guaranteed Future Purchase Offers – If you do not elect one of the optional automatic inflation protection benefits described above, your coverage will include the Guaranteed Future Purchase Offers feature, as described in Section 9 above.

Inflation Protection – Graphic Comparisons

The charts below compare and contrast the growth of an initial Benefit Bank amount of \$300,000 and a 1% Monthly Benefit Access Limit (\$3,000 initially) over a 21-year period, considering four variations:

- 1) a plan with the Automatic 3% Compound Inflation Protection Benefit;
- 2) a plan with the Automatic 5% Compound Inflation Protection Benefit;
- 3) a plan with Guaranteed Future Purchase Offers where *all* such offers are accepted; and
- 4) a plan with Guaranteed Future Purchase Offers where *no* such offers are accepted.

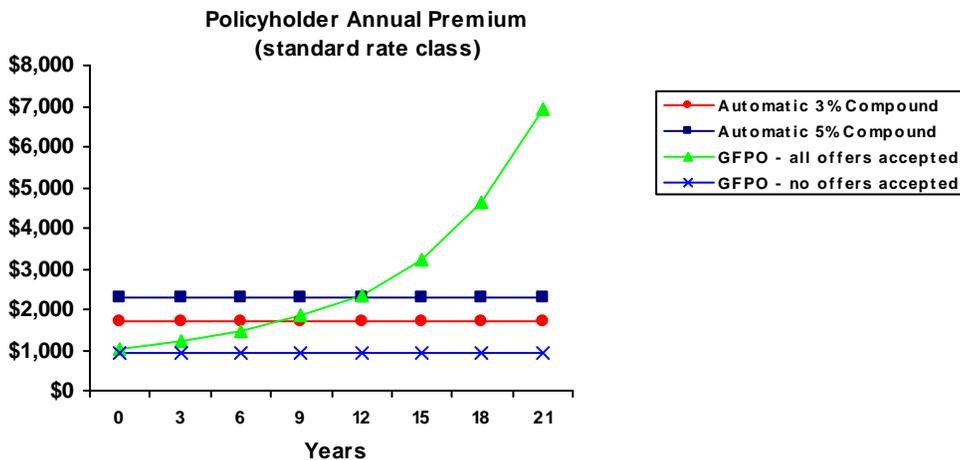
Example



The chart below compares and contrasts the annual premium applicable to a person who purchases a policy at 55 years of age with an initial Benefit Bank amount of \$300,000 and a 1% Monthly Benefit Access Limit over a 21-year period, considering four variations:

- 1) a plan with the Automatic 3% Compound Inflation Protection Benefit;
- 2) a plan with the Automatic 5% Compound Inflation Protection Benefit;
- 3) a plan with Guaranteed Future Purchase Offers where *all* such offers are accepted; and
- 4) a plan with Guaranteed Future Purchase Offers where *no* such offers are accepted.

Example



12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Once your Application for coverage under the policy is approved, the policy provides coverage for treatment of Alzheimer's disease, Parkinson's disease, senile dementia, and other forms of organic brain disease.

13. PREMIUM

Refer to the table below to find the premium applicable to the coverage amounts and policy design of your choice.

PREMIUM	Benefit Bank: \$ _____ Monthly Benefit Access Limit: ____ %	
Premium Payment Mode	Base Policy Coverage Premium:	\$ _____
Ⓒ Annual	Money-Back Promise Option:	\$ _____
Ⓒ Semi-Annual	Lapse Protection Benefit:	\$ _____
Ⓒ Quarterly	Automatic 3% Compound Inflation Protection Benefit:	\$ _____
Ⓒ Monthly EFT	Automatic 5% Compound Inflation Protection Benefit:	\$ _____
Ⓒ Monthly Credit Card	Total Annual Premium:	\$ _____
Ⓒ Bi-Weekly		
Ⓒ Other Payroll Cycle		
Premium Payment Time Period		
Ⓒ Lifetime		
Ⓒ 10-years		
Ⓒ To-Age-65		
	Modal Premium (based on Mode & Time Period elected):	\$ _____

14. ADDITIONAL FEATURES

Underwriting – Medical underwriting is required. We will underwrite your Application by reviewing one or more of the following: the information submitted on your Application; an attending Physician's report; copies of your medical records; a medical evaluation; a telephone interview; and an in-person interview.

Extension of Benefits – If your policy terminates due to failure to pay premium, we will recognize your basis for a claim for your Confinement in a Nursing Home or an Assisted Living Facility before the date your policy ended in the same manner as if your policy was in force. Extension of Benefits stops on the earlier of the date when you no longer meet the Eligibility for the Payment of Benefits requirements; the date you are no longer Confined in a Nursing Home or an Assisted Living Facility; or the date your Benefit Bank is exhausted.

Reinstatement Provision – If your coverage is terminated due to non-payment of premiums, you may apply for reinstatement by notifying us. We have the right to require evidence of insurability. If approved, the premium due from the date of the first unpaid premium must be paid, and coverage will be reinstated retroactive to the date of termination of coverage. We have the right to decline a request for reinstatement of coverage.

Added Protection Against Lapse – If your coverage terminates due to non-payment of premiums because you were Chronically Ill before the Grace Period expired, your coverage will be reinstated if we receive proof from a Licensed Health Care Practitioner (or other proof approved by us) that you were Chronically Ill. Such proof must be provided within 5 months of the termination date. You must pay all past due premiums for the coverage that was in force immediately prior to the date of termination.

15. CONTACT THE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. SEE ATTACHMENT 1 FOR CONTACT INFORMATION IN YOUR STATE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY.

Senior Health Insurance Information Program
Arkansas State Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Phone: 800-224-6330

http://www.accessarkansas.org/insurance/srinsnetwork/seniorshlth_p1.html

16. DEFINITIONS

Activities of Daily Living: Each of the following functions is an Activity of Daily Living:

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.

Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring: Moving into or out of a bed, chair or wheelchair.

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 catheter or colostomy bag.)

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.

Adult Day Care: A program for six or more individuals of social and health-related services provided during the day in a community group setting. The purpose is to support frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Adult Day Care Center: A facility that is licensed, registered or certified to provide a planned program of Adult Day Care services by the state in which it operates. If the state does not license such facilities, then it must be operated pursuant to law and meet certain standards.

Application: The written or electronic application form provided by us and completed by you when you apply for coverage.

Assisted Living Facility: A facility that is engaged primarily in providing ongoing care and related services that: (a) has the appropriate state licensure or certification as an Assisted Living Facility where required; and (b) meets certain requirements.

Beneficiary: The person designated by you to receive benefits, if any are payable, under the policy after your death, or to receive a refund of premiums paid beyond your death, if applicable.

Benefit Bank: The overall maximum benefit amount payable under the policy. This amount decreases for benefits paid and increases for applicable optional inflation protection benefits (if elected by you), Guaranteed Future Purchase Offers that are accepted, and underwritten coverage amount increases.

Benefit Wait Period: The total number of days that you remain Chronically Ill before benefits are payable. The Benefit Wait Period begins on the first day that we verify you are Chronically Ill. Days more than 12 months prior to the date you submit your initial claim request will not count towards meeting the Benefit Wait Period, even if it can be established that you were Chronically Ill at that time. The Benefit Wait Period need only be met once during your lifetime. You do not have to be receiving Qualified Long Term Care Services in order to satisfy the Benefit Wait Period. Any day on which we verify that you are Chronically Ill will count toward the Benefit Wait Period.

Chronically III: You are Chronically III when you have been certified by a Licensed Health Care Practitioner as: a) being unable to perform, without Substantial Assistance from another person, at least two Activities of Daily Living for a period that is expected to last at least 90 consecutive days due to a loss of functional capacity; or b) requiring Substantial Supervision to protect yourself from threats to health and safety due to a Severe Cognitive Impairment. You will not meet the definition of Chronically III unless within the preceding 12-month period a Licensed Health Care Practitioner has certified that you meet such requirements.

Substantial Assistance means either Hands-on Assistance or Standby Assistance.

Hands-on Assistance means the physical assistance of another person without which you would be unable to perform the Activity of Daily Living. **Standby Assistance** means the presence of another person, within your arm's reach, that is necessary to prevent, by physical intervention, your injury while you are performing the Activity of Daily Living.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect you from threats to your health or safety (including, but not limited to, such threats as may result from wandering.)

Confinement or Confined: A period of time you are a resident in a Nursing Home or an Assisted Living Facility during which a room and board charge is made.

Covered Expenses: Costs for Qualified Long Term Care Services received in a Nursing Home, Assisted Living Facility, Adult Day Care Center, Hospice Care facility, or through a Home Care Agency, or by an Independent Provider or at-home Hospice Care provider.

Covered Expenses for Nursing Home care, Assisted Living Facility care or facility-based Hospice Care include expenses you incur for Qualified Long Term Care Services during your Confinement in a Nursing Home, Assisted Living Facility or Hospice Care facility for:

- Room and board (including charges to reserve your bed when you are absent for any reason except discharge);
- Ancillary services;
- Patient supplies provided by the Nursing Home, Assisted Living Facility or Hospice Care facility for care of its residents; and
- Hospice Care services.

Covered Expenses for Home Care Agency or Independent Provider care or at-home Hospice care include expenses you incur for Qualified Long Term Care Services provided to you by a Home Care Agency, an Independent Provider or at-home Hospice Care provider:

- Home Care Services;
- Maintenance or Personal Care Services; and
- Hospice Care services.

Covered Expenses for any type of provider do not include the cost of drugs.

Flexible Benefit: The benefit available to you if you meet the Eligibility for the Payment of Benefits requirements and have not depleted the full amount of your Monthly Benefit Access Limit for Covered Expenses for Qualified Long Term Care Services incurred in a given calendar month. This benefit is designed to address various forms of care, services and/or products which are recognized to effectively support or serve special needs of a Chronically III individual, but which are not formally defined within the policy under the term Covered Expenses.

Home Care Agency: An entity that is regularly engaged in providing Home Care Services, or Maintenance or Personal Care Services for compensation and employs staff who are qualified by training or experience to provide such care. The entity must: be supervised by a qualified professional such as a Registered Nurse (RN), a licensed social worker, or a Physician; keep clinical records or care plans on all patients; provide ongoing supervision and training to its employees appropriate to the services to be provided; and have the appropriate state licensure, accreditation or certification, where required.

Home Care Services: The following services provided in your home: part-time or intermittent skilled services provided by licensed nursing personnel; home health aide or personal care attendant services, including assistance with or performance of personal hygiene, Activities of Daily Living, medication management or other related supportive services; and homemaker services, such as meal preparation, laundry, housekeeping, transportation and shopping *when provided in conjunction with any other Home Care Services specified above.*

Hospice Care: Services designed to provide palliative care to someone diagnosed with a Terminal Illness in order to help alleviate that person's physical, emotional and/or spiritual discomforts during the last phases of life. Hospice Care can be provided in your home, or in a separate facility. The provider of Hospice Care services must be licensed or certified to provide Hospice Care by the state in which it is located.

Terminal Illness means an illness or injury which a Physician certifies is likely to result in a person's death within six months.

Independent Provider: A home health aide, certified nursing assistant, Nurse, or physical, occupational, respiratory or speech therapist who is working independently and is not affiliated with a Home Care Agency. Such person must be licensed, registered or certified to provide Home Care Services and Maintenance or Personal Care Services by the state in which he or she is providing the services.

Licensed Health Care Practitioner: Any of the following who is not a family member: a Physician (as defined in Section 1861(r)(1) of the Social Security Act); a registered professional nurse; a licensed social worker; or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

LifeSecure Care Advisor: A Licensed Health Care Practitioner designated by us who is qualified by training and experience to assist in identifying and coordinating the overall care needs of a person who is Chronically III.

Maintenance or Personal Care Services: Any care the primary purpose of which is the provision of needed assistance with helping you conduct your Activities of Daily Living while you are Chronically III. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Medicare: Title XVIII of the Social Security Act as amended.

Nursing Home: A facility or distinctly separate part of a hospital or other institution that is appropriately licensed or certified, or complies with the state's facility licensing requirements to engage primarily in providing nursing care to inpatients under a planned program supervised by a Physician. A Nursing Home provides 24-hour-a-day nursing care at skilled, intermediate, and/or custodial levels.

Physician: A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

Plan of Care: A written individualized plan of services prescribed by a LifeSecure Care Advisor or another Licensed Health Care Practitioner. The Plan of Care specifies your long term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services. The Plan of Care will be modified as required to reflect changes in: your functional or cognitive abilities, your social situation, and your care service needs.

Qualified Long Term Care Services: Necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are required by a Chronically Ill individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Severe Cognitive Impairment: A loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in your: short-term or long-term memory; orientation as to people, places or time; deductive or abstract reasoning; and judgment as it relates to safety awareness.

Usual and Customary Charges: amounts customarily charged in a given geographic region for similar forms of care, services and/or products which are recognized to effectively support the long term care needs of a Chronically Ill individual, as recommended by a Licensed Health Care Practitioner.



March 19, 2009

Department of Insurance
State of Arkansas
1200 West Third Street
Little Rock, AR 72201

RE: **LifeSecure Insurance Company**
FEIN # 75-0956156 NAIC # 77720
INDIVIDUAL ACCIDENT AND HEALTH INSURANCE
Long Term Care Insurance Policy - LS-0002 AR 03/09
Outline of Coverage – LS-0052 AR 03/09
Potential Rate Disclosure Form – LS-0101 ST 02/09
Arkansas LTC Partnership Solicitation Form – LS-0127A AR 02/09'
Arkansas LTC Partnership Disclosure Notice –LS-0127B AR 02/09

To Whom it may Concern:

Enclosed for your review and approval are the above captioned forms. The following is description of the forms submitted.

Form LS-0002 AR 03/09 will replace our previously approved policy form LS-0002 AR 07/07. The previous form was approved by you on 9/10/2007. The SERFF tracking number is LFSC-125167273. To date we have not issued any policies. The form was brought into compliance with Arkansas regulation revisions. The only change to this form, from the previous form is the additional of language in the definition of "Severe Cognitive Impairment."

Form LS-0052 AR 03/09 will replace our previously approved outline of coverage (Form LS-0052 ST 05/07). The Outline of Coverage was changed to reflect the policy change described above.

Form LS-0101 ST 02/09 has been updated to reflect the limited pay language in your regulation. It will replace form LS-0101 ST 05/07 formally filed and approved on 9/10/2007.

It is our intention to offer this policy as a partnership qualified policy. Therefore, the following forms are being submitted:

Form LS-0127A AR 02/09 – This form will be used during solitaiion by our licensed agents.

Form LS-0127B AR 02/09 – This form will be issued with our policies, if the policy purchased falls under the qualifications of partnership status.

We are also submitting the Issuer Certification form, certified by our Vice President and CFO.

I trust you will find these forms in compliance with Arkansas rules and regulations. Please contact me if you have any questions. I can be reached at (810) 220-4610 or by email at Jlucas@lifecureltc.com.

Respectfully Submitted,

A handwritten signature in cursive script that reads "Judy Lucas".

Judy Lucas
Senior Compliance Specialist



**APPENDIX C
ISSUER CERTIFICATION FORM**

(relating to Qualified State Long-Term Care Insurance Partnership)

In order to provide each State insurance commissioner with information necessary to provide a certification for policies, this Issuer Certification Form requests 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.

I. GENERAL INFORMATION

A. Name, address and telephone number of issuer:

**LifeSecure Insurance Company
10559 Citation Dr. Ste 300
Brighton, MI 48116
(810) 220-7700**

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:

**Sue R. Howard
Compliance Manager
LifeSecure Insurance Company
10559 Citation Dr. Ste. 300
Brighton, MI 48116
(810) 220-8774 – phone
(810) 220-7707 – fax
Showard@lifeseecureltc.com**

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):

LS-0002 AR 03/09

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 XX 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.

03/19/2009
Date

Stephen H. Kellar, Vice President & CFO
Name and title of officer of the Issuer



Signature of officer of the Issuer