

SERFF Tracking Number: LFCR-126074870 State: Arkansas
Filing Company: Minnesota Life Insurance Company State Tracking Number: 41826
Company Tracking Number: ML7600 AR
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Integrity LTCi
Project Name/Number: /

Filing at a Glance

Company: Minnesota Life Insurance Company

Product Name: Integrity LTCi

TOI: LTC03I Individual Long Term Care

Sub-TOI: LTC03I.001 Qualified

Filing Type: Form/Rate

SERFF Tr Num: LFCR-126074870

SERFF Status: Closed

Co Tr Num: ML7600 AR

Co Status:

Authors: Smith Darlene, Trudy

Weigel

Date Submitted: 03/13/2009

State: ArkansasLH

State Tr Num: 41826

State Status: Approved-Closed

Reviewer(s): Marie Bennett

Disposition Date: 06/01/2009

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/01/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 06/01/2009

Corresponding Filing Tracking Number:

Deemer Date:

Filing Description:

RE: MINNESOTA LIFE INSURANCE COMPANY - NAIC # 66168

Long Term Care filing of Tax-Qualified Policy Forms as listed in the
Form Filing Cover Sheet

The above referenced forms are being filed for your review and approval as new forms.

This policy is intended to be a qualified long term care insurance contract, in compliance with the HIPAA, Public Law 104-191.

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Policy Form ML7600P-AR is a guaranteed renewable long term care insurance policy. The policy will pay the daily benefit selected on an indemnity basis for skilled, intermediate and custodial nursing care, while confined in a nursing care facility or an assisted living facility, as well as other benefits.

Benefits are also provided for optional home and community based care (HCBC), which is included in the policy. If the HCBC benefit is selected, the policy will pay the actual charges incurred up to the daily benefit amount selected, for professional nursing care, therapeutic care, services provided by a qualified home health care agency or independent home health caregiver, including homemaker services, dietician services and adult day care. A caregiver training benefit is also available to provide training by a health care professional to an informal caregiver.

The benefit amount payable under the policy is determined by the daily benefit and benefit period (5, 4, 3, or 2 year) selections. A lifetime benefit period, providing an unlimited benefit amount, may also be selected.

Eligibility for the payment of benefits is based upon an assessment that the insured is chronically ill. This means that within the previous 12 months a licensed health care practitioner has certified that the insured is unable to perform two or more activities of daily living; or has a severe cognitive impairment. The assessment includes a plan of care, which recommends the services to be performed, as defined in the policy. Benefits are payable after satisfaction of a 0, 30, 90 or 180-day elimination period for nursing care. The elimination period is not applicable to HCBC and days on which benefits are payable for HCBC (when covered under the policy) will count toward the elimination period for nursing care. Once the elimination period has been satisfied, no elimination period will be required for any future benefits under the policy.

Other benefits provided by this policy are as follows:

Benefits are payable for coverage outside the United States, or its territories, or Canada for up to 30 days per calendar year. The benefit payable under the policy will be the daily benefit for nursing care, or if selected, the actual daily HCBC charges incurred for covered services, up to the daily benefit selected.

Bed reservation benefits are payable at the daily benefit selected for nursing care, when charged by a nursing care facility or an assisted living facility to reserve accommodations during a temporary absence from the facility. The benefit is payable for up to 60 days per calendar year.

A Hospice Care Benefit is available to a terminally ill insured. The benefit is paid on an indemnity basis for each day of nursing care or actual expenses incurred up to the daily benefit selected for each day of HCBC.

The Respite Care Benefit provides for short term care to relieve family or friends providing long term care to the insured. The benefit is paid on an indemnity basis for each day of nursing care or actual expenses incurred up to the daily benefit selected for each day of HCBC. Benefits are payable for a maximum of 30 days per calendar year.

Premiums are waived when the insured is confined in a nursing care facility or an assisted living facility after satisfaction of any applicable elimination period. Premiums are also waived if the insured is receiving HCBC for covered services at

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least once per week.

An optional alternative plan of care is available for qualified long term care services not specifically shown as being available in the policy, if agreed to by the insured, the licensed health care practitioner and the company as the most cost efficient way to handle the claim. An alternative plan of care provides for equipment purchases or rentals, or care services not normally covered under the HCBC benefit.

If HCBC is selected, a Home Modification Benefit is payable for actual charges incurred up to the Maximum Lifetime Home Modification Benefit that is equal to 30 times the daily benefit selected for HCBC. This Maximum Lifetime Home Modification Benefit is payable in addition to the benefit amount payable under the policy.

If requested, an optional personal care advisor is accessible through a toll-free number to provide assistance to policyholders.

If after speaking with the personal care advisor the insured requests additional care coordination assistance, we will arrange for a care coordinator to contact the insured. These are optional services and there are no costs associated with either.

The policy will be issued to insureds ages 40-84 (age nearest birthday) with a daily benefit choice of \$40-\$300. Joint coverage is available for two people who live in the same household. As described in the actuarial memorandum, discounted premiums will be available for association or employer groups.

10-year and 20-year premium payment options are offered (Endorsement Forms MLE-10P and MLE-20P) under which the policies may be paid up in either 10 or 20 years with no further premiums required. These endorsements were previously approved for use on 2-14-06.

Several optional riders are available for attachment to the policy.

ML7600R-ROP, Full Return of Premium Rider, provides a return of premium benefit in the event of the death of the insured (last to die in the case of joint coverage). If the insured dies while the policy is in force, the total of premiums paid for the policy and any attached riders will be paid to a beneficiary.

ML7600R-SBN, Shortened Benefit Period Nonforfeiture Rider is designed to meet the NAIC minimum standards for nonforfeiture benefits. If the policy has been in force for at least three years and lapses for nonpayment of premiums, this rider provides continued coverage based on the daily benefit in effect on the date of lapse. The total benefit payable becomes equal to the greater of the total premium paid for the policy and all riders or at least 30 times the daily benefit in effect on the date of lapse.

ML7600R-CBI, Compound Benefit Increase Rider, provides a 5% or 3% compounded annual increase of the daily benefit amount and the remaining benefit amount.

ML7600R-SBI, Simple Benefit Increase Rider, provides a 5% simple interest annual increase of the daily benefit amount originally issued. The remaining benefit amount will also be increased by the same proportion as the increase in daily

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benefits.

ML7600R-IND, HCBC Indemnity Benefit Rider changes HCBC benefits payable from an expense incurred basis to an indemnity basis. This rider is not available if the Monthly HCBC Benefit Rider is purchased.

ML7600R-MTH, Monthly HCBC Benefit Rider, changes the daily benefit payable to a monthly benefit for HCBC up to the daily benefit amount selected times the number of actual days in that calendar month. This rider is not available if the HCBC Indemnity Benefit Rider is purchased. The Compound Benefit Increase Rider must also be chosen.

ML7600R-SBA, Shared Benefit Amount Rider is available for benefit periods of less than Lifetime. It provides a third shared benefit amount on joint policies after either or both insureds have exhausted their own benefit amount under the policy. This rider is not available with the Restoration of Benefits Rider.

ML7600R-SVR, Paid-Up Survivor Benefit Rider provides that the policy and any attached riders will be paid-up after both of the following have occurred: 1) the end of the 10th policy year; and 2) the date of death of either insured. If one insured dies prior to the end of the 10th policy year. The remaining insured will pay the individual premium that would have been charged at the original issue age and risk class for the balance of the 10 year period. This rider is only available for joint coverage with a lifetime premium payment period.

ML7600R-ROB, Restoration of Benefits Rider, is available with benefit periods other than lifetime. If the policy remains in force and claims paid during a single claim period have not exceeded the benefit amount and the insured is not eligible for the payment of benefits for 180 consecutive days, the benefit amount payable will be restored. Restoration of Benefits is subject to a maximum of twice the benefit amount selected. This is not available with the Shared Benefit Amount Rider.

The long term care insurance policy and all riders will be applied for on Application ML7600A-AR.

Form ML7500AUT, Authorization for Disclosure, Receipt and Use of Personal Health Information, meets the requirements of HIPAA, as set forth in 45 CFR, Section 164.508. The Disclosure Statement and Conditions of Coverage, Form ML7500AD will be provided to all applicants. Medicare Supplement Duplication Notice, Form MLN-MED is provided at time of application. Replacement Form MLN-REP will be provided at the time of application when applicable. If the owner of the policy will be other than the insured, Supplemental Application ML7500AO will be used All of these forms were previously approved for use on the same date indicated above.

The outline of coverage relevant to this policy, ML7600OC-AR, is also included.

In compliance with state requirements we are including Contingent Benefit Upon Lapse Endorsement, Form MLE-CNF which will be issued with each policy if optional nonforfeiture benefits are not selected. Endorsement Form MLE-CNF-LP will also be issued with limited payment policies. In addition, we will issue Lowering Premiums by Reducing Benefit Endorsement Form MLE-RED with every policy. Things You Should Know Before You Buy Long Term Care Insurance, Form MLN-LTC and Potential Rate Increase Disclosure; Form MLN-PRI-LP will be left with the applicant at time of

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application. All of these forms were previously filed and approved for use.

Long Term Care Personal Worksheet, Form ML7600WRK will be completed and submitted along with the application. Also included is a sample copy of the suitability letter that will be utilized if it appears that coverage may not meet the applicant's financial needs.

The forms listed above are also intended to be used in the Arkansas Long Term Care Partnership program. Application Form ML7600A-AR and Outline of Coverage ML7600OC-AR include a line and box for each applicant to choose a partnership policy and to show the ages at which inflation protection is required.

Forms MLD-PRT-AR and MLN-PRT-AR will be attached to each policy that becomes a partnership policy as chosen in the Application and Outline. The QP checklist for the policy ML7600P-AR is attached to certify that the policies qualify as a partnership policy.

Finally, we are including copies of the actuarial memorandum and Flesch certification.

These forms are being filed concurrently for use in the Company's state of domicile, Minnesota.

Thank you for your assistance with this filing.

Sincerely,

Karina Amaral
Compliance Analyst
(800) 366-5463 ext. 2307
Email: Karina.Amaral@lifecareassurance.com

Company and Contact

Filing Contact Information

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

Karina Amaral, Compliance Analyst 1 - karina.amaral@lifecareassurance.com

Advertising

21600 Oxnard Street (818) 867-2307 [Phone]

Woodland Hills, CA 91367 (818) 867-2508[FAX]

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Filing Company Information

Minnesota Life Insurance Company
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
(818) 867-2450 ext. [Phone]

CoCode: 66168
Group Code: 869
Group Name:
FEIN Number: 41-0417830

State of Domicile: Minnesota
Company Type:
State ID Number:

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Filing Fees

Fee Required? Yes
Fee Amount: \$150.00
Retaliatory? No
Fee Explanation: Form & Rate: \$150.00/filing x 1 filing = \$150.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Minnesota Life Insurance Company	\$150.00	03/13/2009	26422581

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Marie Bennett	06/01/2009	06/01/2009

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Disposition

Disposition Date: 06/01/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		Yes
Supporting Document	Cover Sheet		Yes
Supporting Document	Certificate of Compliance		Yes
Supporting Document	Partnership Issuer Certification		Yes
Supporting Document	Previously Approved Forms For Use With This Product		Yes
Form	Long Term Care Insurance Policy		Yes
Form	Outline of Coverage for Long Term Care Insurance		Yes
Form	Full Return of Premium Rider		Yes
Form	Shortened Benefit Period Nonforfeiture Rider		Yes
Form	Compound Benefit Increase Rider		Yes
Form	Simple Benefit Increase Rider		Yes
Form	Home and Community Based Care Indemnity Benefit Rider		Yes
Form	Monthly Home and Community Based Care Benefit Rider		Yes
Form	Restoration of Benefits Rider		Yes
Form	Shared Benefit Amount Rider		Yes
Form	Paid-up Survivor Benefit Rider		Yes
Form	Application for Long Term Care Insurance Policy		Yes
Form	Partnership Program Notice		Yes
Form	Important Notice Regarding Your LTC Insurance Partnership Status		Yes

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Form Schedule

Lead Form Number: ML7600P-AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ML7600P-AR	Policy/Cont	Long Term Care ract/Fratern Insurance Policy al Certificate	Initial		50	ML7600P-AR.pdf
	ML7600OC-AR	Outline of Coverage	Outline of Coverage for Long Term Care Insurance	Initial		0	ML7600OC-AR.pdf
	ML7600R-ROP	Policy/Cont	Full Return of ract/Fratern Premium Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50	ML7600R-ROP.pdf
	ML7600R-SBN	Policy/Cont	Shortened Benefit ract/Fratern Period Nonforfeiture al Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		52	ML7600R-SBN.pdf
	ML7600R-CBI	Policy/Cont	Compound Benefit ract/Fratern Increase Rider al Certificate: Amendmen t, Insert Page,	Initial		55	ML7600R-CBI.pdf

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Project Name/Number	Description	Initial	Page	File Name
ML7600R-SBI	Policy/Cont Simple Benefit ract/Fratern Increase Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	56	ML7600R-SBI.pdf
ML7600R-IND	Policy/Cont Home and ract/Fratern Community Based al Care Indemnity Certificate: Benefit Rider Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50	ML7600R-IND.pdf
ML7600R-MTH	Policy/Cont Monthly Home and ract/Fratern Community Based al Care Benefit Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	58	ML7600R-MTH.pdf
ML7600R-ROB	Policy/Cont Restoration of ract/Fratern Benefits Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	51	ML7600R-ROB.pdf

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ML7600R-SBA	Policy/Cont Shared Benefit ract/Fratern Amount Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50	ML7600R-SBA.pdf
ML7600R-SVR	Policy/Cont Paid-up Survivor ract/Fratern Benefit Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	58	ML7600R-SVR.pdf
ML7600A-AR	Application/ Application for Long Enrollment Term Care Insurance Form Policy	Initial	0	ML7600A-AR.pdf
MLN-PRT-AR	Other Partnership Program Notice	Initial		MLN-PRT-AR.pdf
MLD-PRT-AR	Other Important Notice Regarding Your LTC Insurance Partnership Status	Initial		MLD-PRT-AR.pdf

LONG TERM CARE INSURANCE POLICY

Read this policy carefully. It is a legal contract between you and us.

This policy is intended to be a federally tax-qualified long term care insurance contract as defined under section 7702B(b) of the Internal Revenue Code of 1986, as amended. In the event that future changes in federal law require this policy to be amended in order to maintain its status as a federally tax-qualified long term care insurance contract, you will be provided with the opportunity to accept or reject any such amendments. You should consult with your attorney, accountant or tax advisor regarding the tax implications of purchasing this long term care insurance.

NOTICE TO BUYER: Should you have any questions about your insurance, contact us at our Administrative Office shown below or call the Policyholder Service Department at (888) 505-9817. If you are not satisfied, you may contact the Arkansas Department of Insurance, Consumer Services Division, at 1200 W. Third Street, Little Rock, AR 72201 1904 (800) 852-5494 or (501) 371-2640.

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. No prior hospital confinement is required in order to qualify for benefits under this policy and attached riders, if any.

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 is enclosed. If your answers are incorrect or untrue, we have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the address shown below.

This policy provides benefits for Qualified Long Term Care Services as defined herein, subject to all terms and provisions. In this policy, Minnesota Life Insurance Company will be referred to as "we", "us", or "our". The Insured(s) named on the Policy Schedule will be referred to as "you" or "your".

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY: If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from us.

RENEWAL PROVISION: This policy is guaranteed renewable for life. To renew, pay the premium due by the Premium Due Date or within the Grace Period. We cannot cancel or refuse to renew this policy. Premiums are subject to change. We can only change the premium for this policy if we change premiums for everyone in your state with the same class. A class includes persons with the same benefits, issue age, and premium rate class at issue. We will give you at least 60 days written notice at your last address shown in our records before we change your premium.

YOUR 30-DAY RIGHT TO EXAMINE YOUR POLICY: If you are not satisfied with your policy, you may return it to us or our agent within 30 days from the date you receive it. We will then refund any premium you have paid and your policy will be considered to be void from its beginning.

Signed for Minnesota Life Insurance Company, a stock company, at St. Paul, Minnesota on the policy Effective Date.



Secretary



Chairman and Chief Executive Officer

MINNESOTA LIFE

Minnesota Life Insurance Company
Home Office: St. Paul, MN 55101-2098
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.9817 Tel • 818.887.4595 Fax

GUIDE TO YOUR POLICY

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Policy Number: 17-12345678
Insured: John Doe
Insured: Mary Doe

BENEFIT INFORMATION

ALL BENEFITS, THE ELIMINATION PERIOD AND THE BENEFIT AMOUNT SHOWN BELOW APPLY INDIVIDUALLY TO EACH INSURED NAMED ABOVE.

ELIMINATION PERIOD: Nursing Care - 90 Days
Home and Community Based Care - None

BENEFIT PERIOD: 3 Years (1,095 Days)

BENEFIT AMOUNT: \$109,500.00
Daily Benefit of \$100.00 times Benefit Period of 3 Years (1095 Days)

BENEFIT	DAILY BENEFIT
Nursing Care (in a Nursing Care or Assisted Living Facility):	\$100.00
Home and Community Based Care: up to	\$100.00
Maximum Lifetime Home Modification Benefit: up to	\$3,000.00
Maximum Lifetime Caregiver Training Benefit: up to	\$1,000.00
Bed Reservation Benefit: up to	60 days per calendar year
Respite Care Benefit: up to	30 days per calendar year
Coverage Outside the United States or its territories, or Canada: up to	30 days per calendar year

Our toll-free number for policy service and claims is 888.505.9817. This is an option available to you for your convenience.

PART 1: INSURING AGREEMENT AND EFFECTIVE DATE

Subject to the terms and conditions described in your policy, Minnesota Life Insurance Company agrees to pay to you the benefits described in your policy. We make this agreement and issue your policy in consideration of: (1) the statements made in your signed application, which is attached to and made a part of your policy; and (2) payment of the initial premium. Your policy takes effect on the Effective Date shown on the Policy Schedule.

PART 2: DEFINITIONS

Activities of Daily Living means:

1. 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.
2. 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).
3. Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
4. 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.
5. Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. Transferring: Moving into or out of a bed, chair, or wheelchair.

Adult Day Care means a program of services provided to Chronically Ill individuals during the day in a community group setting through an Adult Day Care Center that includes:

1. social and health-related services; and
2. Maintenance or Personal Care Services.

The purpose of such a program 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 means a facility licensed or certified under state law, if any, to provide Adult Day Care to adults who do not require 24-hour institutional care, but are not capable of full-time, independent living.

Assisted Living Facility means a place which:

1. is licensed or certified under state law to perform the services it is providing, where such licensing or certification is required;
2. has at least one trained staff member on duty 24 hours per day;
3. provides continuous room and board; and
4. provides Maintenance or Personal Care Services required by residents due to their inability to perform the Activities of Daily Living or due to a Severe Cognitive Impairment.

Assisted Living Facilities do not include Hospitals. Unless otherwise excluded in your policy, Assisted Living Facilities include facilities otherwise named, which meet the above criteria, including secure Alzheimer's units.

Caregiver Training means training provided by a health care professional, approved by us, to an informal caregiver. The informal caregiver may be an unpaid member of your Family, a friend or neighbor providing care in a setting other than a Hospital, Nursing Care Facility or Assisted Living Facility. Examples of such training may include, but are not limited to:

1. the proper care and use of medical devices such as catheters, intravenous medications, colostomy bags or suctioning tubes;
2. assistance with medications, bandages and dressings; or
3. the proper performance of various procedures to assist you with your Activities of Daily Living.

Chronically Ill means that within the previous 12 months you have been certified by a Licensed Health Care Practitioner as:

1. being unable to perform, without Substantial Assistance, at least two Activities of Daily Living for a period of at least 90 days due to loss of functional capacity; or
2. having a Severe Cognitive Impairment.

Effective Date means the date coverage under your policy and any attached riders is first in force. This date is shown on the Policy Schedule.

Elimination Period means the number of days you must receive Nursing Care, beginning with the day you satisfy the Eligibility for the Payment of Benefits provision, before we will begin paying benefits. Your Elimination Period is shown on the Policy Schedule. Each day you receive Nursing Care under your policy counts towards your Elimination Period. Once you have satisfied the

Elimination Period, no future Elimination Period is required. Days may be accumulated under separate claims in order to satisfy the Elimination Period. The Elimination Period applies to each insured individually in the case of joint coverage.

The Elimination Period is not applicable to Home and Community Based Care (if covered under the policy). However, days on which benefits are payable for Home and Community Based Care (if covered under the policy) will also count towards satisfaction of the Elimination Period for Nursing Care.

In addition, the Elimination Period is not applicable to Caregiver Training, Respite Care Benefits or Home Modification Benefits and is waived for the first 90 days of Hospice Care. Use of Caregiver Training, Respite Care, Home Modification and the first 90 days of Hospice Care do not count toward satisfaction of the Elimination Period for any other benefits payable under your policy.

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

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

Home and Community Based Care means Qualified Long Term Care Services provided to you through Adult Day Care, Home Health Care and Caregiver Training.

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

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

Home Health Care means a program of medical and nonmedical services provided to ill, disabled or infirm persons through a Home Care Agency or Home Health Caregiver, including:

1. professional nursing care by or under the supervision of an RN or other licensed nurse;
2. care by a Home Health Aide;
3. therapeutic care services by or under the supervision of a speech, occupational, physical, or respiratory therapist licensed or certified under state law, if any, or a registered dietician; or

4. Homemaker Services.

Home Health Care is provided in a setting other than a Hospital, Nursing Care Facility or Assisted Living Facility.

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

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

Homemaker Services means services which are designed to maintain independent living. Services shall consist of the following where applicable: Shopping, menu planning, meal preparation and light housekeeping.

Home Modification means permanent or temporary changes to your residence (such as installation of a ramp, rail, bar, stair lift, or widening of doorway) which allows you increased independence in your residence while performing the Activities of Daily Living, as well as reducing the need for Substantial Assistance.

Changes to your residence do not include items such as swimming pools or hot tubs, repairs, maintenance or other changes requested solely to increase the value of your residence.

Hospice Care means Qualified Long Term Care Services which provide a program of care to meet your needs in the event you become Terminally Ill.

Hospital means an institution or facility that is:

1. licensed as a Hospital by the proper authority of the state in which it is located; or
2. accredited as a Hospital by the Joint Commission on Accreditation of Hospitals.

Licensed Health Care Practitioner means:

1. a Physician;
2. a Registered Nurse; or
3. a Licensed Social Worker.

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

Licensed Social Worker means a duly licensed social worker acting within the scope of his or her license at the time the treatment or service is performed.

Maintenance or Personal Care Services means any care provided primarily to give needed assistance to you as a

result of your being Chronically Ill (including protection of your health and safety due to a Severe Cognitive Impairment).

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Mental or Nervous Disorders means affective disorders, anxiety disorders, personality disorders, psychotic disorders, or other mental or emotional disease or disorders. However, this definition does not include Alzheimer's or other demonstrable organic diseases such as senile dementia.

Nursing Care means:

1. Qualified Long Term Care Services provided to you in a Nursing Care Facility or Assisted Living Facility; or
2. Maintenance or Personal Care Services performed in an Assisted Living Facility.

Nursing Care Facility means a facility or institution, other than a Hospital, that:

1. is licensed or certified by the state in which it is located;
2. is a separate facility or a distinct part of another health care facility;
3. provides 24-hour per day skilled, intermediate or custodial nursing care under the supervision of an RN or Physician; and
4. maintains a daily record on each patient.

Nursing Care Facility does not include:

1. a convalescent home, board and rest home, home for the aged, residential care facility, domiciliary and retirement care facility or training center; or
2. government or veteran's facility or any other facility where the patient is not required to pay.

Physician, as defined in section 1861(r)(1) of the Social Security Act, means 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, including osteopathic practitioners within the scope of his or her practice as defined by state law.

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

appropriate providers for such services. The Plan of Care is updated as your needs change.

Policy Schedule means the pages of your policy that show Insured, Premium and Benefit Information.

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

Registered Nurse (RN) means a duly licensed registered graduate professional nurse acting within the scope of his or her license at the time the treatment or service is performed.

Respite Care means Qualified Long Term Care Services provided on a short term basis to relieve family or friends who are the primary caregivers in your residence. Respite Care may be provided in your home, a Nursing Care Facility, Assisted Living Facility or through a community based program.

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

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

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

Single Claim Period means a claim for benefits under your policy that is not interrupted by a period of 180 consecutive days. If you do not satisfy the Eligibility for the Payment of Benefits provision (because you have recovered and you are no longer receiving benefits under your policy) for 180 consecutive days or longer, a new Single Claim Period will be established.

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

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

Substantial Supervision means continual supervision by another person to protect you or others from threats to health or safety (such as may result from wandering) when

you have a Severe Cognitive Impairment. Such supervision may include cueing by verbal prompting, gestures or other similar demonstrations.

Terminally Ill means a medical prognosis given by a Physician that the insured's life expectancy is six months or less.

PART 3: BENEFIT PROVISIONS

BENEFIT AMOUNT

Your Benefit Amount is shown on the Policy Schedule. The total of all benefits we pay under your policy and attached riders will not exceed the Benefit Amount. If a Maximum Lifetime Home Modification Benefit is shown on the Policy Schedule, we will pay this benefit in addition to the Benefit Amount.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

While your policy is in force, you will be eligible for the Payment of Benefits if you are Chronically Ill. This means that within the previous 12 months, you have been certified by a Licensed Health Care Practitioner as:

1. being unable to perform, without Substantial Assistance, at least two Activities of Daily Living for an expected period of at least 90 days due to loss of functional capacity; or
2. having a Severe Cognitive Impairment.

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

PAYMENT OF BENEFITS

While your policy is in force, we will pay benefits if:

1. you satisfy the Eligibility for the Payment of Benefits provision;
2. you have satisfied any applicable Elimination Period shown on the Policy Schedule;
3. you receive services covered under your policy pursuant to a Plan of Care;
4. you are not receiving any other benefits covered under your policy, except when a Home Modification Benefit is paid;
5. you have not been paid benefits that exceed the Benefit Amount shown on the Policy Schedule;

6. you satisfy the requirements under the CLAIM PROCEDURES section; and
7. your claim is not subject to any limitations or exclusions contained in your policy.

COVERAGE OUTSIDE THE UNITED STATES BENEFIT

After you satisfy the Payment of Benefits provision, we will pay you a Daily Benefit for covered services outside the United States or its territories, or Canada for up to 30 days per calendar year.

We will either pay the Daily Benefit for Nursing Care, or if covered under your policy, the actual daily Home and Community Based Care charges you incur, up to the Daily Benefit, as shown on the Policy Schedule. We will subtract the benefits we pay from the Benefit Amount.

NURSING CARE BENEFIT

After you satisfy the Payment of Benefits provision, we will pay a Daily Benefit for each day of Nursing Care that you receive in a Nursing Care Facility or Assisted Living Facility.

We will pay the Daily Benefit for Nursing Care shown on the Policy Schedule. We will subtract the benefits we pay from the Benefit Amount.

BED RESERVATION BENEFIT

After you satisfy the Payment of Benefits provision, we will pay a benefit for your Bed Reservation if you:

1. are receiving Nursing Care;
2. incur a temporary absence from a Nursing Care Facility or Assisted Living Facility; and
3. are charged by the facility to reserve your accommodations.

We will pay the Daily Benefit for Nursing Care shown on the Policy Schedule. We will subtract the benefits we pay from the Benefit Amount. This benefit is payable for a maximum of 60 days per calendar year.

HOSPICE CARE BENEFIT

If you are Terminally Ill, we will pay a benefit for each day of Hospice Care that you receive. This benefit is not subject to the Elimination Period for the first 90 days you receive Qualified Long Term Care Services for Hospice Care.

After the first 90 days, if you continue receiving Hospice Care, you must then satisfy the Elimination Period shown on the Policy Schedule before we will pay any additional benefits for Hospice Care.

We will pay the Daily Benefit for Nursing Care, or if covered under your policy, the actual daily Home and Community Based Care charges you incur, up to the Daily Benefit, as shown on the Policy Schedule. We will subtract the benefits we pay from the Benefit Amount.

HOME AND COMMUNITY BASED CARE BENEFIT

The Home and Community Based Care Benefit is covered and will be payable if shown on the Policy Schedule. After you satisfy the Payment of Benefits provision, we will pay a Daily Benefit for each day of covered Home and Community Based Care (Adult Day Care and Home Health Care) you receive.

We will pay the actual daily Home and Community Based Care charges you incur, up to the Daily Benefit shown on the Policy Schedule. We will subtract the benefits we pay from the Benefit Amount. This benefit is not payable if you are receiving Nursing Care Benefits, or you are confined in a Hospital.

CAREGIVER TRAINING BENEFIT

If Home and Community Based Care is covered under your policy and after you satisfy the Payment of Benefits provision, we will pay a benefit for Caregiver Training, if prescribed in your Plan of Care. This benefit is not subject to the Elimination Period. Use of this benefit does not count towards satisfaction of the Elimination Period for any other benefits payable under your policy.

We will pay the actual Caregiver Training charges you incur, up to the Maximum Lifetime Caregiver Training Benefit shown on the Policy Schedule. We will subtract benefits we pay from the Benefit Amount. The Maximum Lifetime Caregiver Training Benefit is the maximum amount that we will reimburse for all Caregiver Training charges while you are insured under your policy. We will not pay for Caregiver Training provided to a person who will be paid as your caregiver.

RESPIRE CARE BENEFIT

After you satisfy the Payment of Benefits provision, we will pay a benefit for each day of Respite Care that you receive. This benefit is not subject to the Elimination Period. Use of these services does not count towards satisfaction of the Elimination Period for any other benefits payable under your policy.

We will pay the Daily Benefit for Nursing Care, or if covered under your policy, the actual daily Home and Community Based Care charges you incur, up to the Daily Benefit, as shown on the Policy Schedule. We will subtract the benefits we pay from the Benefit Amount. Respite Care Benefits are payable for a maximum of 30 days per calendar year.

HOME MODIFICATION BENEFIT

If Home and Community Based Care is covered under your policy and after you satisfy the Payment of Benefits provision, we will pay a benefit for Home Modification, as defined in this policy. We reserve the right to make the final decision on any request for a Home Modification Benefit. This benefit is not subject to the Elimination Period. Use of this benefit does not count towards satisfaction of the Elimination Period for any other benefits payable under your policy.

We will reimburse the actual Home Modification charges you incur, up to the Maximum Lifetime Home Modification Benefit shown on the Policy Schedule if:

1. the Home Modification is required by a Plan of Care submitted by your Licensed Health Care Practitioner; and
2. the Plan of Care specifies how such Home Modification will reduce the need for Home Health Care; and
3. you submit verification of the completion of the Home Modification.

This benefit is payable in addition to the Benefit Amount shown on the Policy Schedule. However, benefits paid will be subtracted from the Maximum Lifetime Home Modification Benefit shown on the Policy Schedule. The Maximum Lifetime Home Modification Benefit is the maximum amount that we will reimburse for Home Modification charges while you are insured under your policy.

ALTERNATIVE PLAN OF CARE BENEFIT

If you are Chronically Ill and satisfy the Payment of Benefits provision, we will consider paying benefits for an Alternative Plan of Care for Qualified Long Term Care Services not specifically shown as being available under your policy. Such benefits may include equipment purchases or rentals, or care services not normally covered under the Home and Community Based Care Benefit. An Alternative Plan of Care is not available for providing Home and Community Based Care Benefits if your policy provides Nursing Care Benefits only. We reserve the right to make the final decision on any request for an Alternative Plan of Care.

The Alternative Plan of Care amount agreed upon, divided by the Daily Benefit shown on the Policy Schedule, equals the number of subsequent days for which we will not pay additional benefits for Home and Community Based Care or Nursing Care. This number of subsequent days will be considered to have been paid by the Alternative Plan of Care Benefit Amount agreed upon.

We will pay for an Alternative Plan of Care if:

1. you have satisfied the Payment of Benefits provision;
2. you, your Licensed Health Care Practitioner and we agree that an Alternative Plan of Care is: (1) medically acceptable; and (2) the most cost effective manner in which to provide benefits for your claim under your policy; and
3. you agree that you will not receive payments for any other benefits under your policy while Alternative Plan of Care Benefits are being paid.

We will subtract benefits we pay under an Alternative Plan of Care from the Benefit Amount.

OPTIONAL PERSONAL CARE ADVISOR

Your Optional Personal Care Advisor will, if requested by you, assist you with questions regarding such matters as:

1. Eligibility for the Payment of Benefits provision;
2. appropriate level of care;
3. availability of facilities and other care and service resources in your area; or
4. any other questions you may have about a claim for benefits.

You may contact your Optional Personal Care Advisor by calling the toll-free number shown on the Policy Schedule.

You are not required to use these services in order to file a claim and there is no cost to you if you choose to use these services. No benefits will be deducted from the Benefit Amount for their use.

OPTIONAL CARE COORDINATION

At your request, if you need Optional Care Coordination assistance you may call the toll-free number shown on the Policy Schedule and we will arrange for a care coordinator to contact you. The care coordinator will be an RN who will:

1. assess and coordinate appropriate care and services;
2. provide assistance in developing a Plan of Care;
3. if you wish, maintain a continuing role in arranging and monitoring services being provided; and
4. assist with necessary claims documentation.

You are not required to use these services in order to file a claim and there is no cost to you if you choose to use these services. No benefits will be deducted from the Benefit Amount for their use.

LOWERING PREMIUMS BY REDUCING BENEFITS

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

1. reducing the Benefit Amount shown on the Benefit Schedule; or
2. reducing the Daily Benefit shown on the Benefit Schedule.

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

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

PART 4: LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR THE PAYMENT OF BENEFITS

LIMITATIONS AND EXCLUSIONS

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

1. provided to you by a person in your Family;
2. provided outside the United States or its territories, or Canada, except as described under the Coverage Outside the United States Benefit in the Benefit Provisions section of your policy;
3. for which you have no financial liability or that is provided at no charge in the absence of insurance;
4. provided in facilities operated primarily for the treatment of alcoholism or drug addiction; or
5. provided in facilities operated primarily for the treatment of Mental or Nervous Disorders.

NONDUPLICATION OF BENEFITS

Benefits are not payable under your policy for: (1) expenses incurred for Home and Community Based Care (if covered under your policy) to the extent that such expenses are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount; or (2) any other state or federal workers' compensation plan, or other governmental program (except Medicaid).

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

PART 5: CLAIM PROCEDURES

To file a claim for benefits, please provide us with advance notice or advise us as quickly as possible by calling the toll-free number shown on the Policy Schedule.

NOTICE OF CLAIM – You must give us written Notice of Claim within 30 days after you begin receiving care or services covered under your policy, or as soon thereafter as reasonably possible. You may give notice or you may have someone do it for you. The notice must provide us with sufficient information to identify you. It should be mailed to us at our Long Term Care Administrative Office or to one of our agents.

CLAIM FORMS – After you notify us of a claim, we will send you or your representative a claim form used for filing Proof of Loss. You or your representative must complete it and return it to us.

If we do not send you a claim form within 15 days of your notice to us, you may meet the Proof of Loss requirement by giving us a written statement within the time limit stated in the Proof of Loss provision. The written statement must give us information sufficient to identify you and must outline the nature and extent of your loss.

PROOF OF LOSS – You will be considered to have provided Proof of Loss when we receive a completed claim form and any necessary statements or bills which include the date, nature and charges for all covered care you have received. Proof of Loss must be sent to us within 90 days after the date of your loss. If it is not possible to give us timely Proof of Loss, we will not reduce or deny your claim if Proof of Loss is filed as soon as you reasonably can provide the information to us.

If we do not pay benefits upon receipt of written Proof of Loss, we will mail you within 30 working days, a letter which states our reasons for not paying the claim, either in whole or in part. The letter will also provide you with a written itemization of any documents or other information needed to process the claim or any portions not paid.

In no event, except in the event of legal incapacity, may Proof of Loss be submitted later than one year from 90 days after the date of your loss.

TIME OF PAYMENT OF CLAIMS – Benefits payable under your policy will be paid promptly after we receive proper written Proof of Loss.

PAYMENT OF CLAIMS – We will pay all benefits to you, or to the owner of this policy if other than you, or to your assignee. Upon our receipt of proper written documentation, unassigned benefits remaining due upon your death may be paid to your estate. If benefits are payable to your estate, we may pay up to \$1,000 to any relative of yours by blood or marriage who we find is entitled to it. Any payments made in good faith will discharge us with regard to such payment.

We may pay all or a portion of any benefits for care or services covered under your policy to the provider of such care or services unless you instruct us in writing to do otherwise when you file your Proof of Loss with us. We do not require that you receive care or services from a specifically designated provider.

EXTENSION OF BENEFITS – Termination of your policy will not terminate any benefits payable for Nursing Care if your confinement begins while your policy is in force and continues without interruption after your policy terminates. Any benefits payable under this provision are subject to the Benefit Amount, any applicable Elimination Period and all other provisions and limitations or exclusions of your policy.

PLAN OF CARE UPDATES AND EXAMINATIONS – While you are receiving benefits under your policy we will periodically require copies of updates to your Plan of Care, as well as an updated Licensed Health Care Practitioner certification as described under the Eligibility for the Payment of Benefits provision in your policy.

In addition, we may require that a Licensed Health Care Practitioner examine you or provide us with an assessment while a claim is pending or while you are receiving benefits, as often as reasonably required. We will pay for these examinations or assessments and will choose the individual to perform them.

BENEFIT APPEALS – We will evaluate your claim based on the provisions of your policy and the information given by you, your Licensed Health Care Practitioner and other available sources. We will inform you in writing if we deny your claim or any part of your claim. If you do not agree with a claim decision, you or your representative may appeal the denial. The appeal must be in writing to us and include all information that pertains to the claim. No special form is needed. We will review your request and notify you or your representative of our decision within 30 working days of receiving the request.

RIGHT OF RECOVERY – If we make any errors in processing your claim, we have the right to recover any overpayment of benefits. We will recover by offset any amounts that have not been previously recovered at the time we make another benefit payment.

LEGAL ACTION – Legal action to obtain benefits under your policy may not be started earlier than 60 days after required Proof of Loss has been filed with us. Further, no legal action may be started later than three years after required Proof of Loss was filed with us.

PART 6: PREMIUM PAYMENTS

PREMIUM DUE DATES – The first premium is due on the Effective Date shown on the Policy Schedule. After the first premium has been paid, premiums will be due in the amount and frequency shown on the premium statement that we will mail to you.

WAIVER OF PREMIUM – After you (either insured in the case of joint coverage) have been confined in a Nursing Care Facility or an Assisted Living Facility, or are receiving Home and Community Based Care (if covered under the policy) at least once per week and you satisfy the Payment of Benefits provision, no premiums will be due.

We will return any unearned premium to you on a pro-rata basis. The premium will be waived until you no longer satisfy the Eligibility for the Payment of Benefits provision (because you have recovered and you are no longer confined in a Nursing Care Facility or Assisted Living Facility, or are no longer receiving Home and Community Based Care). Premium payments will then again become due.

PAYMENT RESPONSIBILITY – You are responsible for payment of all your premiums due while coverage is in force. Payment must be sent to us at our Long Term Care Administrative Office, or any other office that we may designate.

UNPAID PREMIUM – We may deduct any premium due and unpaid from any claim payment payable under your policy.

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

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

If your premium is not paid within 35 days after notice is sent, your policy will lapse for nonpayment of premium.

REFUND OF UNEARNED PREMIUM – Upon your death, we will refund any unearned premium for your policy on a pro-rata basis. We will make this refund in accordance with the Payment of Claims provision, within 30 days of receipt of proof of your death.

If you (both insureds in the case of joint coverage) request in writing to cancel your policy, we will refund any unearned premium to you on a pro-rata basis. Cancellation will be effective upon receipt of your request or a later date specified by you. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

PART 7: GENERAL POLICY PROVISIONS

MISSTATEMENT OF AGE – If your age is misstated on the application, we may, at any time, adjust your benefits and/or premiums to reflect your correct age. If no coverage would have been provided based on your correct age, our liability is limited to a refund of any premium paid for your policy, and your policy is null and void as of the Effective Date.

ENTIRE CONTRACT; CHANGES – Your policy, the attached application, plus any riders and additional attachments, is the entire contract. No agent, employee, or person other than one of our officers has authority to change your policy. Any change must be shown on your policy and approved in writing.

INCONTESTABILITY – If your policy has been in force for less than six months, upon a showing of misrepresentation that is material to the acceptance of coverage, we may rescind your policy or deny an otherwise valid claim on your policy.

If your policy has been in force for at least six months, but less than two years, and if we can show the misrepresentation is both material to the acceptance of coverage and that it pertains to the condition for which benefits are sought, we may rescind your policy or deny an otherwise valid claim on your policy.

After your policy has been in force for two years it is not contestable upon the grounds of misrepresentation alone. After two years, your policy may be contested only upon a showing that you knowingly and intentionally misrepresented relevant facts relating to your health.

POLICY TERMINATION – Your policy will terminate and your coverage will end on the earliest of:

1. the date that the total of all benefits paid under your policy is equal to the Benefit Amount shown on the Policy Schedule, without regard to any unpaid benefits under the Maximum Lifetime Home Modification Benefit, if shown on the Policy Schedule;
2. the date we receive a written request from you (both insureds in the case of joint coverage) to cancel your policy (or a later date specified by you in the cancellation request);
3. the date your policy lapses for nonpayment of premium as described under the Unintentional Lapse provision; or
4. the date of your death (last of your deaths in the case of joint coverage).

If your policy provides joint coverage and only one of you has exhausted the Benefit Amount as described above, coverage will continue for the remaining insured as described under the Joint Coverage provision below.

REINSTATEMENT – LAPSE DUE TO SEVERE COGNITIVE IMPAIRMENT OR FUNCTIONAL INCAPACITY – If your coverage has lapsed due to your Severe Cognitive Impairment or functional incapacity, your coverage may be reinstated without an application if:

1. you or your representative requests reinstatement in writing within six months after your last premium was due;
2. we receive evidence satisfactory to us that you have a Severe Cognitive Impairment or functional incapacity; and
3. we receive all past due and unpaid premiums.

Your policy will then be reinstated as of the date of lapse and both you and we shall have the same rights that existed prior to the due date of the premium in default. Premium rates for your reinstated policy will be based on your original issue age.

REINSTATEMENT – LAPSE DUE TO NONPAYMENT OF PREMIUM – Your coverage may be reinstated within one year after lapse if:

1. you complete the application for reinstatement;
2. we receive all past due and unpaid premiums (for which we will give you a conditional receipt); and

3. you are insurable under our underwriting rules in effect at the time you apply for reinstatement.

Reinstatement by application will be effective:

1. on the date we approve your application; or
2. on the 45th day following the date of the conditional receipt, if we have not previously declined your application in writing.

Your reinstated policy will cover only loss due to:

1. sickness incurred more than 10 days after the date of reinstatement; and
2. injury sustained after the date of reinstatement.

Upon reinstatement of your policy both you and we shall have the same rights that existed prior to the due date of the premium in default. Premium rates for your reinstated policy will be based on your original issue age.

JOINT COVERAGE – Your policy provides equal coverage for two persons if both apply and are issued coverage under your policy. The name of each insured covered under your policy is shown on the Policy Schedule.

All benefits, Eligibility for the Payment of Benefits provision, Payment of Benefits provision, Elimination Periods, Benefit Amount and limitations or exclusions described in your policy or shown on the Policy Schedule apply to each insured individually and separately, unless otherwise noted.

When one of you dies (and we receive proof of death), or one of you exhausts your benefits or terminates coverage as described under the Policy Termination provision, coverage continues for the remaining insured. The new premium rate will be the premium that would have been charged for an individual policy at the original issue age and risk class of the remaining insured. The premium will be based on the premium rate table in effect at the time of the death, exhaustion of benefits or termination. Any unearned portion of the difference between the original joint premium and the new premium will be refunded to the remaining insured on a pro-rata basis. The new premium for the continued coverage will be due on your policy's next Premium Due Date.

If each of you provides a written request for termination of joint coverage, we will convert your joint policy to separate individual policies with the same coverage, effective on the next Premium Due Date, terminating your joint coverage on that date. Your converted coverage will be at the same premium rate that would have been charged for an individual policy at your original issue age and risk class. The premium will be based on the premium rate table in effect on the date the conversion is effective. Each of you

will have 30 days to examine your converted policy. It may be returned to us or our agent within 30 days after it is received. We will then refund any premium paid for your converted coverage and your policy will be considered void from the date of conversion. Once joint coverage is terminated, your individual policies may not be converted back to joint coverage. Any applicable nonforfeiture benefits will be divided proportionately between your individual policies based on the individual premiums shown on the Policy Schedule.

OWNER – You (both insureds in the case of joint coverage) are the owner of your policy unless otherwise provided in the application or changed by written request. While you are living, the owner may exercise every right and receive every benefit provided by your policy. If the

owner is not you and the owner dies while you are living, unless otherwise provided, all rights of the owner shall be transferred to the owner's executors or administrators.

ASSIGNMENT – No assignment of interest under your policy will be binding upon us unless the original or a copy of the assignment is filed with us at our Long Term Care Administrative Office. We do not assume any responsibility for the validity of an assignment.

CONFORMITY WITH STATE STATUTES – Any part of your policy that, on the Effective Date, conflicts with the laws of the state in which you reside on such date, is hereby amended to meet the minimum requirements of those laws.

LONG TERM CARE INSURANCE POLICY

**This policy provides benefits for Qualified Long Term Care Services as defined herein,
subject to all terms and provisions.**

MINNESOTA LIFE

Minnesota Life Insurance Company
Home Office: St. Paul, MN 55101-2098
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.9817 Tel • 818.887.4595 Fax

ML7600P-AR

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MINNESOTA LIFE

Minnesota Life Insurance Company
Home Office: St. Paul, MN 55101-2098
Long Term Care Administrative Office
P.O. Box 4243
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OUTLINE OF COVERAGE FOR LONG TERM CARE INSURANCE POLICY FORM ML7600P-AR

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

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

The policy is an individual policy of insurance.

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

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

TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED - RENEWABILITY: THE POLICY IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of the policy, to continue the policy as long as you pay your premiums on time. Minnesota Life Insurance Company cannot change any of the terms of the policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

WAIVER OF PREMIUM - Premiums for the policy and attached riders will be waived after you (either insured in the case of joint coverage) have been confined in a nursing care facility or assisted living facility, or are receiving Home and Community Based Care (if covered under the policy) at least once per week and you satisfy the Payment of Benefits provision. We will return any unearned premium to you on a pro-rata basis. The premium will be waived until you no longer satisfy the Eligibility for the Payment of Benefits provision (because you have recovered and you are no longer confined in a nursing care facility or assisted living facility, or are no longer receiving Home and Community Based Care). Premium payments will then again become due.

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

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

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE - If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from us. Neither Minnesota Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

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

The policy provides coverage for Qualified Long Term Care Services in the form of a fixed dollar indemnity benefit for covered nursing care and assisted living expenses and an expense incurred benefit for covered care outside of a nursing care facility or an assisted living facility, subject to policy Elimination Periods, limitations or exclusions described below.

BENEFITS PROVIDED BY THE POLICY

COVERED SERVICES - The policy provides benefits for Qualified Long Term Care Services performed in a nursing care facility or assisted living facility and Maintenance or Personal Care Services performed in an assisted living facility. In addition, benefits are provided for Bed Reservation, Respite Care, Hospice Care and an Alternative Plan of Care. You may select coverage under the policy for Home and Community Based Care, including benefits for home health care, adult day care and Caregiver Training. If Home and Community Based Care is selected, a Home Modification Benefit is also available.

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

The Elimination Period is not applicable to Home and Community Based Care (if covered under the policy). However, days on which benefits are payable for Home and Community Based Care (if covered under the policy) will also count towards satisfaction of the Elimination Period for Nursing Care. In addition, the Elimination Period is not applicable to Caregiver Training, Respite Care Benefits or Home Modification Benefits and is waived for the first 90 days of Hospice Care. Use of Caregiver Training, Respite Care, Home Modification and the first 90 days of Hospice Care do not count toward satisfaction of the Elimination Period for any other benefits payable under your policy.

BENEFIT AMOUNT - A Lifetime Benefit Period is available which results in an Unlimited Benefit Amount payable for all benefits under the policy. Alternatively, you may select either a 1,825 Day (5 Year), 1,460 Day (4 Year), 1,095 Day (3 Year), or 730 Day (2 Year) Benefit Period. Your Benefit Amount is determined by multiplying the Daily Benefit selected by the number of days of coverage desired. This will result in your Benefit Amount payable for all benefits under the policy. In the case of joint coverage, the policy provides for a separate Benefit Amount for each insured. A Shared Benefit Amount Rider is also available as described below.

COVERAGE OUTSIDE THE UNITED STATES - Benefits are payable for covered services received outside the United States or its territories, or Canada for up to 30 days per calendar year. The benefit payable under the policy will be the Daily Benefit shown on the Policy Schedule. Benefits we pay are subtracted from the Benefit Amount.

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

BED RESERVATION - This benefit is payable if you are receiving Nursing Care benefits under the policy, you incur a temporary absence from the nursing care facility or assisted living facility and are charged by the facility to reserve your accommodations. The benefit payable will be the Daily Benefit selected. This benefit is payable for a maximum of 60 days per calendar year. Benefits we pay are subtracted from the Benefit Amount.

HOSPICE CARE - If you are Terminally Ill benefits are payable for Qualified Long Term Care Services provided to you under a hospice care program. This benefit is not subject to the Elimination Period for the first 90 days. After the first 90 days of Hospice Care, any applicable Elimination Period must be satisfied before we pay additional benefits for Hospice Care.

The benefit payable under the policy will be the Daily Benefit for Nursing Care shown on the Policy Schedule or if covered under your policy, the actual daily Home and Community Based Care charges you incur, up to the Daily Benefit shown on the Policy Schedule. Benefits we pay are subtracted from the Benefit Amount.

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

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

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

The benefit payable under the policy will be the actual Caregiver Training charges incurred, up to a Maximum Lifetime Caregiver Training benefit that is equal to 10 times the Daily Benefit selected for Home and Community Based Care. You need not satisfy the Elimination Period to receive this benefit; however, use of the benefit does not count toward satisfaction of the Elimination Period for any other benefits payable under the policy. Benefits we pay are subtracted from the Benefit Amount.

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

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

HOME MODIFICATION BENEFIT – If Home and Community Based Care is covered under the policy, we will pay a benefit for Home Modification, as defined in this outline. We reserve the right to make the final decision on any request for a Home Modification Benefit. The Home Modification must be required in a Plan of Care submitted by your Licensed Health Care Practitioner and specify how such Home Modification will reduce the need for Home Health Care. Verification of the completion of the Home Modification will also be required. You need not satisfy the Elimination Period to receive this benefit; however, use of the benefit does not count toward satisfaction of the Elimination Period for any other benefits payable under the policy.

The benefit payable under the policy will be the actual charges you incur, up to the Maximum Lifetime Home Modification Benefit that is equal to 30 times the Daily Benefit selected for Home and Community Based Care. This benefit is payable in addition to the Benefit Amount payable under the policy. Benefits we pay are subtracted from the Maximum Lifetime Home Modification Benefit. The Maximum Lifetime Home Modification Benefit is the maximum amount that we will reimburse for Home Modification charges while you are insured under the policy.

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

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

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

DEFINITIONS

Activities of Daily Living means:

1. **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.
2. **Continance:** the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
3. **Dressing:** putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
4. **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.
5. **Toileting:** getting to and from the toilet, getting on or off the toilet, and performing associated personal hygiene.
6. **Transferring:** moving into or out of bed, a chair or wheelchair.

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

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

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

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

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

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

Home Modification means permanent or temporary changes to your residence (such as installation of a ramp, rail, bar, stair lift, or widening of doorway) which allows you increased independence in your residence while performing the Activities of Daily Living, as well as reducing the need for Substantial Assistance.

Changes to your residence do not include items such as swimming pools or hot tubs, or repairs, maintenance or other changes requested solely to increase the value of your residence.

Licensed Health Care Practitioner means:

1. a physician;
2. a registered nurse; or
3. a licensed social worker.

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

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

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

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

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

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

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

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

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

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

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

Terminally Ill means a medical prognosis given by a physician that the insured's life expectancy is six months or less.

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

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

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR THE PAYMENT OF BENEFITS

NON-ELIGIBLE FACILITIES

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

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

1. non-eligible facilities; or
2. a facility that is not licensed or certified (if licensing or certification is required in your state).

LIMITATIONS AND EXCLUSIONS

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

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

NONDUPLICATION OF BENEFITS

Benefits are not payable under the policy for: (1) expenses incurred for Home and Community Based Care (if covered under the policy) to the extent that such expenses are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount; or (2) any other state or federal workers' compensation plan, or other governmental program (except Medicaid).

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

PAYMENT OF BENEFITS

While the policy is in force, we will pay benefits if:

1. you satisfy the Eligibility for the Payment of Benefits provision;
2. you have satisfied any applicable Elimination Period shown on the Policy Schedule page of the policy;
3. you receive services covered under the policy pursuant to a Plan of Care;
4. you are not receiving any other benefits covered under the policy, except when a Home Modification Benefit is paid;
5. you have not been paid benefits that exceed the Benefit Amount or if shown on the Policy Schedule page of the policy, the Maximum Benefit Amount With Restoration of Benefits or the Shared Benefit Amount;
6. your claim is properly filed according to the requirements described in the policy; and
7. your claim is not subject to any limitations or exclusions contained in the policy.

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

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

ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS - Subject to Eligibility for the Payment of Benefits, Payment of Benefits and any limitations or exclusions described above, the policy provides coverage if you are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses.

PREMIUM PAYMENTS

PREMIUM PAYMENT OPTIONS

10-YEAR AND 20-YEAR PREMIUM PAYMENT OPTIONS - These options provide that at the end of the premium payment period if each required premium has been paid, the policy will automatically be renewed for the rest of your life with no further premium payments required. During the premium payment period, premiums will be subject to change as described under "TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED" above.

LONG TERM CARE INSURANCE POLICY

* *If a **PARTNERSHIP POLICY** is selected below and you are age 60 or younger, the Compound 3% or Compound 5% Benefit Increase Rider must be selected and will be issued with your policy. If you are age 61-75, one of the following Benefit Increase Riders must be selected and will be issued with your policy: Compound 3% or Compound 5% or Simple Benefit Increase Rider.*

Partnership Policy Non-Partnership Policy

Elimination Period (for Nursing Care only – no Elimination Period is required for HCBC):

0 Days 30 Days 90 Days 180 Days

Daily Benefit: \$ 100.00

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

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

Comprehensive Coverage is Nursing Care plus Home and Community Based Care (HCBC)

	Premium
Select only one of the following coverage combinations:	
<input type="checkbox"/> Nursing Care Only	\$ _____
<input checked="" type="checkbox"/> Comprehensive	\$ <u>625.28</u>
<input type="checkbox"/> Comprehensive with HCBC Indemnity Benefit Rider (Form ML7600R-IND)	\$ _____
<input type="checkbox"/> Comprehensive with Monthly HCBC Benefit Rider (Form ML7600R-MTH) (The Compound Benefit Increase Rider must also be selected)	\$ _____
Benefit Increase Riders (select only one) *:	
Compound Benefit Increase (Form ML7600R-CBI)	
<input checked="" type="checkbox"/> Compound 5%	\$ <u>1,250.56</u>
<input type="checkbox"/> Compound 3%	\$ _____
<input type="checkbox"/> Simple Benefit Increase (Form ML7600R-SBI)	\$ _____
Nonforfeiture Rider:	
<input checked="" type="checkbox"/> Shortened Benefit Period Nonforfeiture (Form ML7600R-SBN)	\$ <u>656.54</u>
Benefit Extension Riders (select only one):	
(Not available with Lifetime Benefit Period)	
<input type="checkbox"/> Restoration of Benefits (Form ML7600R-ROB)	\$ _____
<input type="checkbox"/> Shared Benefit Amount (Form ML7600R-SBA)	\$ _____
Additional Benefits:	
<input type="checkbox"/> Full Return of Premium Rider (Form ML7600R-ROP)	\$ _____
<input type="checkbox"/> Paid-Up Survivor Rider (Form ML7600R-SVR)	\$ _____
(Available with Joint Coverage and Lifetime Premium Payment Option)	
Premium Payment Options: <input type="checkbox"/> Lifetime	
<input type="checkbox"/> 20-Year Premium	\$ _____
<input checked="" type="checkbox"/> 10-Year Premium	\$ <u>3,798.57</u>
TOTAL ANNUAL PREMIUM:	\$ <u>6,330.95</u>

ADDITIONAL FEATURES

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

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

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

NONFORFEITURE BENEFITS - If you choose not to select the following optional nonforfeiture rider, a contingent benefit upon lapse will be available if: (1) the policy lapses as described under the Grace Period and Unintentional Lapse provisions of the policy; and (2) the premium rates for the policy are substantially increased. The benefit provided will be in the form of a Shortened Benefit Period as described below.

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

OPTIONAL RIDERS (available for an additional premium payment)

SHORTENED BENEFIT PERIOD NONFORFEITURE RIDER - The rider provides a benefit when the policy remains in force for at least 3 years and lapses due to nonpayment of premium. Coverage will continue and benefits will be payable based on the Daily Benefit in effect on the date of lapse. The new Benefit Amount payable under the rider will become equal to the greater of: (1) the total of premiums paid for the policy and all riders; or (2) 30 times the Daily Benefit in effect at the time of lapse. Any benefits we pay after the policy lapses will be subtracted from this new Benefit Amount.

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

HOME AND COMMUNITY BASED CARE INDEMNITY BENEFIT RIDER - The rider will pay the full Daily Benefit selected for Home and Community Based Care (if covered under the policy), regardless of the actual expenses incurred by you. Benefits we pay are subtracted from the Benefit Amount. An Indemnity Benefit is not payable for the Maximum Lifetime Home Modification Benefit shown on the Policy Schedule.

MONTHLY HOME AND COMMUNITY BASED CARE BENEFIT RIDER - The rider will pay the actual Home and Community Based Care expenses incurred, on a monthly basis during any calendar month, up to the Daily Benefit selected for Home and Community Based Care times the actual number of days in that calendar month. Benefits we pay are subtracted from the Benefit Amount.

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

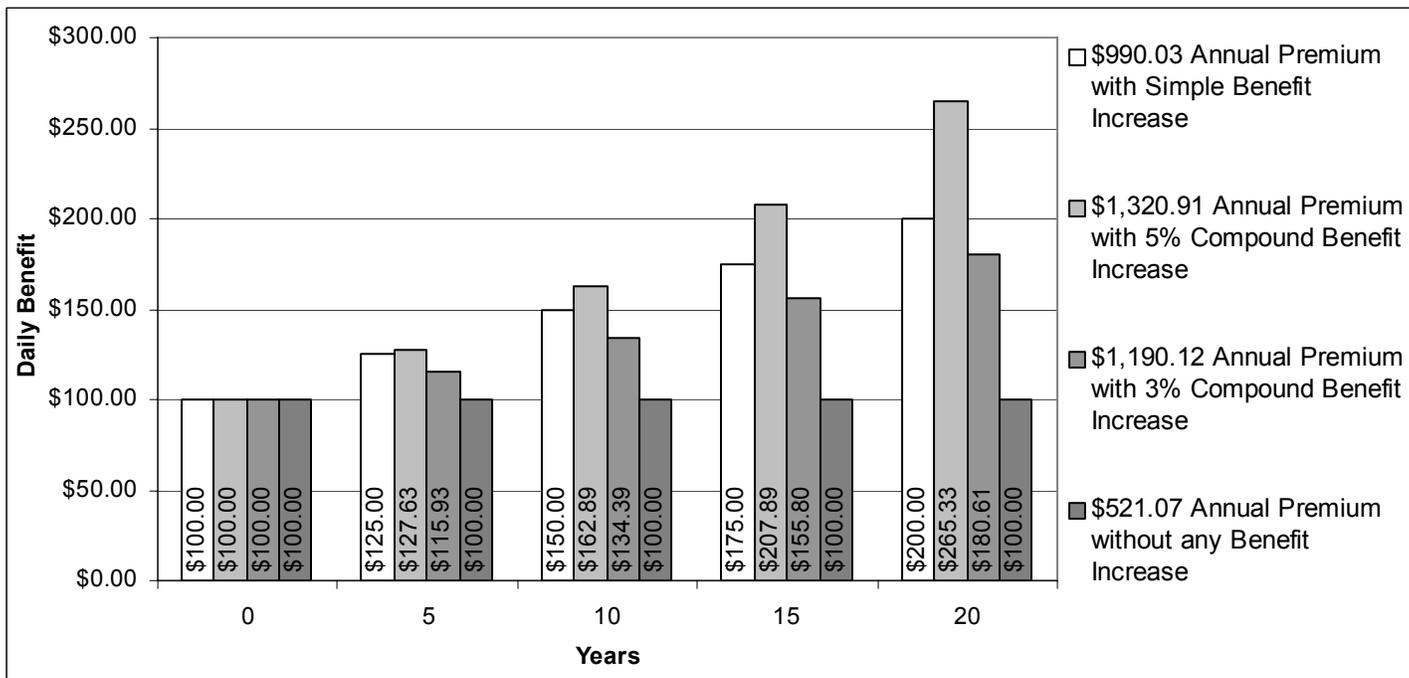
PAID-UP SURVIVOR BENEFIT RIDER - The rider provides that the policy to which this rider is attached will be paid-up and no further premiums will be required for the policy or any attached riders after both of the following have occurred: (a) the end of the 10th policy year; and (b) the date of death of either insured. In the event one insured dies prior to the 10th policy year, the remaining insured will pay the individual premium rate that would have been charged at the original issue age and risk class for the balance of the 10-Year period, after which the policy will be paid-up and no further premium due.

SHARED BENEFIT AMOUNT RIDER - The rider provides a jointly Shared Benefit Amount in the event either or both joint insureds exhaust the Benefit Amount under the policy. The Shared Benefit Amount will be equal to the Benefit Amount shown on the Policy Schedule. Benefits we pay are subtracted from the Shared Benefit Amount. If shown on the Policy Schedule, the Maximum Lifetime Home Modification Benefit will not be available under the Shared Benefit Amount.

BENEFIT INCREASE RIDERS - These riders provide that on each policy anniversary, we will increase the Daily Benefit and Benefit Amount payable under the policy, as well as any applicable Maximum Lifetime Caregiver Training, Maximum Lifetime Home Modification, and either the Maximum Benefit Amount with Restoration of Benefits or Shared Benefit Amount benefits. The Simple Benefit Increase Rider increases the Daily Benefit by 5% of the dollar amount

originally issued. The remaining Benefit Amount is increased by the same proportion as the Daily Benefit. The Compound Benefit Increase Rider increases the Daily Benefit by 5% or 3% of the previous year's dollar amount. The remaining Benefit Amount is also increased by 5% or 3%. Under both riders, the Daily Benefit and Benefit Amount will continue to increase annually while you are receiving benefits under the policy.

The following graph compares the benefits and premiums between a policy with the Simple Benefit Increase Rider, a policy with the Compound Benefit Increase Rider of 5% or 3% and a policy without either rider. For purposes of illustration, the sample shown is for a policy with a 1,095-day (3-year) Benefit Period for Nursing Care and Home and Community Based Care, issued at age 55, a 90-day Elimination Period for Nursing Care, and a \$100.00 Daily Benefit.



John Q. Porter

Agent

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Phone Number

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

FULL RETURN OF PREMIUM RIDER

This rider is part of your policy. The Effective Date for this rider is shown on the Policy Schedule of the attached policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, limitations or exclusions of your policy apply to this rider unless changed by this rider.

FULL RETURN OF PREMIUM BENEFIT

If you (both insureds in the case of joint coverage) die while your policy is in force, the total of premiums paid for your policy and any attached riders will be paid to your Beneficiary. There will be no additional refund of premiums as described under the Refund of Unearned Premium provision in your policy.

BENEFICIARY

The Beneficiary will be the person or persons, named in the application or subsequently changed by written request, to receive any unassigned benefit payments due upon your death (last of your deaths in the case of joint coverage).

You may change the Beneficiary at any time by giving us written notice. A change will not be effective until recorded by us. Once recorded, the change will apply as of the date the request was signed. We will not be liable for

any action taken or payment made before a Beneficiary change is recorded. The Beneficiary's consent is not required to change your policy or Beneficiary, unless the designation of the Beneficiary is irrevocable.

If you designate more than one person as Beneficiary, the interests of all Beneficiaries will be equal unless your designation specifically provides otherwise. The share of any Beneficiary who does not survive you shall pass equally to the surviving Beneficiaries, unless your designation specifically provides otherwise. If no Beneficiary is designated or no Beneficiary survives you, then your estate will be the Beneficiary.

YOUR 30 DAY RIGHT TO EXAMINE YOUR RIDER

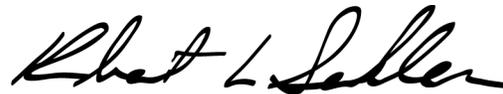
If you are not satisfied with your rider, you may return it to us or our agent within 30 days after you receive it. We will then refund any premium you have paid and the rider will be considered to be void from its beginning.

Read this rider carefully. It is a part of a legal contract between you and us.

Signed for Minnesota Life Insurance Company, a stock company, at St. Paul, Minnesota on the policy Effective Date.



Secretary



Chairman and Chief Executive Officer

MINNESOTA LIFE

Minnesota Life Insurance Company
Home Office: St. Paul, MN 55101-2098
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.9817 Tel • 818.887.4595 Fax

ML7600R-ROP

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SHORTENED BENEFIT PERIOD NONFORFEITURE RIDER

This rider is part of your policy. The Effective Date for this rider is shown on the Policy Schedule of the attached policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, limitations or exclusions of your policy apply to this rider unless changed by this rider.

SHORTENED BENEFIT PERIOD

If your policy has been in force for three or more years and your policy lapses for nonpayment of premium as described under the Grace Period and Unintentional Lapse provisions of your policy:

1. Your coverage will continue and benefits will be payable based on the Daily Benefit shown on the Policy Schedule (and any previous increases due to a Benefit Increase Rider) in effect on the date of lapse. No further benefit increases will occur under any Benefit Increase Rider, if attached to your policy.
2. The new Benefit Amount becomes equal to the greater of: (1) the total of premiums paid for your policy and all riders; or (2) 30 times the Daily Benefit in effect on the date of lapse. This new Benefit Amount replaces

the Benefit Amount in effect on the date of lapse. Any benefits paid to you after your policy lapses will be subtracted from this new Benefit Amount.

3. Your coverage under this rider is subject to the same policy benefit provisions, Elimination Period, Limitations and Exclusions and all other provisions of your policy and riders that were in effect prior to policy lapse, except any Benefit Increase Rider, if attached to your policy.

YOUR 30 DAY RIGHT TO EXAMINE YOUR RIDER

If you are not satisfied with your rider, you may return it to us or our agent within 30 days after you receive it. We will then refund any premium you have paid and the rider will be considered to be void from its beginning.

Read this rider carefully. It is a part of a legal contract between you and us.

Signed for Minnesota Life Insurance Company, a stock company, at St. Paul, Minnesota on the policy Effective Date.



Secretary



Chairman and Chief Executive Officer

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ML7600R-SBN

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COMPOUND BENEFIT INCREASE RIDER

This rider is part of your policy. The Effective Date for this rider is shown on the Policy Schedule of the attached policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, limitations or exclusions of your policy apply to this rider unless changed by this rider.

COMPOUND BENEFIT INCREASE

On each Policy Anniversary Date, we will increase the Daily Benefit shown on the Policy Schedule. The increase will be based on the previous year's Daily Benefit amount at the percentage increase rate selected on your application and/or shown on the Policy Schedule.

On each Policy Anniversary Date, we will also increase by the same percentage increase rate the remaining Benefit Amount and if shown on the Policy Schedule:

1. the Maximum Lifetime Caregiver Training Benefit; and

2. the Maximum Lifetime Home Modification Benefit; and either
3. the Maximum Benefit Amount with Restoration of Benefits; or
4. the remaining Shared Benefit Amount.

Benefits will continue to increase annually while your policy is in force, including while you are receiving benefits under your policy.

YOUR 30 DAY RIGHT TO EXAMINE YOUR RIDER

If you are not satisfied with your rider, you may return it to us or our agent within 30 days after you receive it. We will then refund any premium you have paid and the rider will be considered to be void from its beginning.

Read this rider carefully. It is a part of a legal contract between you and us.

Signed for Minnesota Life Insurance Company, a stock company, at St. Paul, Minnesota on the policy Effective Date.



Secretary



Chairman and Chief Executive Officer

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ML7600R-CBI

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SIMPLE BENEFIT INCREASE RIDER

This rider is part of your policy. The Effective Date for this rider is shown on the Policy Schedule of the attached policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, limitations or exclusions of your policy apply to this rider unless changed by this rider.

SIMPLE BENEFIT INCREASE

On each Policy Anniversary Date, we will increase the Daily Benefit shown on the Policy Schedule. The increase will be 5% of the original dollar amount issued to you.

On each Policy Anniversary Date, we will also increase by the same proportion as the increase in the Daily Benefit, the remaining Benefit Amount and if shown on the Policy Schedule:

1. the Maximum Lifetime Caregiver Training Benefit; and
2. the Maximum Lifetime Home Modification Benefit; and either



Secretary

3. the Maximum Benefit Amount with Restoration of Benefits; or
4. the remaining Shared Benefit Amount.

Benefits will continue to increase annually while your policy is in force, including while you are receiving benefits under your policy.

YOUR 30 DAY RIGHT TO EXAMINE YOUR RIDER

If you are not satisfied with your rider, you may return it to us or our agent within 30 days after you receive it. We will then refund any premium you have paid and the rider will be considered to be void from its beginning.

Read this rider carefully. It is a part of a legal contract between you and us.

Signed for Minnesota Life Insurance Company, a stock company, at St. Paul, Minnesota on the policy Effective Date.



Chairman and Chief Executive Officer

MINNESOTA LIFE

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ML7600R-SBI

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HOME AND COMMUNITY BASED CARE INDEMNITY BENEFIT RIDER

This rider is part of your policy. The Effective Date for this rider is shown on the Policy Schedule of the attached policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, limitations or exclusions of your policy apply to this rider unless changed by this rider.

HOME AND COMMUNITY BASED CARE INDEMNITY BENEFIT

After you satisfy the Payment of Benefits provision under your policy for Home and Community Based Care, benefits payable to you for Qualified Long Term Care Services will be equal to the full Daily Benefit shown on the Policy Schedule for Home and Community Based Care, regardless of actual charges incurred by you.

An Indemnity Benefit is not payable for the Maximum Lifetime Home Modification Benefit shown on the Policy Schedule.

The Nonduplication of Benefits provision stated in your policy is DELETED in its entirety.

YOUR 30 DAY RIGHT TO EXAMINE YOUR RIDER

If you are not satisfied with your rider, you may return it to us or our agent within 30 days after you receive it. We will then refund any premium you have paid and the rider will be considered to be void from its beginning.

Read this rider carefully. It is a part of a legal contract between you and us.

Signed for Minnesota Life Insurance Company, a stock company, at St. Paul, Minnesota on the policy Effective Date.



Secretary



Chairman and Chief Executive Officer

MINNESOTA LIFE

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ML7600R-IND

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MONTHLY HOME AND COMMUNITY BASED CARE BENEFIT RIDER

This rider is part of your policy. The Effective Date for this rider is shown on the Policy Schedule of the attached policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, limitations or exclusions of your policy apply to this rider unless changed by this rider.

MONTHLY HOME AND COMMUNITY BASED CARE BENEFIT

This rider changes the Daily Benefit to a Monthly Benefit when paid for Home and Community Based Care. If you satisfy the Payment of Benefits provision under your policy for Home and Community Based Care, we will pay the actual Home and Community Based Care expenses you incur during any calendar month, up to the Daily Benefit

shown on the Policy Schedule times the actual number of days in that calendar month.

YOUR 30 DAY RIGHT TO EXAMINE YOUR RIDER

If you are not satisfied with your rider, you may return it to us or our agent within 30 days after you receive it. We will then refund any premium you have paid and the rider will be considered to be void from its beginning.

Read this rider carefully. It is a part of a legal contract between you and us.

Signed for Minnesota Life Insurance Company, a stock company, at St. Paul, Minnesota on the policy Effective Date.



Secretary



Chairman and Chief Executive Officer

MINNESOTA LIFE

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ML7600R-MTH

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RESTORATION OF BENEFITS RIDER

This rider is part of your policy. The Effective Date for this rider is shown on the Policy Schedule of the attached policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, limitations or exclusions of your policy apply to this rider unless changed by this rider.

RESTORATION OF BENEFITS

Benefits we pay during a Single Claim Period will not exceed the Benefit Amount shown on the Policy Schedule and coverage will terminate as described in your policy under the Policy Termination provision. However, we will restore the Benefit Amount if for a period of 180 consecutive days:

1. your policy is in force;
2. you do not satisfy the Eligibility for the Payment of Benefits provision (because you have recovered); and
3. you have not received benefits under your policy.

Benefits will be restored up to a maximum of twice the original Benefit Amount shown on the Policy Schedule.

Subject to the additional terms as described in your policy under the Policy Termination provision, your coverage

will end on the date the total of all benefits paid under your policy is equal to the Maximum Benefit Amount with Restoration of Benefits.

Benefits will not be restored for the Maximum Lifetime Home Modification Benefit, if shown on the Policy Schedule.

If your policy provides joint coverage and only one of you has exhausted the Maximum Benefit Amount with Restoration of Benefits, coverage will continue for the remaining insured as described under the Joint Coverage provision in your policy.

YOUR 30 DAY RIGHT TO EXAMINE YOUR RIDER

If you are not satisfied with your rider, you may return it to us or our agent within 30 days after you receive it. We will then refund any premium you have paid and the rider will be considered to be void from its beginning.

Read this rider carefully. It is a part of a legal contract between you and us.

Signed for Minnesota Life Insurance Company, a stock company, at St. Paul, Minnesota on the policy Effective Date.



Secretary



Chairman and Chief Executive Officer

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ML7600R-ROB

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SHARED BENEFIT AMOUNT RIDER

This rider is part of your policy. The Effective Date for this rider is shown on the Policy Schedule of the attached policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, limitations or exclusions of your policy apply to this rider unless changed by this rider.

SHARED BENEFIT AMOUNT

In the event either or both of you exhaust your Benefit Amount under your policy and you otherwise satisfy the Payment of Benefits provision, a joint Shared Benefit Amount will become accessible to you. The Shared Benefit Amount will be equal to the Benefit Amount shown on the Policy Schedule and will be payable for covered Qualified Long Term Care Services you receive. This Shared Benefit Amount may be accessed by either or both insureds while there is a remaining Shared Benefit Amount available.

Payment will be the Daily Benefit shown for Nursing Care or the actual daily Home and Community Based Care charges incurred, up to the Daily Benefit shown on the Policy Schedule. We will subtract benefits we pay from the Shared Benefit Amount.

Subject to the additional terms as described in the Policy Termination provision of your policy, your coverage will end on the date the total of all benefits payable under the Shared Benefit Amount shown on the Policy Schedule have been paid to you. If only one of you has exhausted

the Shared Benefit Amount and the other insured has a remaining Benefit Amount payable under your policy, coverage will continue for that insured as described in the Joint Coverage provision of your policy.

If one of you dies or terminates coverage as described in the Policy Termination provision of your policy, any benefits remaining under the Shared Benefit Amount will be payable to the remaining insured, subject to the conditions outlined above. If each of you elects to convert joint coverage to separate individual policies, the Shared Benefit Amount Rider will terminate upon such conversion.

If shown on the Policy Schedule, the Maximum Lifetime Home Modification Benefit will not be available under the Shared Benefit Amount.

YOUR 30 DAY RIGHT TO EXAMINE YOUR RIDER

If you are not satisfied with your rider, you may return it to us or our agent within 30 days after you receive it. We will then refund any premium you have paid and the rider will be considered to be void from its beginning.

Read this rider carefully. It is a part of a legal contract between you and us.

Signed for Minnesota Life Insurance Company, a stock company, at St. Paul, Minnesota on the policy Effective Date.



Secretary



Chairman and Chief Executive Officer

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ML7600R-SBA

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PAID-UP SURVIVOR BENEFIT RIDER

This rider is part of your policy. The Effective Date for this rider is shown on the Policy Schedule of the attached policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, limitations or exclusions of your policy apply to this rider unless changed by this rider.

PAID-UP SURVIVOR BENEFIT

The policy to which this rider is attached will be paid-up and no further premium payments will be required for the policy or any attached riders after both of the following have occurred:

- The end of the 10th Policy year; and
- The date of death of either insured.

In the event one insured dies prior to the end of the 10th Policy year, the premium rate payable by the surviving insured for the balance of the 10-year period will be the rate that would have been charged for an individual policy at the original issue age and risk class of the surviving insured. However, the new premium will be based on the

premium rate table in effect at the time of death of the deceased insured. This new premium will be due on the policy's next Premium Due Date. It will be payable until the end of the 10th Policy year at which time the policy will be paid-up and no further premium payments will be due. Any unearned portion of the difference between the old premium and the new premium will be refunded on a pro-rata basis.

YOUR 30 DAY RIGHT TO EXAMINE YOUR RIDER

If you are not satisfied with your rider, you may return it to us or our agent within 30 days after you receive it. We will then refund any premium you have paid and the rider will be considered to be void from its beginning.

Read this rider carefully. It is a part of a legal contract between you and us.

Signed for Minnesota Life Insurance Company, a stock company, at St. Paul, Minnesota on the policy Effective Date.



Secretary



Chairman and Chief Executive Officer

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ML7600R-SVR

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Applicant Information	Applicant (First Name, Middle Initial, Last Name) <i>John Doe</i>			Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Birthplace (City, State) <i>Anytown, ST</i>
	Social Security Number <i>123-45-6789</i>	Height <i>6' 0"</i>	Weight <i>180</i>	Birthdate <i>7-1-53</i>	Age as of Nearest Birthday <i>55</i>
	Residence Address (Street, City, State, Zip) <i>123 Main St., Anytown, ST 12345-1234</i>				Phone Work: <i>(555) 555-1212</i> Home: <i>(555) 555-1212</i> Cell/Other: <i>(555) 555-1212</i>
	Billing Address - If different (Name, Street, City, State, Zip)				Acceptable times to call: <input checked="" type="checkbox"/> Day <input type="checkbox"/> Evening <input type="checkbox"/> Sat/Sun

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



Health Questions (continued)

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

J. Doctor

145 Main St., Anytown, ST 12345-1234

Date last seen: 5-1-08 Reason for visit: Check-up

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

Name / Phone number	Specialty	Reason for visit	Medication / treatment prescribed

6. During the past 12 months have you:

Yes No

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

Additional Information

Yes No

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

Information About Your Insurance Coverage

Yes No

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

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

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

COMPLETE THIS PAGE FOR JOINT COVERAGE APPLICANT ONLY

Applicant Information

Applicant (First Name, Middle Initial, Last Name) <i>Mary Doe</i>			Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Birthplace (City, State) <i>Anytown, ST</i>
Social Security Number <i>234-56-7891</i>	Height <i>5' 5"</i>	Weight <i>130 lbs.</i>	Birthdate <i>7-1-58</i>	Age as of Nearest Birthday <i>50</i>
Phone Work: <i>(555) 555-1212</i> Home: <i>(555) 555-1212</i> Cell/Other: <i>(555) 555-1212</i> Acceptable times to call: <input checked="" type="checkbox"/> Day <input type="checkbox"/> Evening <input type="checkbox"/> Sat/Sun			Relationship to Primary Applicant <i>Wife</i>	

Health Questions

1. During the past 24 months, have you:

Yes No

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

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

Yes No

Yes No

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

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

Yes No

Yes No

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

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

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

COMPLETE THIS PAGE FOR JOINT COVERAGE APPLICANT ONLY

Health Questions (continued)

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

J. Doctor

145 Main St., Anytown, ST 12345-1234

Date last seen: *5-1-08* Reason for visit: *Check-up*

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

Name / Phone number	Specialty	Reason for visit	Medication / treatment prescribed

6. During the past 12 months have you:

Yes No

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

Additional Information

Yes No

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

Information About Your Insurance Coverage

Yes No

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

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

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

* **If a PARTNERSHIP POLICY is selected below and you are age 60 or younger, the Compound 3% or Compound 5% Benefit Increase Rider must be selected and will be issued with your policy. If you are age 61-75, one of the following Benefit Increase Riders must be selected and will be issued with your policy: Compound 3% or Compound 5% or Simple Benefit Increase Rider.**

Coverage Applied For

Partnership Policy Non-Partnership Policy
Comprehensive coverage is Nursing Care plus Home and Community Based Care (HCBC)

Select only one of the following coverage combinations:

- Nursing Care Only
- Comprehensive
- Comprehensive with HCBC Indemnity Benefit Rider
- Comprehensive with Monthly HCBC Benefit Rider
(The Compound Benefit Increase Rider must also be selected)

Elimination Period (Select for Nursing Care only, no Elimination Period is required for HCBC):

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

Daily Benefit Applied For: \$ 100.00

Benefit Period:

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

* Please refer to Partnership Policy requirements above.

Benefit Increase Riders (select only one):

- Compound Benefit Increase
 - Compound 5%
 - Compound 3%
- Simple Benefit Increase

Nonforfeiture Benefit Rider:

- Shortened Benefit Period Nonforfeiture

Benefit Extension Riders (select only one):

(Not available with Lifetime Benefit Period)

- Restoration of Benefits
- Shared Benefit Amount

Additional Benefits:

- Full Return of Premium Rider
- Paid-Up Survivor

(Available with Joint Coverage and Lifetime Premium Payment Option)

Required Benefit Rejection

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

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

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

Initial here:
 Primary Joint
 Applicant Applicant

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

Initial here:
 Primary Joint
 Applicant Applicant

Premium Information

Primary Applicant Rate Class:

- Preferred Select Preferred Standard

Joint Applicant Rate Class:

- Preferred Select Preferred Standard

Premium Payment Options (select only one):

- Lifetime Premium
- 20-Year Premium
- 10-Year Premium

Payment Mode (select only one):

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

Approved Employer or Association Group?

Yes No If "Yes," Group Identification Code or Name: _____

Paid with Application

\$ 6,330.95

Beneficiary Name and Relationship

Jane Doe Sister

Special Request / Requested Effective Date

PROTECTION AGAINST UNINTENTIONAL LAPSE

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

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

Name: Paul Doe Telephone Number: (555) 555-1414
Address: 123 First St. Anytown ST 12345-1234
Relationship: Brother

ADDITIONAL DETAILS

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

Multiple horizontal lines for providing additional details.

AGREEMENT - The answers given are complete and true to the best of my knowledge and belief. I understand that the Company will rely on my written answers to the questions in this application and that if my answers are not complete and true, my policy may not be valid.

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

"I" means the applicant and if applicable, the joint applicant applying for coverage under this application. CAUTION: If your answers on this application are incorrect or untrue, Minnesota Life Insurance Company has the right to deny benefits or rescind your policy. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at: Anytown, ST
City, State

X John Doe 8-1-08
Applicant's Signature Date

X Mary Doe 8-1-08
Joint Applicant's Signature Date

Agent Must Complete Statement on Next Page

AGENT'S STATEMENT

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

- Known well for ____ years Met very recently
 Known slightly for ____ years Relative? _____

Yes No

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

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

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

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

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

If "No," provide details: _____

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

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

John Q. Porter

Licensed Agent's Name (please print)

x

John Q. Porter

Licensed Agent's Signature

1234

Ident. Code

100

Split %

(555) 555-1515

Agent Phone

(555) 555-1414

Agent Fax

5678

Agency Number

8-1-08

Date

 Second Agent's Name (Please Print)

 Ident. Code

 Split %

 Third Agent's Name (Please Print)

 Ident. Code

 Split %

Agent's Statement

MINNESOTA LIFE

Minnesota Life Insurance Company
Home Office: St. Paul, MN 55101-2098
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.9817 Tel • 818.887.4595 Fax

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

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

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

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

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

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

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

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

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

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

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

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

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

What Could Disqualify Your Policy as a Partnership Policy? If you make any changes to your policy, such changes could affect whether your policy continues to be a Partnership Policy. ***Before you make any changes, you should consult with Minnesota Life Insurance Company to determine the effect of a proposed change.*** In addition, if you move to a State that does not maintain a Partnership Program or does not recognize your policy as a Partnership Policy, you would not receive beneficial treatment of your policy under the Medicaid program of that State. The information contained in this 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 Minnesota Life Insurance Company. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Arkansas Department of Human Services.

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

SERFF Tracking Number: LFCR-126074870 State: Arkansas
Filing Company: Minnesota Life Insurance Company State Tracking Number: 41826
Company Tracking Number: ML7600 AR
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Integrity LTCi
Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: LFCR-126074870 State: Arkansas
Filing Company: Minnesota Life Insurance Company State Tracking Number: 41826
Company Tracking Number: ML7600 AR
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Integrity LTCi
Project Name/Number: /

Supporting Document Schedules

Review Status:
Satisfied -Name: Flesch Certification 03/13/2009
Comments:
Attachment:
Flesch Certification.pdf

Review Status:
Bypassed -Name: Application 03/13/2009
Bypass Reason: Application is attached in Form Schedule
Comments:

Review Status:
Bypassed -Name: Outline of Coverage 03/13/2009
Bypass Reason: Outline of Coverage is attached in Form Schedule
Comments:

Review Status:
Satisfied -Name: Cover Sheet 03/13/2009
Comments:
Attachment:
ML7600P RS Cover Sheet -AR.pdf

Review Status:
Satisfied -Name: Certificate of Compliance 03/13/2009
Comments:
Attachment:
AR Certificate of Compliance.pdf

Review Status:
Satisfied -Name: Partnership Issuer Certification 03/13/2009
Comments:
Attachment:

SERFF Tracking Number: LFCR-126074870 *State:* Arkansas
Filing Company: Minnesota Life Insurance Company *State Tracking Number:* 41826
Company Tracking Number: ML7600 AR
TOI: LTC03I Individual Long Term Care *Sub-TOI:* LTC03I.001 Qualified
Product Name: Integrity LTCi
Project Name/Number: /

AR Partnership Issuer Certification.pdf

SERFF Tracking Number: LFCR-126074870 State: Arkansas
Filing Company: Minnesota Life Insurance Company State Tracking Number: 41826
Company Tracking Number: ML7600 AR
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Integrity LTCi
Project Name/Number: /

Review Status:

Satisfied -Name: Previously Approved Forms For
Use With This Product

03/13/2009

Comments:

Attachments:

ML7500AD.pdf
ML7500AO.pdf
ML7500AUT.pdf
MLE-10P.pdf
MLE-20P.pdf
MLE-CNF.pdf
MLE-CNF-LP.pdf
MLE-RED.pdf
MLN-REP.pdf
MLN-MED.pdf
MLN-LTC.pdf
MLN-PRI-LP.pdf
ML7600WRK.pdf
MLIC Suitability Letter.pdf

FORM FILING COVER SHEET

ML7600P-AR et al

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

ML7600P-AR	Long Term Care Insurance Policy
ML7600OC-AR	Outline of Coverage for Long Term Care Insurance
ML7600R-ROP	Full Return of Premium Rider
ML7600R-SBN	Shortened Benefit Period Nonforfeiture Rider
ML7600R-CBI	Compound Benefit Increase Rider
ML7600R-SBI	Simple Benefit Increase Rider
ML7600R-IND	Home and Community Based Care Indemnity Benefit Rider
ML7600R-MTH	Monthly Home and Community Based Care Benefit Rider
ML7600R-ROB	Restoration of Benefits Rider
ML7600R-SBA	Shared Benefit Amount Rider
ML7600R-SVR	Paid-Up Survivor Benefit Rider
ML7600A-AR	Application for Long Term Care Insurance Policy
MLN-PRT-AR	Partnership Program Notice
MLD-PRT-AR	Important Notice Regarding Your LTC Insurance Partnership Status

PREVIOUSLY APPROVED FORMS FOR USE WITH THIS PRODUCT

ML7500AD	Disclosure Statement and Conditions of Coverage
ML7500AO	Supplemental Application for Policy Ownership
ML7500AUT	Authorization for Disclosure, Receipt and Use of Personal Health Information
MLE10P	10-Year Premium Payment Endorsement
MLE-20P	20-Year Premium Payment Endorsement
MLE-CNF	Contingent Benefit Upon Lapse Endorsement
MLE-CNF-LP	Contingent Benefit Upon Lapse Endorsement for use with Limited Pay Policy
MLE-RED	Lowering Premiums by Reducing Benefits Endorsement
MLN-REP	Replacement Form
MLN-MED	Medicare Supplement Duplication Notice
MLN-LTC	Things You Should Know Before You Buy Long Term Care Insurance
MLN-PRI-LP	Potential Rate Increase Disclosure Form
ML7600WRK	Long Term Care Insurance Personal Worksheet (previously approved as ML7500WRK)
	Sample Long Term Care Insurance Suitability Letter
	Actuarial Memorandum

CERTIFICATION OF COMPLIANCE

Insurer: _____

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

Signature: _____

Name: _____

Title: _____

Date: _____

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

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

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

I. GENERAL INFORMATION

A. Name, address and telephone number of issuer:

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:

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):

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

II. CERTIFICATIONS

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

Date

Name and title of officer of the Issuer

Signature of officer of the Issuer

MINNESOTA LIFE

Minnesota Life Insurance Company
Home Office: St. Paul, MN 55101-2098
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.9817 Tel • 818.887.4595 Fax

Disclosure Statement and Conditions of Coverage

DISCLOSURE STATEMENT

NOTICE OF INSURANCE INFORMATION PRACTICES — To evaluate your application, we will need some personal information about you. It may be necessary to obtain some of that information from sources other than yourself. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information. The information we obtain about you will be used by Minnesota Life Insurance Company to determine eligibility for insurance and/or benefits under an existing policy and for other business purposes in connection with the insurance relationship. A detailed description of our information practices is contained in the Notice of Privacy Practices furnished to you with your application.

CONDITIONS OF COVERAGE

I/We _____ the applicant(s) have applied for a long term care insurance policy from Minnesota Life Insurance Company (the Company) and have submitted \$ _____ to the Company, however, payment does not bind coverage as of the application date. The minimum amount of premium which may accompany an application is a monthly premium amount. It is understood and agreed that no liability is created or assumed by the Company, except for the refund of any premium amount submitted, unless and until a long term care insurance policy becomes effective. If approved, the effective date will be stated in the policy issued to the applicant(s).

The insurance applied for will become effective and in force only if:

1. This application is approved by the Company; and
2. A policy is issued during the lifetime of the applicant(s); and
3. The initial premium payment has been paid; and
4. Until the effective date of the policy as set by the Company, the health status of the applicant(s) remains insurable under the Company's underwriting standards.

Requests for a specific effective date are honored at the Company's discretion in accordance with its published guidelines on policy dating upon the conclusion of the underwriting review.

Should the applicant(s) be determined uninsurable based on the Company's underwriting standards, or if we are unable to obtain required underwriting information within 90 days, the amount submitted will be returned to the applicant(s). Should the amount submitted not be honored by the applicant's bank, the Company will discontinue consideration of the application.

No agent or broker has the authority to waive or alter any of the terms or conditions of the application for insurance or these Conditions of Coverage.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO MINNESOTA LIFE INSURANCE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT, AGENCY, OR LEAVE PAYEE BLANK.

I/We have read and understand the Conditions of Coverage.

Signed at _____
City, State _____ Date _____

Applicant's Signature _____ Joint Applicant's Signature _____

Licensed Agent's Signature _____ Date _____

MINNESOTA LIFE

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SUPPLEMENTAL APPLICATION FOR POLICY OWNERSHIP (PLEASE PRINT) ML7500AO

Applicant (First Name, Initial, Last Name)		Birthdate	Social Security Number
Joint Applicant (First Name, Initial, Last Name)		Birthdate	Social Security Number
Policy Owner and Relationship to Applicant(s)			Social Security or Tax I.D. Number
Residence Address (Street, City, State, Zip)			
Bill to: <input type="checkbox"/> Owner <input type="checkbox"/> Insured	Owner's Billing Address - If Different (Name, Street, City, State, Zip)		
Policy Owner is: <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Trustee			
Contingent Policy Owner and Relationship to Applicant(s)			Social Security or Tax I.D. Number
Residence Address (Street, City, State, Zip)			
Contingent Owner's Billing Address - If Different (Name, Street, City, State, Zip)			
Contingent Policy Owner is: <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Trustee			

Signed at: _____
City, State

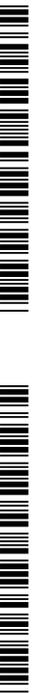
Date

Applicant's Signature

Policy Owner's Signature

Joint Applicant's Signature

Agent's Signature



MINNESOTA LIFE

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AUTHORIZATION FOR DISCLOSURE, RECEIPT AND USE OF PERSONAL HEALTH INFORMATION

"I", "me", "my" means each Applicant signing this Authorization.

AUTHORIZATION FOR DISCLOSURE

I authorize any licensed physician or licensed health care practitioner, hospital, clinic, medical facility, health care provider, insurance company or health plan that has provided treatment, payment or health care services to me, or any other insurance company to which I have applied for insurance coverage ("My Providers"), to disclose my entire medical record and any knowledge of my past or present health or medical condition to Minnesota Life Insurance Company, its reinsurers and any third party administrator designated by Minnesota Life Insurance Company. This includes any information relating to HIV, AIDS and any sexually transmitted diseases, mental illness, the use of drugs, alcohol and tobacco, but excludes psychotherapy notes. Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes the following information which is subject to disclosure under this Authorization: medication prescription and monitoring; counseling session start and stop times; the modalities and frequencies of treatment furnished; results of clinical tests; and any summary of the following items: diagnosis; functional status; the treatment plan; symptoms; prognosis; and progress to date.

By my signature below, I terminate any agreements I have made with My Providers to restrict information in my medical records or any knowledge of my past or present health or medical condition and I instruct My Providers to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

AUTHORIZATION FOR RECEIPT AND USE

I authorize the employees and business associates of Minnesota Life Insurance Company, its reinsurers and any third party administrator designated by Minnesota Life Insurance Company who are responsible for the processing of my application for long term care insurance to receive and use any information I have provided on my application form or provided by me during the course of a personal interview with me and to receive and use any information provided by other parties under the above Authorization For Disclosure for the purpose of determining my eligibility to obtain coverage under the long term care insurance policy for which I have applied, and to determine the rates and terms which apply to the policy.

I understand that the information which will be provided under this Authorization is necessary for the Company to determine my eligibility for coverage under the long term care insurance policy I have applied for and that the Company will condition approval and issuance of the policy on my providing this Authorization. I also understand that my application may be denied if I refuse to provide this Authorization.

REDISCLASURE OF INFORMATION

I understand that if the person or entity that receives information provided pursuant to this Authorization is not subject to federal privacy regulations, the information may be redisclosed and will no longer be protected by the federal privacy regulations. In the case of this Authorization, however, the information described above will be received by an insurance company which is covered by the federal privacy regulations, and will not be used or redisclosed except as described above, and the information will continue to be protected under the federal privacy regulations.

REVOCAION OF AUTHORIZATION

I understand that I may revoke this Authorization in writing at any time by sending a written revocation to: *Minnesota Life Insurance Company, ATTN: Privacy Administrator, P.O. Box 4243, Woodland Hills, CA 91365-4243*. I also understand that any such revocation will not be effective to the extent that action has been taken by the Company in reliance on this Authorization or the extent that the Company has a legal right to contest a claim under the policy which I have applied for or to contest the policy itself.

EXPIRATION OF AUTHORIZATION

This Authorization will be valid for 24 months from the date of my signature below. A copy of this Authorization is as valid as the original.

Applicant's Name (Please Print)

Date of Birth

Applicant's Signature

Date

Joint Applicant's Name (Please Print)

Date of Birth

Joint Applicant's Signature

Date



MINNESOTA LIFE

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AUTHORIZATION FOR DISCLOSURE, RECEIPT AND USE OF PERSONAL HEALTH INFORMATION

"I", "me", "my" means each Applicant signing this Authorization.

AUTHORIZATION FOR DISCLOSURE

I authorize any licensed physician or licensed health care practitioner, hospital, clinic, medical facility, health care provider, insurance company or health plan that has provided treatment, payment or health care services to me, or any other insurance company to which I have applied for insurance coverage ("My Providers"), to disclose my entire medical record and any knowledge of my past or present health or medical condition to Minnesota Life Insurance Company, its reinsurers and any third party administrator designated by Minnesota Life Insurance Company. This includes any information relating to HIV, AIDS and any sexually transmitted diseases, mental illness, the use of drugs, alcohol and tobacco, but excludes psychotherapy notes. Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes the following information which is subject to disclosure under this Authorization: medication prescription and monitoring; counseling session start and stop times; the modalities and frequencies of treatment furnished; results of clinical tests; and any summary of the following items: diagnosis; functional status; the treatment plan; symptoms; prognosis; and progress to date.

By my signature below, I terminate any agreements I have made with My Providers to restrict information in my medical records or any knowledge of my past or present health or medical condition and I instruct My Providers to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

AUTHORIZATION FOR RECEIPT AND USE

I authorize the employees and business associates of Minnesota Life Insurance Company, its reinsurers and any third party administrator designated by Minnesota Life Insurance Company who are responsible for the processing of my application for long term care insurance to receive and use any information I have provided on my application form or provided by me during the course of a personal interview with me and to receive and use any information provided by other parties under the above Authorization For Disclosure for the purpose of determining my eligibility to obtain coverage under the long term care insurance policy for which I have applied, and to determine the rates and terms which apply to the policy.

I understand that the information which will be provided under this Authorization is necessary for the Company to determine my eligibility for coverage under the long term care insurance policy I have applied for and that the Company will condition approval and issuance of the policy on my providing this Authorization. I also understand that my application may be denied if I refuse to provide this Authorization.

REDISCLOSURE OF INFORMATION

I understand that if the person or entity that receives information provided pursuant to this Authorization is not subject to federal privacy regulations, the information may be redisclosed and will no longer be protected by the federal privacy regulations. In the case of this Authorization, however, the information described above will be received by an insurance company which is covered by the federal privacy regulations, and will not be used or redisclosed except as described above, and the information will continue to be protected under the federal privacy regulations.

REVOCAION OF AUTHORIZATION

I understand that I may revoke this Authorization in writing at any time by sending a written revocation to: *Minnesota Life Insurance Company, ATTN: Privacy Administrator, P.O. Box 4243, Woodland Hills, CA 91365-4243*. I also understand that any such revocation will not be effective to the extent that action has been taken by the Company in reliance on this Authorization or the extent that the Company has a legal right to contest a claim under the policy which I have applied for or to contest the policy itself.

EXPIRATION OF AUTHORIZATION

This Authorization will be valid for 24 months from the date of my signature below. A copy of this Authorization is as valid as the original.

Applicant's Name (Please Print)

Date of Birth

Applicant's Signature

Date

Joint Applicant's Name (Please Print)

Date of Birth

Joint Applicant's Signature

Date

10-YEAR PREMIUM PAYMENT ENDORSEMENT

This endorsement is attached to and made part of your policy as of the Effective Date. It is issued in consideration of your application and premium submitted by you for this endorsement.

10-YEAR PREMIUM PAYMENT OPTION

This endorsement provides that your policy premiums will be payable over a 10-year period, after which no further premiums will be due.

The following language is added to the **RENEWABILITY** provision shown on the first page of your policy:

To renew during the 10-Year Premium Payment Period shown on the Policy Schedule, you must pay the premium due by the Premium Due Date or within the Grace Period. At the end of the 10th policy year, if each required premium has been paid, your policy will automatically be renewed for the rest of your life with no further premium due. Premiums are subject to change only during the 10-Year Premium Payment Period.

Signed for Minnesota Life Insurance Company, a stock company, at St. Paul, Minnesota on the policy Effective Date.



Secretary



Chairman and Chief Executive Officer

MINNESOTA LIFE

Minnesota Life Insurance Company
Home Office: St. Paul, MN 55101-2098
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.9817 Tel • 818.887.4595 Fax

20-YEAR PREMIUM PAYMENT ENDORSEMENT

This endorsement is attached to and made part of your policy as of the Effective Date. It is issued in consideration of your application and premium submitted by you for this endorsement.

20-YEAR PREMIUM PAYMENT OPTION

This endorsement provides that your policy premiums will be payable over a 20-year period, after which no further premiums will be due.

The following language is added to the **RENEWABILITY** provision shown on the first page of your policy:

To renew during the 20-Year Premium Payment Period shown on the Policy Schedule, you must pay the premium due by the Premium Due Date or within the Grace Period. At the end of the 20th policy year, if each required premium has been paid, your policy will automatically be renewed for the rest of your life with no further premium due. Premiums are subject to change only during the 20-Year Premium Payment Period.

Signed for Minnesota Life Insurance Company, a stock company, at St. Paul, Minnesota on the policy Effective Date.



Secretary



Chairman and Chief Executive Officer

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CONTINGENT BENEFIT UPON LAPSE ENDORSEMENT

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

CONTINGENT BENEFIT UPON LAPSE

If we:

- (a) increase the premium rates under your policy which results in a cumulative increase of the annual premium equal to or exceeding the percentage of your initial annual premium, as set forth in the table below; and
- (b) your policy lapses as described in the Grace Period and Unintentional Lapse provisions of your policy within 120 days of the due date for the payment of the increased premium; then
- (c) the following options will become available under your policy:
 - A. The Benefit Amount shown on the Policy Schedule page of your policy may be reduced. This may be accomplished by either reduction of the Daily Benefit or Benefit Period, (subject to the availability of either one), to provide for a Benefit Amount that the current premium payable under your policy will purchase. Reduction of the Benefit Amount will not be subject to evidence of insurability; or
 - B. Your policy may be converted to a paid-up status with the Shortened Benefit Period described below. This option may be elected at any time during the 120-day period referenced above. In addition, if your policy lapses for nonpayment of premium during this 120-day period, this option will automatically be provided under your policy.

SHORTENED BENEFIT PERIOD

Your coverage will continue and benefits will be payable based on the Daily Benefit shown on the Policy Schedule (and any previous increases due to a Benefit Increase Rider) in effect on the date of lapse, but only until the total of benefits payable under your policy and riders equals the total of premium paid. No further benefit increases will occur under any Benefit Increase Rider, if attached to your policy.

The Benefit Amount becomes equal to the greater of: (1) the total of premiums paid for your policy and all riders; but (2) in no event less than thirty (30) times the Daily Benefit in effect on the date of lapse. This Benefit Amount replaces the Benefit Amount in effect on the date of lapse. Any benefits paid to you after your policy lapses will be subtracted from this new Benefit Amount.

Your coverage is subject to the same policy benefit provisions, Elimination Period, limitations or exclusions, and all other provisions of your policy and riders that were in effect prior to policy lapse, except any Benefit Increase Rider, if attached to your policy.

(over)

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TRIGGERS FOR A SUBSTANTIAL PREMIUM INCREASE

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

Signed for Minnesota Life Insurance Company, a stock company, at St. Paul, Minnesota on the policy Effective Date.



Secretary



Chairman and Chief Executive Officer

CONTINGENT BENEFIT UPON LAPSE ENDORSEMENT (Limited Premium Payment Policy)

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

Contingent Benefit Upon Lapse

If we:

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

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

(over)

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

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

Signed for Minnesota Life Insurance Company, a stock company, at St. Paul, Minnesota on the policy Effective Date.



Secretary



Chairman and Chief Executive Officer

LOWERING PREMIUMS BY REDUCING BENEFITS ENDORSEMENT

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

LOWERING PREMIUMS BY REDUCING BENEFITS

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

1. reducing the Benefit Amount shown on the Policy Schedule; or
2. reducing the Daily Benefit shown on the Policy Schedule.

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

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



Secretary



Chairman and Chief Executive Officer

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NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

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

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with an individual policy to be issued by Minnesota Life Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE) (Use additional sheets if necessary)

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

1. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of agent, broker or other representative)

(Typed name of agent or broker)

(Typed address of agent or broker)

The above "Notice to Applicant" was delivered to me on:

Date _____ Applicant's signature _____

Date _____ Joint Applicant's signature _____

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NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

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

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with an individual policy to be issued by Minnesota Life Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE) (Use additional sheets if necessary)

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

1. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of agent, broker or other representative)

(Typed name of agent or broker)

(Typed address of agent or broker)

The above "Notice to Applicant" was delivered to me on:

Date _____

Applicant's signature _____

Date _____

Joint Applicant's signature _____

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IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This is long term care insurance that provides benefits for covered nursing home and home care services.
- In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most long term care expenses.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about long term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

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

Medicare

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

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

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

Counseling

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

Facilities

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

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LONG TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM

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

3. **Rate Schedule Adjustments:**

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

4. **Potential Rate Revisions:**

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

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

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

***Contingent Nonforfeiture**

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

You will keep some long term care coverage, if:

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

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

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount will be considered "paid up" with no further premiums due.

Turn the Page

Example:

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

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

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

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

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

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 the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.
- b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

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

Example:

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

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LONG TERM CARE INSURANCE PERSONAL WORKSHEET

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

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

Premium Information

Policy Form Number: _____

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

Type of Policy: Guaranteed Renewable

The Company's Right To Increase Premiums

The Company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state. A class includes persons with the same benefits, issue age, and premium rate class at issue.

Rate Increase History

The Company has sold long term care insurance since 2006 and has sold this policy since 2009. The Company has never raised its rates for any long term care policy it has sold in this state or any other state.

Questions Related To Your Income

How will you pay each year's premium?

- From my income From my Savings/Investments My family will pay
- Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What Is Your Annual Income? (check one)

- Under \$10,000 \$10-20,000 \$20-30,000 \$30-50,000 Over \$50,000

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

- No change Increase Decrease

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

Turn the Page

Will You Buy Inflation Protection? (check one)

Yes No

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

From my income From my Savings/Investments My family will pay

The national average annual cost of care in [2008]¹ was: \$[68,000] in a nursing home; \$[36,000] in an assisted living facility and \$[18,000] for home health care, but these figures vary across the country. In ten years the national average annual cost would be about \$[110,765] in a nursing home; \$[58,640] in an assisted living facility and \$[29,320] for home health care, if costs increase 5% annually.

What Elimination Period Are You Considering?

Number of Days _____

Approximate cost \$ _____ for that period of care.

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

From my income From my Savings/Investments My family will pay

Questions Related To Your Savings and Investments

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

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

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

Stay about the same Increase Decrease

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

Comparison To Current Coverage

If you have existing long term care coverage and you intend to add to or replace your current coverage, please indicate your reason for doing so (check one):

Additional or different benefits (please specify): _____

No change in benefits, but lower premiums

Fewer benefits and lower premiums

Other (please specify): _____

Premium for your current long term care coverage: \$ _____ per _____ .

¹ [2008 U.S. Department of Health and Human Services (www.longtermcare.gov/LTC/Main_Site/index.aspx)]

Disclosure Statement

(Check One)

The answers to the questions above describe my financial situation.

Or

I choose not to complete this information. However, I still want the Company to consider my application.

Authorization to Process Application

My agent has explained to me that my personal financial circumstances are an important consideration in determining whether or not long term care insurance is an appropriate purchase for me.

My agent has also given me a copy of *"Things You Should Know Before You Buy Long Term Care Insurance"* and has explained the importance of completing the Long Term Care Insurance Personal Worksheet.

I hereby confirm that I have chosen not to complete the Long Term Care Insurance Personal Worksheet. Nevertheless, I request that you continue to process my application for long term care insurance.

I acknowledge that the insurer and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** *(This box must be checked in order to consider your application for Long Term Care.)*

Signed: _____ (Applicant) _____ (Date)

_____ (Joint Applicant) _____ (Date)

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

Signed: _____ (Agent) _____ (Date)

_____ (Agent's Printed Name)

IN ORDER FOR US TO PROCESS YOUR APPLICATION, PLEASE RETURN THIS SIGNED STATEMENT TO MINNESOTA LIFE INSURANCE COMPANY, ALONG WITH YOUR APPLICATION.

My agent has advised me that this policy does not appear to be suitable for me. However, I still want the Company to consider my application.

Signed: _____ (Applicant) _____ (Date)

_____ (Joint Applicant) _____ (Date)

The Company may contact you to verify your answers.

This confidential information will be used only to determine your suitability for long term care insurance and may not be used for any other purpose or disseminated outside of the Company or agency.

SAMPLE LONG TERM CARE INSURANCE SUITABILITY LETTER

Dear [Applicant]:

Your recent application for long term care insurance included a “Personal Worksheet”, which asked questions about your finances and your reasons for buying long term care insurance. For your protection, state law requires us to consider this information when we review your application. This prevents issuing a policy to those who may not need coverage.

Your answers on the worksheet indicate that long term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet “Shopper's Guide to Long Term Care Insurance” and the page titled “Things You Should Know Before Buying Long Term Care Insurance”. Your State Insurance Department also has information about long term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.

Your state requires that we confirm your request to proceed before we can continue to underwrite your application. We need to hear from you within the next 60 days to complete the underwriting of your application.

If we do not hear from you within the next 60 days, we cannot issue you a policy and your file will be closed. You should understand that you will not have any coverage until you respond to this letter, we approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

- Yes, I wish to purchase this coverage. Please continue the review of my application.
- No. I have decided not to purchase long term care coverage at this time.

APPLICANT'S SIGNATURE

DATE

***Please return to Minnesota Life Insurance Company Long Term Care Administrative Office at
P.O. Box 4243, Woodland Hills, CA 91365-4243 by [Date].***