

SERFF Tracking Number: LFSC-126386205 State: Arkansas
Filing Company: LifeSecure Insurance Company State Tracking Number: 44127
Company Tracking Number:
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Multi-Life Application Filing - 09/09 Version
Project Name/Number: /

Filing at a Glance

Company: LifeSecure Insurance Company

Product Name: Multi-Life Application Filing - 09/09 Version SERFF Tr Num: LFSC-126386205 State: Arkansas

TOI: LTC03I Individual Long Term Care

SERFF Status: Closed-Approved State Tr Num: 44127

Sub-TOI: LTC03I.001 Qualified

Co Tr Num: State Status: Closed

Filing Type: Form

Reviewer(s): Harris Shearer

Authors: Sue Howard, Judy Lucas Disposition Date: 01/22/2010

Date Submitted: 11/18/2009 Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 01/22/2010

Explanation for Other Group Market Type:

State Status Changed: 01/22/2010

Deemer Date:

Created By: Judy Lucas

Submitted By: Judy Lucas

Corresponding Filing Tracking Number:

Filing Description:

LifeSecure Insurance Company, NAIC 77720

Re: LS-0204 ST 09/09 – Application- Agent Sold Electronic

LS-0100 ST 09/09 - Personal Worksheet -Self Serve Screen Shots & PDF Output

LS-0100E ST 09/09 - Personal Worksheet - Agent Sold Screenshots & PDF Output

To Whom It May Concern;

Enclosed is a revision to our previously approved multi-life application. The application was approved for use in your state on 10/16/2009 During implementation, we noticed several typos and a missing statement. This filing is to correct the typos and add the missing statement from the PDF output of our electronic application. There have been no other

SERFF Tracking Number: LFSC-126386205 State: Arkansas
Filing Company: LifeSecure Insurance Company State Tracking Number: 44127
Company Tracking Number:
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Multi-Life Application Filing - 09/09 Version
Project Name/Number: /

changes than the ones listed below made to these applications:

LS-0204 ST 09/09 Agent Sold Application - PDF Output –
Form number changed to LS-0204 (ST) 09/09

Page 5 – Section D

Added:

Total Monthly Premium[**]: \$- 750

[** If the employer stops contributing to your long term care insurance coverage for any reason in the future, the Total Monthly Premium represents the full amount of monthly premium that is required to keep your policy in force.]

Page 11 – question d – added comma after evaluation.

Page 12 – Question 2 – changed box to “Types of tobacco or nicotine products used”

Page 17 – 2nd paragraph – changed to Section [H][K]

Page 17 – 7th paragraph changed to Section [F][I]

LS-0204 ST 09/09 Agent Sold Application Screen Shot Changes

Form number changed to LS-0204 (ST) 09/09

Section G – question 3(c) added the words “and dates” to the last sentence.

Section (G)(J) changed question 2 to say “Company Name” instead of “with which company”

Section (H)(K) changed the capital “N” in non-profit to a lower case “n”

Section (I)(L) added an “s” to Authorization title

Section (I)(L) changed the lower case “a” to an upper case “A” for Application in the last paragraph.

Section (K)(N) changed title to “Agent’s Report, Certification and Signature”

We are attaching two new personal worksheets that will be used with our multilife applications (the one attached) and the ones previously approved by your department.

SERFF Tracking Number: LFSC-126386205 State: Arkansas
 Filing Company: LifeSecure Insurance Company State Tracking Number: 44127
 Company Tracking Number:
 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
 Product Name: Multi-Life Application Filing - 09/09 Version
 Project Name/Number: /

These applications will replace the previous LS-0204 ST 08/09 application approved for use in your state. Please feel free to contact me at (810) 220-4610 or by email JLucas@lifeseureltc.com if you have any questions or concerns.

Respectfully Submitted,

Judy Lucas
 Senior Compliance Specialist

Company and Contact

Filing Contact Information

Judy Lucas, Senior Compliance Analyst jlucas@lifeseureltc.com
 10559 Citation Drive 810-220-4610 [Phone]
 Suite 300 810-220-4690 [FAX]
 Brighton, MI 48116

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$120.00
 Retaliatory? No
 Fee Explanation: 6 forms at 20.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
LifeSecure Insurance Company	\$120.00	11/18/2009	32140129

SERFF Tracking Number: LFSC-126386205 State: Arkansas
Filing Company: LifeSecure Insurance Company State Tracking Number: 44127
Company Tracking Number:
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Multi-Life Application Filing - 09/09 Version
Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Harris Shearer	01/22/2010	01/22/2010

SERFF Tracking Number: *LFSC-126386205* *State:* *Arkansas*
Filing Company: *LifeSecure Insurance Company* *State Tracking Number:* *44127*
Company Tracking Number:
TOI: *LTC03I Individual Long Term Care* *Sub-TOI:* *LTC03I.001 Qualified*
Product Name: *Multi-Life Application Filing - 09/09 Version*
Project Name/Number: /

Disposition

Disposition Date: 01/22/2010

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: LFSC-126386205 State: Arkansas
 Filing Company: LifeSecure Insurance Company State Tracking Number: 44127
 Company Tracking Number:
 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
 Product Name: Multi-Life Application Filing - 09/09 Version
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	Agent Sold Application - Electronic		Yes
Form	Personal Worksheet - Agent Sold		Yes
Form	Personal Worksheet -Self Serve		Yes

SERFF Tracking Number: LFSC-126386205 State: Arkansas
 Filing Company: LifeSecure Insurance Company State Tracking Number: 44127
 Company Tracking Number:
 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
 Product Name: Multi-Life Application Filing - 09/09 Version
 Project Name/Number: /

Form Schedule

Lead Form Number: LS-0204 ST 09/09

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LS-0204 ST 09/09	Application/ Enrollment Form	Agent Sold Application - Electronic	Revised	Replaced Form #: LS-0204 ST 09/09 Previous Filing #: LS-0204 ST 08/09		LS-0204 ST 09.09- Online Agent Sold PDF- John Doe.pdf LS-0204 ST 09.09-Online Screen Shots- Agent Sold- John Doe.pdf
	LS-0100E ST 09/09	Other	Personal Worksheet - Agent Sold	Initial			LS 0100E ST 09.09 - Agent Sold PDF Personal Worksheet.pdf
	LS-0100 ST 09/09	Other	Personal Worksheet -Self Serve	Initial			LS 0100 ST 09.09 - Self Serve PDF Personal Worksheet.pdf LS 0100 ST 09.09- SelfServe

SERFF Tracking Number: LFSC-126386205 State: Arkansas
Filing Company: LifeSecure Insurance Company State Tracking Number: 44127
Company Tracking Number:
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Multi-Life Application Filing - 09/09 Version
Project Name/Number: /

Screens
Personal
Worksheet.pdf

Section A: Personal Health History

1. Within the *past 12 months*, have you resided in or been advised by a healthcare professional to enter a Nursing Home, Assisted Living Facility or any other type of Long Term Care Facility? Or, within the *past 12 months*, have you used or been advised by a healthcare professional to use Home Health Care or Adult Day Care services? Yes No
2. Do you *currently* use any of the following: Yes No
- Walker
 - Wheelchair
 - Quad Cane
 - Motorized scooter
 - Hospital bed
 - Oxygen equipment
 - Dialysis
3. Do you *currently* require human assistance in order to perform any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? Yes No
4. Do you have or have you ever been diagnosed or treated by a health care professional as having any of the following: Yes No
- **Amyotrophic Lateral Sclerosis (ALS, also called Lou Gehrig's Disease)**
 - Systemic Lupus Disease
 - **Alzheimer's Disease**
 - Dementia/Senility
 - Mental Retardation
 - Psychosis
 - Stroke (CVA) within past 5 years
 - Multiple Sclerosis (MS)
 - Muscular Dystrophy
 - **Parkinson's Disease**
 - Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test
 - Metastatic Cancer
 - Type I (Juvenile) Diabetes
 - Diabetes – treated/controlled with insulin for greater than 15 years or currently treated/controlled with greater than 49 units of insulin per day
 - A Transient Ischemic Attack (TIA) within past 2 years, *or* multiple TIAs within past 5 years
 - Chronic Kidney/Renal Disease
 - **Huntington's Chorea**
 - Cirrhosis of the Liver
 - Organ Transplant
 - Amputation due to Disease (not accident)
5. Are you *currently* receiving Social Security Disability benefits? Yes No

If you answered "Yes" to any part of any question in Section A, PLEASE DO NOT CONTINUE.

We regret that we cannot offer you long term care insurance coverage.

If your circumstances change, you may consider reapplying at a future time.

If you answered "No" to all questions in Section A, please CONTINUE.

Section C: Spouse Or Domestic Partner Information

PLEASE COMPLETE THE INFORMATION BELOW WHETHER OR NOT YOUR SPOUSE OR DOMESTIC PARTNER IS APPLYING.
You may qualify for a couple's discount.

Mr. Mrs. Ms. Dr.

Jane _____ Doe _____
Name (First) (MI) (Last) (Suffix)

125 - 95 - 1236 _____
Social Security Number OR Tax Identification #

Is your spouse or domestic partner also applying for coverage? Yes No

OPTIONAL AUTOMATIC INFLATION PROTECTION: I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of the policy with and without automatic inflation protection. Specifically, I have reviewed options for 5% and 3% Automatic Compound Inflation Protection. My choice is as follows:

- I reject the Automatic Compound Inflation Protection options; however, I understand that my coverage will include the Guaranteed Future Purchase Offers feature.
- I elect Automatic 5% Compound Inflation Protection.
- I elect Automatic 3% Compound Inflation Protection.

OPTIONAL LAPSE PROTECTION BENEFIT:

- Yes. I elect to have the Lapse Protection Benefit as part of my coverage.
- No. I have reviewed the Outline of Coverage and compared the benefits and premiums of the policy with and without Lapse Protection benefits and I reject the Lapse Protection Benefit.

PREMIUM PAYMENT OPTIONS:

- Lifetime Payment Option
- 10-Year Premium Payment Option*
- To-Age-65 Premium Payment Option*

* These two limited-payment options are available only if you elected Automatic 5% Compound Inflation Protection or Automatic 3% Compound Inflation Protection as part of your coverage.

Total Monthly Premium[]:** \$ _____

[** If the employer stops contributing to your long term care insurance coverage for any reason in the future, the Total Monthly Premium represents the full amount of monthly premium that is required to keep your policy in force.]

Section E: Premium Payment Authorization

Complete this section to authorize your preferred premium payment method.

- AUTOMATIC PAYROLL DEDUCTION** (applicable only for participating employers)

By electing this payment method, I authorize my employer to deduct my long term care insurance premiums automatically from my payroll.

Payroll System/Division: _____

Payroll Location: _____

Payroll Frequency: _____

Employee Number: _____

- DIRECT-BILLING (MAIL)**

Select one billing frequency:

annually semi-annually quarterly monthly (\$2.00 monthly fee applicable)

OR

- MONTHLY ELECTRONIC FUNDS TRANSFER**

How Monthly Electronic Funds Transfer Works: Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. LifeSecure Insurance Company will collect the long term care insurance premiums from your bank account electronically. You do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Monthly Electronic Funds Transfer Agreement:

I authorize LifeSecure to electronically withdraw money from my account for the payment of premiums for this insurance policy. I authorize LifeSecure to continue to make these withdrawals if there is a renewal, or other change in the policy. I will compensate LifeSecure for any loss, claim, or liability caused by these withdrawals and will not hold LifeSecure responsible for any such loss, claim, or liability. This authorization will not affect the terms of the policy. Authorizing this automatic payment plan does not put the insurance policy into effect. This authorization may be retracted by me or LifeSecure at any time for any reason by giving written notice. LifeSecure may retract the authorization immediately, without giving me written notice, if any debt is not paid by the bank stated below, for any reason.

Name of Bank: _____

Bank Address: _____

Telephone #: _____

Account Type: checking savings

Account #: _____

Routing #: _____

OR

AUTOMATIC CREDIT CARD PAYMENT

Select Card Type: Visa MasterCard American Express Discover Card]

Credit Card #: _____

Name as it appears on Card: _____

Expiration Date: _____

Section F: Personal Physician Information

Please provide the following information about your personal physician, sometimes called your Primary Care Doctor (i.e., the physician with most of your medical records).

James _____ (MI) Smith _____ (Suffix)
Physician's Name (First) (Last)

5689 First Street _____ 500 _____
Street Address Suite #

Anytown _____ ST _____ 12345 _____
City State Zip Code

810-256-8956 _____
Office Phone Number

Have you seen this physician in the last two years? Yes No

Date of last visit: 01/2009 _____
month/year

Reason for visit:

Annual Physical _____

Section G: Medical History

1. In the *past 3 years*, have you received medical advice or treatment, been diagnosed by or consulted with a healthcare professional for any of the following conditions (check all that apply or NONE OF THE ABOVE).
- 1. Drug or Alcohol Abuse
 - 2. Disorders of Vision or Speech
 - 3. Hypertension/High Blood Pressure, Chest Pain, Angina, Coronary Artery Disease
 - 4. Heart Attack, Angioplasty or Heart Surgery
 - 5. Transient Ischemic Attack (TIA), Carotid Artery Disease or Surgery
 - 6. Congestive Heart Failure (CHF), Atrial Fibrillation, Pacemaker
 - 7. Aneurysm, Peripheral Vascular Disease (PVD)
 - 8. Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Asthma, Chronic Bronchitis
 - 9. Fainting Spells or Blacking Out, Seizures, Epilepsy
 - 10. Tremor, Myasthenia Gravis
 - 11. Paralysis (partial or full), Post Polio Syndrome
 - 12. Cancer, Leukemia, Melanoma, Hodgkin's Disease or other Lymphoma, Multiple Myeloma
 - 13. Depression, Schizophrenia, or other forms of Mental Illness
 - 14. Diabetes, Disease of the Pancreas or other glands
 - 15. Fibromyalgia, Chronic Fatigue, Lupus, Scleroderma, or other connective Tissue Disease
 - 16. Injury due to Falls or Imbalance, Fractures, Amputation or Joint Replacement
 - 17. Rheumatoid Arthritis, Osteoarthritis, Osteoporosis, Paget's Disease of the bone
 - 18. Hepatitis C, Auto Immune Disorder, Ulcerative Colitis, Crohn's Disease
- NONE OF THE ABOVE

Please give details below to all boxes checked in Question #1 of this section.

If you need more space, please attach an additional sheet of paper.

Number	Dates From/To	Physician's Name/Address/Phone	Describe
01	01/1985 to 01/2006	James Smith, Anytown, ST 12345 810-256-8956	Prescription Drug Abuse

2. In the *past 3 years*, have you had any symptoms or knowledge of any other health condition that is not disclosed above? Yes No

If "Yes", please describe.

Acid Reflux

3. In the *past 3 years*, have you:
 a. taken any prescription medications (if "Yes", please list)? Yes No

Medication	Dosage	Reason
Nexium	50 MG	Acid Reflux

- b. been confined in or advised to enter a hospital or rehabilitation facility? Yes No

If "Yes", please explain and include dates and reasons.

01/1986 Rehab Clinic for Prescription Drug Abuse

- c. consulted with or been treated for any reason by a healthcare professional OTHER THAN your Primary Care Doctor, podiatrist, dentist or allergist? Yes No

If "Yes", please provide the Healthcare Professional's name, location, specialty, reason consulted and dates.

Name	City & State	Specialty	Reason(s)	Dates
Dave Jones	Anytown, ST	Gastro Interology	Acid Reflux	01/2000

- d. been advised by a healthcare professional to have a special evaluation, testing or a surgery that has not been performed? Yes No

If "Yes", please explain type, reason and scheduled date of the evaluation, testing or surgery.

Endoscopy, Not Scheduled

- e. required assistance with shopping, using transportation, housekeeping, cooking or taking medications? Yes No

If "Yes", please explain and include dates and reasons.

Can't Drive

Section H: Applicant Profile

1. Please provide your height 6 ft 2 in (ft. & in.) and weight 250 (lbs.)
2. In the *past 3 years*, have you used any form of tobacco or nicotine product? Yes No

Date last used	Types of tobacco or nicotine products used
05/18/2009	Cigarette

3. Do you work 20 or more hours a week outside your home? Yes No
If "Yes", please list your occupation: Financial Analyst

4. Do you drive an automobile? Yes No
If "Yes", please provide approximate annual mileage: _____ miles

5. With whom do you live? alone spouse family other

6. Do you live in some form of a residential retirement community? Yes No
If "Yes", please list the specific services that you are receiving (e.g., housekeeping, laundry, meals).

Driving, Laundry

7. In the *past 3 years*, have you had any nursing home or long term care insurance application denied? Yes No
If "Yes", by which company?

MetLife

Section [F] [I]: Protection Against Unintended Lapse or Termination

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

Please check one of the following:

- I elect NOT to designate another person to receive this notice.
- I elect to designate another person to receive this notice.

Complete the information below ONLY if you elect to name an authorized person.

Jane		Doe	
Name (First)	(MI)	(Last)	(Suffix)
1234 Main Street			
Street Address		Apt #	
Anytown	ST	12345	
City	State	Zip Code	
810-235-6598			
Phone Number			

You may change the named designee at any time by notifying us in writing at the following address:
LifeSecure Administrative Office, P.O. Box 12834, Pensacola, FL 32591

Section [G] [J]: Replacement Inquiry

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage.

All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No

If "Yes", provide details:

Company Name: John Hancock

Individual or Group Policy Number: 012562356

Type of Coverage: Long Term Care

2. Did you have another long term care, nursing home, or home health care insurance policy or certificate in force during the past 12 months? Yes No

If "Yes", provide details:

Company Name: MetLife

If that policy lapsed, when did it lapse? 01/2008

3. Did you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No

If "Yes", provide details:

Company Name: MetLife

Company Address: 1245 Granger, Anytown, ST 12345

-OR-

Individual or Group Policy Number: 0152365

4. Are you currently covered by Medicaid? (not a reference to Medicare) Yes No

Section [H] [K]: Other Notices To Applicant

MEDICAL INFORMATION BUREAU

LifeSecure or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

Medical Information Bureau
P.O. Box 105, Essex Station
Boston, Massachusetts 02111
866.692.6901 (TTY 866.346.3642)

LifeSecure, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

INSURANCE INFORMATION PRACTICES

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may, in certain circumstances, be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding.

Upon your written request, LifeSecure will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write or e-mail us at:

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

info@YourLifeSecure.com

TELEPHONE INTERVIEW INFORMATION

To help process your Application as soon as possible, LifeSecure may have one of its representatives call you by telephone, at your convenience, in order to obtain additional underwriting information, or to clarify information related to your Application.

FRAUD WARNING:

For All States Not Listed Separately Below: Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

To residents of **Arizona:** Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an Application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

To the residents of **DC:** **WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.**

To residents of **Kentucky:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an Application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

To residents of **Louisiana:** 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.

To residents of **New Mexico:** 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 civil fines and criminal penalties.

To the residents of **Oklahoma:** **WARNING:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an Application containing false, incomplete, or misleading information is guilty of a felony.

Section [I] [L]: Applicant Authorizations and Signatures

Your signature, whether electronic or handwritten, represents your acknowledgement, acceptance and authorization of each statement checked below. The first four statements must be accepted before your Application can be processed. The remaining statements must be accepted before your Application can be processed *only* if you elected the optional choices referenced in those statements. Please read each statement carefully before providing your signature authorization.

- I acknowledge that I have received either printed or electronic copies of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Personal Worksheet, Potential Rate Increase Disclosure Form, and *A Shopper's Guide to Long Term Care Insurance*.
- I acknowledge that I have read the Other Notices to Applicant regarding the Medical Information Bureau, Insurance Information Practices and Telephone Interview Information, and the Fraud Warning which appear in Section [H][K] of this Application.
- I acknowledge that I have reviewed my answers and statements to all sections of this Application. I declare that all information supplied here is true and complete to the best of my knowledge.
- I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure has the right to deny benefits or rescind my policy. I agree to notify LifeSecure of any change in my medical condition while my Application is pending. I understand that LifeSecure will have no liability until a policy is issued to me and the full first premium for the issued policy has been paid. I understand that the policy will not take effect until my Application is approved by LifeSecure and there has been no change in my health that would change the answer to any questions in my Application.

CHECK ONLY THE FOLLOWING BOXES THAT APPLY TO OPTIONAL CHOICES MADE BY YOU IN OTHER SECTIONS OF THIS APPLICATION, AS SPECIFIED.

- I acknowledge my rejection of the Automatic Compound Inflation Protection options, as chosen in Section D of this Application.
- I acknowledge my rejection of the Lapse Protection Benefit option, as chosen in Section D of this Application.
- I acknowledge my decision to NOT designate another person to receive a notice of lapse or termination, as chosen in Section [F][I] of this Application.
- I acknowledge that LifeSecure is authorized to accept my premium payment withdrawals from my bank account or credit card, as chosen in Section E of this Application.
- I acknowledge that LifeSecure is authorized to accept my premium payments via automatic payroll deduction, as chosen in Section E of this Application.

CHECK THE BOX BELOW ONLY IF YOU SPECIFIED IN SECTION [G] [J] OF THIS APPLICATION THAT YOU PLAN TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

I acknowledge that I have read the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance. That particular notice was delivered to me on: 05/02/2009.

I certify that I have read, or have had read to me, the completed Application.

Caution: I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure may have the right to deny benefits or rescind my policy.

I understand that I, or my authorized representative, may request to receive a copy of this authorization.

Clicking "Accept" represents my acknowledgement, acceptance and authorization of all statements checked above.

ACCEPT DECLINE Date: 05/18/2009

I certify that I have signed the Application in: Anytown, ST
City, State

The applicant must sign the Application by voice authorization code entry or by signature via faxed Application.

Please indicate the method of signature below:

Voice Authorization Code 052365

Signature Via Faxed Application

Section [J] [M]: Applicant Authorization to Obtain and Disclose Information

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (HIPAA).

By signing this authorization form, I agree to the following:

I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, pharmacy or pharmacy benefit management (PBM) company, insurance company, consumer reporting agency, such as the Medical Information Bureau (MIB), or insurance support organization or other person or organization that has such information, to disclose the following categories of health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as HIV, AIDS or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to LifeSecure Insurance Company (LifeSecure) and any representatives performing services for LifeSecure, including its insurance support organizations, third-party administrators, affiliates, any reinsurers, and any consumer reporting agency such as the MIB.

Such disclosures may be made upon presentation of this form, or a copy of it. I recognize that such health information shall be used in connection with my Application for long term care insurance – specifically, for purposes of underwriting, servicing and claims (in OK: health information shall be used specifically for purposes of underwriting only).

I agree that this authorization will be valid for 24 months from the date signed (in AZ, 180 days). This authorization may be revoked upon submission of a written request to LifeSecure's administrative office: LifeSecure Administrative Office, 3050 Universal Blvd, Suite 150, Weston, FL 33331. Any action taken by LifeSecure (or one of its representatives) before receipt of the written notice of revocation will still be valid.

Although my signature on this form is voluntary, I understand that it is required to determine my insurability and qualification to be issued a long term care insurance policy from LifeSecure. Without my signature, I understand that my Application for long term care insurance cannot be processed. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws.

I understand that a copy of this signed authorization form will be provided to me or my authorized representative.

Clicking "Accept" represents my acknowledgement and understanding of all statements above.

ACCEPT DECLINE

Applicant's Voice Authorization Code: 052365

Date: 05/18/2009

Section [K] [N]: Agent's Report, Certification and Signature

How long have you known the applicant? _____

1. Did you personally see the applicant on the date of this application, ask each question, and accurately record the answers yourself? Yes No

If "No", please provide details in the "Remarks" section below.

2. Are you aware of any information that would adversely affect the applicant's eligibility, acceptability, or insurability? Yes No

If "Yes", please provide details in the "Remarks" section below.

3. Did you observe any physical or mental impairments with regard to walking, talking, or any form of tremor? Yes No

If "Yes", please provide details in the "Remarks" section below.

4. Please list other health insurance policies sold by you to the applicant:

N/A

5. Please list other health insurance policies sold by you to the applicant in the last five years that are no longer in force.

John Hancock Long Term Care

6. Please list all policies that the applicant has in force:

MetLife

7. Is this policy intended to replace any of the above listed policies or any other long term care, medical or health insurance? Yes No

Remarks

He is a smoker and has a bad Hand Tremor.

8 If this application is approved, the Policy Welcome Kit should be sent to the:

Policyholder

Sales Agent (Select Agent Name in Case Split Information section on next page, if applicable.)

If sent to the Policyholder, please select an address:

Policyholder Home Address

New Shipping Address:

Name (First) (MI) (Last) (Suffix)

Street Address Apt #

City State Zip Code

Phone Number

- I have truthfully and accurately recorded the information supplied to me by the applicant for completion of this Application.
- I have provided the applicant copies, either printed or electronic, of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Potential Rate Increase Disclosure Form, and *A Shopper's Guide to Long Term Care Insurance*.
- I have provided the applicant a copy of the Personal Worksheet and have explained the importance of completing the information on their Personal Worksheet.

CHECK THE BOX BELOW ONLY IF THE APPLICANT SPECIFIED IN SECTION [G] [J] OF THIS APPLICATION THAT HE/SHE PLANS TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

- I acknowledge that I have provided the applicant with the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance.

Martin _____ Long _____
Soliciting Agent's Name (First) (MI) (Last)

00000001 _____ 1256892222 _____
LifeSecure ID # Agent License #

00000123 _____ 05/18/2009 _____
Contract # Date

Case Split Information (if applicable)

Check one box for Agent to receive Welcome Kit

Agent Name Martin Long
Agent License # 1256892222
LifeSecure ID # 00000001

% Split 100
Contract #: 00000123

Agent Name _____
Agent License # _____
LifeSecure ID # _____

% Split _____
Contract #: _____

Agent Name _____
Agent License # _____
LifeSecure ID # _____

% Split _____
Contract #: _____

100%
100%

I certify that the applicant has read, or I have read to the applicant, the completed Application. The applicant realizes that any false statement or misrepresentation in the Application may result in loss of coverage under the Policy.

Clicking "Accept" represents my acknowledgement, acceptance and authorization for all statements above.

ACCEPT DECLINE



Log Out | |

Application Tools | Your Workspace |

Application

LTC Application: Section **A B C D E F G H I J K L M N**

Next

Saved Application

Section A: Personal Health History

Quote Calculator

1. Within the *past 12 months*, have you resided in or been advised by a healthcare professional to enter a Nursing Home, Assisted Living Facility or any other type of Long Term Care Facility? Or, within the *past 12 months*, have you used or been advised by a healthcare professional to use Home Health Care or Adult Day Care services? Yes No

Resource Center

2. Do you *currently* use any of the following: Yes No

- Walker
- Wheelchair
- Quad Cane
- Motorized scooter
- Hospital bed
- Oxygen equipment
- Dialysis

3. Do you *currently* require human assistance in order to perform any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? Yes No

4. Do you have or have you ever been diagnosed or treated by a health care professional as having any of the following: Yes No

- Amyotrophic Lateral Sclerosis (ALS, also called Lou Gehrig's Disease)
- Systemic Lupus Disease
- Alzheimer's Disease
- Dementia/Senility
- Mental Retardation
- Psychosis
- Stroke (CVA) within past 5 years
- Multiple Sclerosis (MS)
- Muscular Dystrophy
- Parkinson's Disease
- Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test
- Metastatic Cancer
- Type I (Juvenile) Diabetes
- Diabetes – treated/controlled with insulin for greater than 15 years or currently treated/controlled with greater than 49 units of insulin per day
- A Transient Ischemic Attack (TIA) within past 2 years, *or* multiple TIAs within past 5 years
- Chronic Kidney/Renal Disease
- Huntington's Chorea
- Cirrhosis of the Liver
- Organ Transplant
- Amputation due to Disease (not accident)

5. Are you *currently* receiving Social Security Disability benefits? Yes No

Reset Next

LS-0204 ST 09/09



Log Out | |

Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

LTC Application: Section A **B** C D E F G H I J K L M N

Next

Section B: Applicant Information

Employer/Group Name: ABC COMPANY

Group Number: 00001

Check ONLY one box below:

I, the applicant, am:

an **employee** who regularly works [15] [20] [25] [30] or more hours per week for the employer named above. I am actively-at-work, which means I was working at my usual place of employment on the last regularly scheduled workday before I completed this application.

My date of hire was: 01/01/2005
month/year

a **spouse or domestic partner** of an eligible employee of the employer named above.

His/her date of hire was:
month/year

a **family member** of an eligible employee, or a **retiree/spouse**, or a **part-time employee/spouse** (who regularly works less than [15] [20] [25] [30] hours per week), of the employer named above.

Mr. Mrs. Ms. Dr.

JOHN (First) (MI) DOE (Last) (Suffix)

1234 Main Street
Street Address

Apt. #

Anywhere City ST State 12345 Zip Code

01 / 01 / 1954 Date of Birth (mm/dd/yyyy) 123 - 56 - 7756 Social Security # OR Tax Identification #

Gender: Male Female

Marital Status: Single Married Domestic Partner

810 - 659 - 2356
Work Phone Number

810 - 235 - 6598
Home Phone Number

Best Time to Call: 9 a.m. 5 p.m.

Best Place to Call: Work Home

JOHND@YAHOO.COM
E-mail Address

Employee Number (if applicable)

Reset Next

LS-0204 ST 09/09



Log Out | |

Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

LTC Application: Section A B C **D** E F G H I J K L M N

Next

Section D: Coverage Selections

BENEFIT BANK:

Enter a dollar amount between \$75,000 and \$1,000,000

MONTHLY BENEFIT ACCESS LIMIT:

- 1% of Benefit Bank
- 2% of Benefit Bank
- 3% of Benefit Bank*

* 3% choice not available for Benefit Bank amounts greater than \$500,000.

Your initial Monthly Benefit Access Limit dollar amount: \$ Benefit Bank X % = Monthly Benefit

MONEY-BACK PROMISE OPTION:

- Yes, I elect to have the Money-Back Promise Option as part of my coverage.

This optional benefit provides for a refund of a percentage of premiums (less benefits paid) to a beneficiary of your choice if you should die while holding your policy for 5 or more years.

Please enter the name of a primary and a contingent beneficiary who should receive such a refund, if any. Please Note: If no beneficiary is named, any applicable refund (if any) will be made to your estate.

Primary Beneficiary

Check here if this is your Spouse or Domestic Partner

- Mr.
- Mrs.
- Ms.
- Dr.

Name (First) (MI) (Last) (Suffix)

Relationship

Street Address

City State Zip Code

Contingent Beneficiary

Check here if this is your Spouse or Domestic Partner

- Mr.
- Mrs.
- Ms.
- Dr.

Name (First) (MI) (Last) (Suffix)

Relationship

Street Address

City State Zip Code

- No. I reject the Money-Back Promise Option as part of my coverage.

OPTIONAL AUTOMATIC INFLATION PROTECTION: I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of the policy with and without automatic inflation protection. Specifically, I have reviewed options for 5% and 3% Automatic Compound Inflation Protection. My choice is as follows:

- I reject the Automatic Compound Inflation Protection options; however, I understand that my coverage will include the Guaranteed Future Purchase Offers feature.
- I elect Automatic 5% Compound Inflation Protection.
- I elect Automatic 3% Compound Inflation Protection.

LS-0204 ST 09/09



[Log Out](#) | |

[Application Tools](#) | [Your Workspace](#) |

[Application](#)

[Saved Application](#)

[Quote Calculator](#)

[Resource Center](#)

OPTIONAL LAPSE PROTECTION BENEFIT:

- Yes. I elect to have the Lapse Protection Benefit as part of my coverage.
- No. I have reviewed the Outline of Coverage and compared the benefits and premiums of the policy with and without Lapse Protection benefits and I reject the Lapse Protection Benefit.

Premium Payment Options:

Total Monthly Premium[**]: \$

[** If the employer stops contributing to your long term care insurance coverage for any reason in the future, the Total Monthly Premium represents the full amount of monthly premium that is required to keep your policy in force.]

[Save](#) [Reset](#) [Previous](#) [Next](#)

LS-0204 ST 09/09



Log Out | |

Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

LTC Application: Section A B C D **E** F G H I J K L M N

Next

Section E: Premium Payment Authorization

Complete this section to authorize your preferred premium payment method.

AUTOMATIC PAYROLL DEDUCTION

By electing this payment method, I authorize my employer to deduct my long term care insurance premiums automatically from my payroll.

Payroll System/Division: _____

Payroll Location: _____

Payroll Frequency: _____

Employee Number: _____

DIRECT BILLING (MAIL)

Select billing frequency:

annually semi-annually quarterly monthly (\$2.00 monthly fee applicable)

MONTHLY ELECTRONIC FUNDS TRANSFER

How Monthly Electronic Funds Transfer Works: Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. LifeSecure Insurance Company will collect the long term care insurance premiums from your bank account electronically. You do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Monthly Electronic Funds Transfer Agreement:

I authorize LifeSecure to electronically withdraw money from my account for the payment of premiums for this insurance policy. I authorize LifeSecure to continue to make these withdrawals if there is a renewal, or other change in the policy. I will compensate LifeSecure for any loss, claim, or liability caused by these withdrawals and will not hold LifeSecure responsible for any such loss, claim, or liability. This authorization will not affect the terms of the policy. Authorizing this automatic payment plan does not put the insurance policy into effect. This authorization may be retracted by me or LifeSecure at any time for any reason by giving written notice. LifeSecure may retract the authorization immediately, without giving me written Notice, if any debt is not paid by the bank stated below, for any reason.

Name of Bank: _____

Bank Address: _____

Telephone #: _____ - _____ - _____

Account Type: checking savings

Account #: _____

Routing #: _____

AUTOMATIC CREDIT CARD PAYMENT

Select Card Type: [Visa] [MasterCard] [American Express] [Discover Card]

Credit Card #: _____ (do not enter dashes or spaces)

Name as it appears on Card: _____

Expiration Date: _____ / _____

Save Reset Previous Next

LS-0204 ST 09/09



Log Out | |

Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

LTC Application: Section A B C D E **F** G H I J K L M N

Next

Section F: Personal Physician Information

Please provide the following information about your personal physician, sometimes called your Primary Care Doctor (i.e., the physician with most of your medical records).

JAMES (First) (MI) SMITH (Last) (Suffix)

5689 1ST STREET
Street Address

500
Suite #

ANYTOWN (City) ST (State) 12345 (Zip Code)

810 - 256 - 8956
Office Phone Number

Have you seen this physician in the last two years? Yes No

Date of last visit: 01 / 09
month year

Reason for visit: ANNUAL PHYSICAL

LS-0204 ST 09/09



[Log Out](#) | |

[Application Tools](#) | [Your Workspace](#) |

[Application](#)

[Saved Application](#)

[Quote Calculator](#)

[Resource Center](#)

LTC Application: Section A B C D E F G H I J K L M N

[Next](#)

Section G: Medical History (Part 1)

1. In the *past 3 years*, have you received medical advice or treatment, been diagnosed by or consulted with a healthcare professional for any of the following conditions (check all that apply or NONE OF THE ABOVE).

- 1. Drug or Alcohol Abuse
- 2. Disorders of Vision or Speech
- 3. Hypertension/High Blood Pressure, Chest Pain, Angina, Coronary Artery Disease
- 4. Heart Attack, Angioplasty or Heart Surgery
- 5. Transient Ischemic Attack (TIA), Carotid Artery Disease or Surgery
- 6. Congestive Heart Failure (CHF), Atrial Fibrillation, Pacemaker
- 7. Aneurysm, Peripheral Vascular Disease (PVD)
- 8. Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Asthma, Chronic Bronchitis
- 9. Fainting Spells or Blacking Out, Seizures, Epilepsy
- 10. Tremor, Myasthenia Gravis
- 11. Paralysis (partial or full), Post Polio Syndrome
- 12. Cancer, Leukemia, Melanoma, Hodgkin's Disease or other Lymphoma, Multiple Myeloma
- 13. Depression, Schizophrenia, or other forms of Psychosis or Mental Illness
- 14. Diabetes, Disease of the Pancreas or other glands
- 15. Fibromyalgia, Chronic Fatigue, Lupus, Scleroderma, or other connective Tissue Disease
- 16. Injury due to Falls or Imbalance, Fractures, Amputation or Joint Replacement
- 17. Rheumatoid Arthritis, Osteoarthritis, Osteoporosis, Paget's Disease of the bone
- 18. Hepatitis C, Auto Immune Disorder, Ulcerative Colitis, Crohn's Disease

- NONE OF THE ABOVE

[Save](#) [Reset](#) [Previous](#) [Next](#)

LS-0204 ST 09/09



Log Out | |

Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

LTC Application: Section A B C D E F **G** H I J K L M N

Next

Section G: Medical History (Part 2)

Please give details below to all boxes checked in Question #1 of this section.

1. Drug or Alcohol Abuse

Dates of Condition	Physician's Name/Address/Phone	Description
From: <input type="text" value="01/1985"/> To: <input type="checkbox"/> Present Or <input type="text" value="1/2006"/>	<input checked="" type="checkbox"/> Same as Primary Care Doctor (Section F) name: <input type="text" value="JOHN SMITH"/> address: <input type="text" value="5689 1ST STREET SUITE 500"/> <input type="text"/> city/st/zip: <input type="text" value="ANYTOWN"/> <input type="text" value="ST"/> <input type="text" value="12345"/> phone: <input type="text" value="810"/> - <input type="text" value="256"/> - <input type="text" value="8956"/>	<input type="text" value="PRESCRIPTION DRUG ABUSE"/>

Save Reset Previous Next

LS-0204 ST 09/09



Log Out | |

Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

LTC Application: Section A B C D E F **G** H I J K L M N

Next

Section G: Medical History (Part 3)

2. In the *past 3 years*, have you had any symptoms or knowledge of any other health condition that is not disclosed above? Yes No

Please describe:

ACID REFLUX

3. In the *past 3 years*, have you:
a. taken any prescription medications? (if yes, please list) Yes No

	Medication	Dosage	Reason	
X	NEXIUM	50 MG	ACID REFLUX	
X				

NEXIUM	50 MG	ACID REFLUX
--------	-------	-------------

Add

b. been confined in or advised to enter a hospital or rehabilitation facility? Yes No

Please explain and include dates and reasons:

01/1986 REHAB CLINIC FOR PRESCRIPTION DRUG ABUSE

c. consulted with or been treated for any reason by a healthcare professional OTHER THAN your Primary Care Doctor, podiatrist, dentist or allergist? If Yes, please provide the Healthcare Professional's name, location, specialty, reason consulted and dates. Yes No

	Name/Location/Specialty	Reason Consulted	Dates	
X	DAVE JONES/ANYTOWN, ST/ GATSTRO INTEROLOGIST	ACID REFLUX	01/2000	
X				

--	--	--

Add

d. been advised by a healthcare professional to have a special evaluation, testing or a surgery that has not been performed? Yes No

Please explain type, reason and scheduled date of the evaluation, testing or surgery:

e. required assistance with shopping, using transportation, housekeeping, cooking or taking medications? Yes No

Please explain and include dates and reasons:

Save Reset Previous Next

LS-0204 ST 09/09



Log Out | |

Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

LTC Application: Section A B C D E F G **H** I J K L M N

Next

Section H: Applicant Profile

1. Please provide your height ft. in., and weight lbs.

2. In the *past 3 years*, have you used any form of tobacco or nicotine product? Yes No

	Date Last Used	Types of Tobacco or Nicotine Products Used	
<input checked="" type="checkbox"/>	5/18/2009	cigarettes	
<input checked="" type="checkbox"/>			

<input type="text" value="12/12/2005"/>	<input type="text" value="cigarettes"/>
---	---

Add

3. Do you work 20 or more hours a week outside your home? Yes No

Please list your occupation:

4. Do you drive an automobile? Yes No

Please provide approximate annual mileage: miles

5. With whom do you live? alone spouse family other

6. Do you live in some form of a residential retirement community? Yes No

Please list the specific services that you are receiving (e.g., housekeeping, laundry, meals):

<input type="text" value="Driving, Laundry"/>

7. In the *past 3 years*, have you had any nursing home or long term care insurance application denied? Yes No

By which company?

<input type="text" value="MetLife"/>

Save Reset Previous Next

LS-0204 ST 09/09



Log Out | |

Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

LTC Application: Section A B C D E F G H **I** J K L M N

Next

Section [F] [I]: Protection Against Unintended Lapse or Termination

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

Please check one of the following:

- I elect NOT to designate another person to receive this Notice.
- I elect to designate another person to receive this Notice.

Complete the information below ONLY if you elect to name an authorized person.

<input type="text" value="JANE"/>	<input type="text"/>	<input type="text" value="DOE"/>	<input type="text"/>
Name (First)	(MI)	(Last)	(Suffix)

Street Address

Apt. #

<input type="text" value="ANYTOWN"/>	<input type="text" value="ST"/>	<input checked="" type="checkbox"/>	<input type="text" value="12345"/>
City	State		Zip Code

<input type="text" value="810"/>	-	<input type="text" value="235"/>	-	<input type="text" value="3598"/>
Phone Number				

You may change the named designee at any time by notifying us in writing at the following address: LifeSecure Administrative Office, P.O. Box 12834, Pensacola, FL 32591

Save Reset Previous Next

LS-0204 ST 09/09



Log Out | |

Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

LTC Application: Section A B C D E F G H I **J** K L M N

Next

Section [G] [J]: Replacement Inquiry

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

- 1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No

Please provide the following details:

Company Name:

Individual or Group Policy Number:

Type of Coverage:

- 2. Did you have another long term care, nursing home, or home health care insurance policy or certificate in force during the past 12 months? Yes No

Company Name?

If that policy lapsed, when did it lapse?

- 3. Did you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No

If "Yes", provide details:

Company Name:

Company Address:

-OR-

Individual or Group Policy Number:

- 4. Are you currently covered by Medicaid? (not a reference to Medicare) Yes No

Save Reset Previous Next

LS-0204 ST 09/09



[Log Out](#) | |

[Application Tools](#) | [Your Workspace](#) |

[Application](#)

[Saved Application](#)

[Quote Calculator](#)

[Resource Center](#)

LTC Application: Section A B C D E F G H I J K L M N

[Next](#)

Section [H] [K]: Other Notices to Applicant

MEDICAL INFORMATION BUREAU

LifeSecure or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

Medical Information Bureau
P.O. Box 105, Essex Station
Boston, Massachusetts 02111
866.692.6901 (TTY 866.346.3642)

LifeSecure, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

INSURANCE INFORMATION PRACTICES

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may, in certain circumstances, be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding.

Upon your written request, LifeSecure will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write or e-mail us at:

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

info@YourLifeSecure.com

TELEPHONE INTERVIEW INFORMATION

To help process your Application as soon as possible, LifeSecure may have one of its representatives call you by telephone, at your convenience, in order to obtain additional underwriting information, or to clarify information related to your Application.

FRAUD WARNING:

For All States Not Listed Separately Below: Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

To residents of **Arizona:** Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

To the residents of **DC: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.**

To residents of **Kentucky:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

To residents of **Louisiana:** 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.

LS-0204 ST 09/09



[Log Out](#) | |

[Application Tools](#) | [Your Workspace](#) |

[Application](#)

[Saved Application](#)

[Quote Calculator](#)

[Resource Center](#)

To residents of **New Mexico**: 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 civil fines and criminal penalties.

To the residents of **Oklahoma**: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony.

LS-0204 ST 09/09

[Save](#) [Reset](#) [Previous](#) [Next](#)



Log Out | |

Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

LTC Application: Section A B C D E F G H I J K L M N

Next

Section [I] [L]: Applicant Authorizations and Signatures

Your signature, whether electronic or handwritten, represents your acknowledgement, acceptance and authorization of each statement checked below. The first four statements must be accepted before your Application can be processed. The remaining statements must be accepted before your Application can be processed *only* if you elected the optional choices referenced in those statements. Please read each statement carefully before providing your signature authorization.

- I acknowledge that I have received either printed or electronic copies of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Personal Worksheet, Potential Rate Increase Disclosure Form, and *A Shopper's Guide to Long Term Care Insurance*.
- I acknowledge that I have read the Other Notices to Applicant regarding the Medical Information Bureau, Insurance Information Practices and Telephone Interview Information, and the Fraud Notice which appear in Section [H] [K] of this Application.
- I acknowledge that I have reviewed my answers and statements to all sections of this Application. I declare that all information supplied here is true and complete to the best of my knowledge.
- I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure has the right to deny benefits or rescind my policy. I agree to notify LifeSecure of any change in my medical condition while my Application is pending. I understand that LifeSecure will have no liability until a policy is issued to me and the full first premium for the issued policy has been paid. I understand that the policy will not take effect until my Application is approved by LifeSecure and there has been no change in my health that would change the answer to any questions in my Application.

CHECK ONLY THE FOLLOWING BOXES THAT APPLY TO OPTIONAL CHOICES MADE BY YOU IN OTHER SECTIONS OF THIS APPLICATION, AS SPECIFIED.

- I acknowledge my rejection of the Automatic Compound Inflation Protection options, as chosen in Section D of this Application.
- I acknowledge my rejection of the Lapse Protection Benefit option, as chosen in Section D of this Application.
- I acknowledge my decision to NOT designate another person to receive a notice of lapse or termination, as chosen in Section [F] [I] of this Application.
- I acknowledge that LifeSecure is authorized to accept my premium payment withdrawals from my bank account or credit card, as chosen in Section E of this Application.
- I acknowledge that LifeSecure is authorized to accept my premium payments via automatic payroll deduction, as chosen in Section E of this Application.

CHECK THE BOX BELOW ONLY IF YOU SPECIFIED IN SECTION [G] [J] OF THIS APPLICATION THAT YOU PLAN TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

- I acknowledge that I have read the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance.
That particular notice was delivered to me on: / /

I certify that I have read, or have had read to me, the completed Application.

Caution: I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure may have the right to deny benefits or rescind my policy.

I understand that I, or my authorized representative, may request to receive a copy of this authorization.

Clicking "Accept" represents my acknowledgement, acceptance and authorization of all statements checked above.

ACCEPT **DECLINE** Date: / /

I certify that I have signed the Application in

The applicant must sign the Application by voice authorization code entry or by signature via faxed Application. Please indicate the method of signature below:

- Voice Authorization Code
- Signature Via Faxed Application

Save Reset Previous Next

LS-0204 ST 09/09



Log Out | |

Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

LTC Application: Section A B C D E F G H I J K L **M** N

Next

Section [J] [M]: Applicant Authorization to Obtain and Disclose Information

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (HIPAA).

By signing this authorization form, I agree to the following:

I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, pharmacy or pharmacy benefit management (PBM) company, insurance company, consumer reporting agency, such as the Medical Information Bureau (MIB), or insurance support organization or other person or organization that has such information, to disclose the following categories of health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as HIV, AIDS or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to LifeSecure Insurance Company (LifeSecure) and any representatives performing services for LifeSecure, including its insurance support organizations, third-party administrators, affiliates, any reinsurers, and any consumer reporting agency such as the MIB.

Such disclosures may be made upon presentation of this form, or a copy of it. I recognize that such health information shall be used in connection with my Application for Long Term Care Insurance from LifeSecure – specifically, for purposes of underwriting, servicing and claims (**in OK**: health information shall be used specifically for purposes of underwriting only).

I agree that this authorization will be valid for 24 months from the date signed (**in AZ**, 180 days). This authorization may be revoked upon submission of a written request to LifeSecure's administrative office: LifeSecure Administrative Office, 3050 Universal Blvd, Suite 150, Weston, FL 33331. Any action taken by LifeSecure (or one of its representatives) before receipt of the written notice of revocation will still be valid.

Although my signature on this form is voluntary, I understand that it is required to determine my insurability and qualification to be issued a long term care insurance policy from LifeSecure. Without my signature, I understand that my Application for Long Term Care Insurance cannot be processed. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws.

I understand that a copy of this signed authorization form will be provided to me or my authorized representative.

Clicking "Accept" represents my acknowledgement and understanding of all statements above.

ACCEPT **DECLINE**

Applicant's Voice Authorization Code:

Date: / /

[Save](#) [Reset](#) [Previous](#) [Next](#)

LS-0204 ST 09/09



Log Out | |

Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

LTC Application: Section A B C D E F G H I J K L M **N**

Next

Section [K] [N]: Agent's Report, Certification and Signature

How long have you known the applicant? 6Y

Statements

- 1. Did you personally see the applicant on the date of this Application, ask each question, and accurately record the answers yourself? Yes No
If "No", please provide details in the "Remarks" section below.
- 2. Are you aware of any information that would adversely affect the applicant's eligibility, acceptability, or insurability? Yes No
If "Yes", please provide details in the "Remarks" section below.
- 3. Did you observe any physical or mental impairments with regard to walking, talking, or any form of tremor? Yes No
If "Yes", please provide details in the "Remarks" section below.

4. Please list other health insurance policies sold by you to the applicant:

N/A

5. Please list other health insurance policies sold by you to the applicant in the last five years that are no longer in force.

JOHN HANDCOCK LONG TERM CARE

6. Please list all policies that the applicant has in force:

METLIFE

7. Is this policy intended to replace any of the above listed policies or any other long term care, medical or health insurance? Yes No

Remarks

HIS IS A SMOKER AND HAS A BAD HAND TREMOR

8. If this Application is approved, the Policy Welcome Kit should be sent to the: Policyholder Sales Agent (Select Agent Name in Case Split Information section below.)

If sent to the policyholder, please select an address:

Policyholder Home Address New Shipping Address

Name (First) (MI) (Last) (Suffix)

Street Address Apt. #

City State Zip Code

Phone Number

LS-0204 ST 09/09



Log Out | |

Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

- I have truthfully and accurately recorded the information supplied to me by the applicant for completion of this Application.
- I have provided the applicant copies, either printed or electronic, of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Potential Rate Increase Disclosure Form, and *A Shopper's Guide to Long Term Care Insurance*.
- I have provided the applicant a copy of the Personal Worksheet and have explained the importance of completing the information on their Personal Worksheet.

CHECK THE BOX BELOW ONLY IF THE APPLICANT SPECIFIED IN SECTION [G] [J] OF THIS APPLICATION THAT HE/SHE PLANS TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

- I acknowledge that I have provided the applicant with the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance.

<input type="text" value="MARTIN LONG"/>	<input type="text" value="0000001"/>	<input type="text" value="1256892222"/>
Soliciting Agent's Name	LifeSecure ID#	Agent License #
<input type="text" value="05"/> / <input type="text" value="18"/> / <input type="text" value="2009"/>	<input type="text" value="1256892222"/> <input checked="" type="checkbox"/>	
Date	Contract Number	

Case Split Information (if applicable)

Check one box for Agent to receive Welcome Kit

	LifeSecure ID#	Agent Name	Agent License #	Contract#	% Split
<input checked="" type="radio"/>	<input type="text" value="0000001"/>	<input type="text" value="MARTIN LONG"/>	<input type="text" value="1256892222"/> <input checked="" type="checkbox"/>	<input type="text" value="125"/> <input checked="" type="checkbox"/>	<input type="text" value="100"/>
<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/>
<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/>
<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/>
<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/>
<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/>
<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/>
<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/>
<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/>
<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/>
<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text"/>
Total:					100%

I certify that the applicant has read, or I have read to the applicant, the completed Application. The applicant realizes that any false statement or misrepresentation in the Application may result in loss of coverage under the Policy.

Clicking "Accept" represents my acknowledgement, acceptance and authorization for all statements above. **ACCEPT** **DECLINE**

[Save](#) [Reset](#) [Previous](#) [Next](#)

LS-0204 ST 09/09



[Log Out](#) | |

[Application Tools](#) | [Your Workspace](#) |

[Application](#)

[Saved Application](#)

[Quote Calculator](#)

[Resource Center](#)

LTC Application: Section [A](#) [B](#) [C](#) [D](#) [E](#) [F](#) [G](#) [H](#) [I](#) [J](#) [K](#) [L](#) [M](#) [N](#)

[Next](#)

Live Chat Session

Once you have submitted this on-line Application, you may initiate a Live Chat session to engage an underwriter to evaluate the Application responses and approve the Application, if possible. However, if a face-to-face interview, phone history interview or request for medical records is required, please inform the applicant that it may take additional business days to fully evaluate the Application and provide a final decision. (Note: Such additional requirements are not applicable to applicants who qualify for Simplified Issue Underwriting.)

Coverage Summary

Premium Plan: **[Lifetime Payment Option]**
[10-Year Payment Option]
[To-Age-65 Option]

<u>Benefit Bank Amount</u>	[\$75,000 - \$1,000,0000]
<u>Monthly Benefit Access Limit</u>	[\$XX,XXX] [(1%)] [(2%)] [(3%)]
<u>Monthly Premium</u>	[\$XXX.XX]
<u>Benefit Wait Period</u>	[90] calendar days
<u>Other Benefits Included</u>	

[Previous](#)

[Submit Completed Application](#)

LS-0204 ST 09/09

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 coverage.

PREMIUM INFORMATION

Policy Form Series: LS-0002

The Premium for the coverage you are considering will be \$ _____ per month, or
\$ _____ per year.

Type of Policy: **Guaranteed Renewable – Individual Long Term Care Insurance**

THE COMPANY'S RIGHT TO INCREASE PREMIUMS

LifeSecure Insurance Company has the right to increase premiums on this policy form in the future, provided it raises premiums for all policies in the same class in this state.

RATE INCREASE HISTORY

LifeSecure Insurance Company has sold long term care insurance since 2006 and has sold this policy since 2007. LifeSecure Insurance 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 coverage if the premiums went up, for example, by 20%?

What is your annual income? (Check one)

- Under \$10,000 \$10,000 – \$20,000 \$20,000 – \$30,000 \$30,000 – \$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 coverage if the premiums will be more than 7% of your income.

Will you buy inflation protection? (Check one) Yes No

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

- From my income From my savings/investments My family will pay

The national average annual cost of nursing home care in [2008] was [\$74,210] for a private room, but this figure varies across the country. In ten years the national average annual costs would be about [\$120,880] if costs increase 5% annually.

What elimination period (also referred to as Benefit Wait Period) are you considering?

Number of days: _____ Approximate cost of \$ _____ 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 your assets (your savings and investments) worth? (Check one)

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

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

- Stay about the same Increase Decrease

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

DISCLOSURE STATEMENT (Check one)

- The answers to the questions above describe my financial situation.
- I choose not to complete the questions related to my financial situation. I acknowledge that I **should read the National Association of Insurance Commissioners' (NAIC) A Shopper's Guide to Long Term Care Insurance.** I also understand that the policy has a 30-day Free Look provision which allows me to return my policy for a full refund of premium for any reason within that period of time. Finally, I understand that this policy may not be suitable for me; however, after careful consideration, I am requesting the Company to consider my Application and issue my long term care insurance policy if I meet their underwriting guidelines.
-

- I (**Applicant**) acknowledge that the carrier 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 needs to be checked).
- I (**Agent**) explained to the applicant the importance of completing this information.
- My agent has advised me that this policy does not seem to be suitable for me. However, I still want LifeSecure to consider my Application.

Clicking "Accept" represents my acknowledgement and understanding for all statements above.

- ACCEPT DECLINE

LifeSecure Insurance Company may contact you to verify your answers.



Log Out | |

Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

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 coverage.

PREMIUM INFORMATION

Policy Form Series: **LS-0002**

The Premium for the coverage you are considering will be \$ per month, or \$ per year.

Type of Policy: **Guaranteed Renewable – Individual Long Term Care Insurance**

THE COMPANY'S RIGHT TO INCREASE PREMIUMS

LifeSecure Insurance Company has the right to increase premiums on this policy form in the future, provided it raises premiums for all policies in the same class in this state.

RATE INCREASE HISTORY

LifeSecure Insurance Company has sold long term care insurance since 2006 and has sold this policy since 2007. LifeSecure Insurance 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 coverage if the premiums went up, for example, by 20%?

What is your annual income? (Check one)

Under \$10,000 \$10,000 – \$20,000 \$20,000 – \$30,000 \$30,000 – \$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 coverage if the premiums will be more than 7% of your income.

Will you buy inflation protection? (Check one) Yes No

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

From my income From my savings/investments My family will pay

The national average annual cost of nursing home care in [2008] was [\$74,210] for a private room, but this figure varies across the country. In ten years the national average annual cost would be about [\$120,880] if costs increase 5% annually.

What elimination period (also referred to as Benefit Wait 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

LS-0100E ST 09/09



Log Out | |

Application Tools | Your Workspace |

Application

Saved Application

Quote Calculator

Resource Center

QUESTIONS RELATED TO YOUR SAVINGS AND INVESTMENTS

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

(Check one)

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

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

- Stay about the same Increase Decrease

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

DISCLOSURE STATEMENT (Check one)

- The answers to the questions above describe my financial situation.
- I choose not to complete the questions related to my financial situation. I acknowledge that I should read the National Association of Insurance Commissioners' (NAIC) *A Shopper's Guide to Long Term Care Insurance*. I also understand that the policy has a 30-day Free Look provision which allows me to return my policy for a full refund of premium for any reason within that period of time. Finally, I understand that this policy may not be suitable for me; however, after careful consideration, I am requesting the Company to consider my Application and issue my long term care insurance policy if I meet their underwriting guidelines.

- I (**Applicant**) acknowledge that the carrier 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.**
- I (**Agent**) explained to the applicant the importance of completing this information.
- My agent has advised me that this policy does not seem to be suitable for me. However, I still want LifeSecure to consider my Application.

Clicking "Accept" represents my acknowledgement and understanding for all statements above.

- ACCEPT** **DECLINE**

LifeSecure Insurance Company may contact you to verify your answers.

Print this Worksheet

Save

Reset

Previous

Next

LS-0100E ST 09/09

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 coverage.

PREMIUM INFORMATION

Policy Form Series: LS-0002

The Premium for the coverage you are considering will be \$ _____ per month, or
\$ _____ per year.

Type of Policy: **Guaranteed Renewable – Individual Long Term Care Insurance**

THE COMPANY'S RIGHT TO INCREASE PREMIUMS

LifeSecure Insurance Company has the right to increase premiums on this policy form in the future, provided it raises premiums for all policies in the same class in this state.

RATE INCREASE HISTORY

LifeSecure Insurance Company has sold long term care insurance since 2006 and has sold this policy since 2007. LifeSecure Insurance 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 coverage if the premiums went up, for example, by 20%?

What is your annual income? (Check one)

- Under \$10,000 \$10,000 – \$20,000 \$20,000 – \$30,000 \$30,000 – \$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 coverage if the premiums will be more than 7% of your income.

Will you buy inflation protection? (Check one) Yes No

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

- From my income From my savings/investments My family will pay

The national average annual cost of nursing home care in [2008] was [\$74,210] for a private room, but this figure varies across the country. In ten years the national average annual costs would be about [\$120,880] if costs increase 5% annually.

What elimination period (also referred to as Benefit Wait Period) are you considering?

Number of days: _____ Approximate cost of \$ _____ 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 your assets (your savings and investments) worth? (Check one)

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

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

- Stay about the same Increase Decrease

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

DISCLOSURE STATEMENT (Check one)

- The answers to the questions above describe my financial situation.
- I choose not to complete the questions related to my financial situation. I acknowledge that I should read the National Association of Insurance Commissioners' (NAIC) *A Shopper's Guide to Long Term Care Insurance*. I also understand that the policy has a 30-day Free Look provision which allows me to return my policy for a full refund of premium for any reason within that period of time. Finally, I understand that this policy may not be suitable for me; however, after careful consideration, I am requesting the Company to consider my Application and issue my long term care insurance policy if I meet their underwriting guidelines.
-
- I (Applicant) acknowledge that I have reviewed this form 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.)

Clicking "Accept" represents my acknowledgement and understanding for all statements above.

- ACCEPT DECLINE

LifeSecure Insurance Company may contact you to verify your answers.

Application

Application Status

About LifeSecure

About Long Term Care

About Our Product

Quote Calculator

Resource Center

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 coverage.

PREMIUM INFORMATION

Policy Form Series: **LS-0002**

The Premium for the coverage you are considering will be \$ per month, or \$ per year.

Type of Policy: **Guaranteed Renewable – Individual Long Term Care Insurance**

THE COMPANY'S RIGHT TO INCREASE PREMIUMS

LifeSecure Insurance Company has the right to increase premiums on this policy form in the future, provided it raises premiums for all policies in the same class in this state.

RATE INCREASE HISTORY

LifeSecure Insurance Company has sold long term care insurance since 2006 and has sold this policy since 2007. LifeSecure Insurance 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 coverage if the premiums went up, for example, by 20%?

What is your annual income? (Check one)

Under \$10,000 \$10,000 – \$20,000 \$20,000 – \$30,000 \$30,000 – \$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 coverage if the premiums will be more than 7% of your income.

Will you buy inflation protection? (Check one) Yes No

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

From my income From my savings/investments My family will pay

The national average annual cost of nursing home care in [2008] was [\$74,210] for a private room, but this figure varies across the country. In ten years the national average annual cost would be about [\$120,880] if costs increase 5% annually.

What elimination period (also referred to as Benefit Wait Period) are you considering?

Number of days: Approximate cost \$ for that period of care.

LS-0100 ST 09/09

- [Application](#)

- [Application Status](#)

- [About LifeSecure](#)

- [About Long Term Care](#)

- [About Our Product](#)

- [Quote Calculator](#)

- [Resource Center](#)

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 your assets (your savings and investments) worth?
(Check one)

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

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

Stay about the same Increase Decrease

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

DISCLOSURE STATEMENT (Check one)

- The answers to the questions above describe my financial situation.
- I choose not to complete the questions related to my financial situation. I acknowledge that I should read the National Association of Insurance Commissioners' (NAIC) *A Shopper's Guide to Long Term Care Insurance*. I also understand that the policy has a 30-day Free Look provision which allows me to return my policy for a full refund of premium for any reason within that period of time. Finally, I understand that this policy may not be suitable for me; however, after careful consideration, I am requesting the Company to consider my Application and issue my long term care insurance policy if I meet their underwriting guidelines.

I (**Applicant**) acknowledge that I have reviewed this form 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.)

Clicking "Accept" represents my acknowledgement and understanding for all statements above.

ACCEPT **DECLINE**

LifeSecure Insurance Company may contact you to verify your answers.

	Print this Worksheet	Save	Reset	Previous	Next
--	--------------------------------------	----------------------	-----------------------	--------------------------	----------------------

LS-0100 ST 09/09

SERFF Tracking Number: LFSC-126386205 State: Arkansas
 Filing Company: LifeSecure Insurance Company State Tracking Number: 44127
 Company Tracking Number:
 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
 Product Name: Multi-Life Application Filing - 09/09 Version
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Flesch Certification Bypass Reason: N/A - Application Only - LTC Comments:		
Satisfied - Item: Application Comments: Application attached to form schedule tab		
Bypassed - Item: Health - Actuarial Justification Bypass Reason: No change from previous approved rates Comments:		
Bypassed - Item: Outline of Coverage Bypass Reason: Using formally approved long term care outline of coverage Comments:		