

SERFF Tracking Number: LFSC-126944562 State: Arkansas  
Filing Company: LifeSecure Insurance Company State Tracking Number: 47528  
Company Tracking Number: APP-LS-0204A ST 08/09  
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified  
Product Name: LTC Applications  
Project Name/Number: E-Sig/

## Filing at a Glance

Company: LifeSecure Insurance Company

Product Name: LTC Applications

TOI: LTC03I Individual Long Term Care

Sub-TOI: LTC03I.001 Qualified

Filing Type: Form

SERFF Tr Num: LFSC-126944562 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 47528

Co Tr Num: APP-LS-0204A ST State Status: Approved-Closed  
08/09

Reviewer(s): Harris Shearer,  
Stephanie Fowler

Authors: Sue Howard, Judy Lucas, Disposition Date: 01/13/2011  
Karilynn Bagnell

Date Submitted: 12/14/2010 Disposition Status: Approved-  
Closed

Implementation Date Requested:

State Filing Description:

Implementation Date:

## General Information

Project Name: E-Sig

Project Number:

Requested Filing Mode: File & Use

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Sue Howard

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 01/13/2011

State Status Changed: 01/13/2011

Created By: Sue Howard

Corresponding Filing Tracking Number: LFSC-  
126126721

Filing Description:

December 14, 2010

Arkansas Department Of Insurance

Product Filing

RE: LifeSecure Insurance Company NAIC #77720

SERFF Tracking Number: LFSC-126944562 State: Arkansas  
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Individual Long Term Care Insurance  
Agent Sold Simplified Issue Application LS-0204A ST 08/09

The above application was approved by your Department on 06/12/2009, SERFF Tracking Number LFSC-126126721. This simplified issue application was filed for use as a paper agent-sold application.

We are writing to advise that we intend to use this form to allow the agent to complete application online using a signature pad as the electronic signature. The application will be completed electronically and all currently approved language and sections will remain the same. A copy of the completed, signed application will be included in the Policy Welcome Kit at time of issue.

If you have any questions or wish for additional information, please feel free to contact me. I can be reached at (810) 220-8774 or showard@lifeseureltc.com.

Sincerely,  
Sue R. Howard  
Compliance Manager

## Company and Contact

### Filing Contact Information

Sue Howard, Compliance Manager  
10559 Citation Drive  
Suite 300  
Brighton, MI 48116

Showard@lifeseureltc.com  
810-220-8774 [Phone]  
810-220-7707 [FAX]

### Filing Company Information

LifeSecure Insurance Company  
10559 Citation Drive  
Suite 300  
Brighton, MI 48116  
(810) 220-8774 ext. [Phone]

CoCode: 77720 State of Domicile: Michigan  
Group Code: 572 Company Type: Life, A & H  
Group Name: BCBS of MI GRP State ID Number:  
FEIN Number: 75-0956156

## Filing Fees

Fee Required? No  
Retaliatory? No

SERFF Tracking Number: LFSC-126944562 State: Arkansas  
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Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
LifeSecure Insurance Company	\$0.00	12/14/2010	

SERFF Tracking Number: LFSC-126944562 State: Arkansas  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	01/13/2011	01/13/2011

*SERFF Tracking Number:* LFSC-126944562      *State:* Arkansas  
*Filing Company:* LifeSecure Insurance Company      *State Tracking Number:* 47528  
*Company Tracking Number:* APP-LS-0204A ST 08/09  
*TOI:* LTC03I Individual Long Term Care      *Sub-TOI:* LTC03I.001 Qualified  
*Product Name:* LTC Applications  
*Project Name/Number:* E-Sig/

## **Disposition**

Disposition Date: 01/13/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: LFSC-126944562 State: Arkansas  
 Filing Company: LifeSecure Insurance Company State Tracking Number: 47528  
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Cover Letter	Approved	Yes

SERFF Tracking Number: LFSC-126944562 State: Arkansas  
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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<p><b>Bypassed - Item:</b> Flesch Certification  <b>Bypass Reason:</b> N/A Form previously approved  <b>Comments:</b></p>		
<p><b>Satisfied - Item:</b> Application  <b>Comments:</b>            We are filing to advise of using this previously approved application for electroinic signature using a signature pad.  <b>Attachment:</b>            LS-0204A ST 08.09 - Agent Sold Paper.pdf</p>	Approved	01/13/2011
<p><b>Bypassed - Item:</b> Health - Actuarial Justification  <b>Bypass Reason:</b> Form Filing Only  <b>Comments:</b></p>		
<p><b>Bypassed - Item:</b> Outline of Coverage  <b>Bypass Reason:</b> OOC previously approved with product filnig.  <b>Comments:</b></p>		
<p><b>Satisfied - Item:</b> Cover Letter  <b>Comments:</b>  <b>Attachment:</b>            AR LTC ELEC SIG 12.10.pdf</p>	Approved	01/13/2011

# Multi-Life Application

SECTION	PAGE
A PERSONAL HEALTH HISTORY	1
B APPLICANT INFORMATION	2
C SPOUSE OR DOMESTIC PARTNER INFORMATION	3
D COVERAGE SELECTIONS	4-5
E PREMIUM PAYMENT AUTHORIZATION	6

Sections F, G and H are *not* required for those applicants who qualify for Simplified Issue.

F PERSONAL PHYSICIAN INFORMATION	7
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H APPLICANT PROFILE	11

I PROTECTION AGAINST UNINTENDED LAPSE OR TERMINATION	12
J REPLACEMENT INQUIRY	13
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M APPLICANT AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION	18
N AGENT'S REPORT, CERTIFICATION AND SIGNATURE	19-21

## 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.**







**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.

## 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: \_\_\_\_\_

**OR**

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

DO NOT COMPLETE THIS SECTION IF YOU QUALIFY FOR SIMPLIFIED ISSUE.

Refer to Simplified Issue Qualifications.

## 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).

\_\_\_\_\_  
Physician's Name (First) (MI) (Last) (Suffix)

\_\_\_\_\_  
Street Address Suite #

\_\_\_\_\_  
City State Zip Code

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

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

Date of last visit: \_\_\_\_\_  
month/year

Reason for visit:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DO NOT COMPLETE THIS SECTION IF YOU QUALIFY FOR SIMPLIFIED ISSUE.**

**Refer to Simplified Issue Qualifications.**

## **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

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.

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

Medication	Dosage	Reason

b. been confined in or advised to enter a hospital or rehabilitation facility?  Yes  No  
 If "Yes", please explain and include dates and reasons.

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- 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

- 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.

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

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

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DO NOT COMPLETE THIS SECTION IF YOU QUALIFY FOR SIMPLIFIED ISSUE.

Refer to Simplified Issue Qualifications.

## 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	List types of tobacco or nicotine products used

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

If "Yes", please list your occupation: \_\_\_\_\_

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).

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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?

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# Section 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.

_____	_____	_____	_____
<b>Name (First)</b>	<b>(MI)</b>	<b>(Last)</b>	<b>(Suffix)</b>
_____		_____	
<b>Street Address</b>		<b>Apt #</b>	
_____	_____	_____	
<b>City</b>	<b>State</b>	<b>Zip Code</b>	
_____			
<b>Phone Number</b>			

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 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: \_\_\_\_\_  
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  
If "Yes", provide details:  
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

**LEAVE THIS PAGE WITH THE APPLICANT.**

**DO NOT SUBMIT WITH APPLICATION.**

## **Section 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](mailto: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 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 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 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 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.**

**My signature below represents my acknowledgement, acceptance and authorization of all statements checked above.**

\_\_\_\_\_  
Applicant's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Last 4 Digits of SSN

I certify that I have signed the application in: \_\_\_\_\_ on Date: \_\_\_\_\_  
City, State

# Section 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.

## My signature below represents my acknowledgement, acceptance and authorization for all statements above.

\_\_\_\_\_  
Applicant's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Last 4 Digits of SSN

Signed at: \_\_\_\_\_  
City, State

on Date: \_\_\_\_\_

# Section 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:

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

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

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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

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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 (listed in Section B)

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 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.

**Case Split Information (if applicable)**

Check one box for Agent to receive Welcome Kit

Agent Name \_\_\_\_\_ % Split \_\_\_\_\_  
Agent License # \_\_\_\_\_ Contract #: \_\_\_\_\_  
LifeSecure ID # \_\_\_\_\_

Agent Name \_\_\_\_\_ % Split \_\_\_\_\_  
Agent License # \_\_\_\_\_ Contract #: \_\_\_\_\_  
LifeSecure ID # \_\_\_\_\_

Agent Name \_\_\_\_\_ % Split \_\_\_\_\_  
Agent License # \_\_\_\_\_ Contract #: \_\_\_\_\_  
LifeSecure ID # \_\_\_\_\_

\_\_\_\_\_  
**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.**

\_\_\_\_\_  
Soliciting Agent's Signature Date

\_\_\_\_\_  
Soliciting Agent's Name (First) (MI) (Last)

\_\_\_\_\_  
LifeSecure ID # Agent License #

\_\_\_\_\_  
Contract #



December 14, 2010

Arkansas Department Of Insurance  
Product Filing

RE: LifeSecure Insurance Company            NAIC #77720  
Individual Long Term Care Insurance  
Agent Sold Simplified Issue Application LS-0204A ST 08/09

The above application was approved by your Department on 06/12/2009, SERFF Tracking Number LFSC-126126721. This simplified issue application was filed for use as a paper agent-sold application.

We are writing to advise that we intend to use this form to allow the agent to complete application online using a signature pad as the electronic signature. The application will be completed electronically and all currently approved language and sections will remain the same. A copy of the completed, signed application will be included in the Policy Welcome Kit at time of issue.

If you have any questions or wish for additional information, please feel free to contact me. I can be reached at (810) 220-8774 or [showard@lifefecureltc.com](mailto:showard@lifefecureltc.com).

Sincerely,

A handwritten signature in cursive script that reads "Sue R. Howard".

Sue R. Howard  
Compliance Manager