

SERFF Tracking Number: STFH-128148464 State: Arkansas
Filing Company: State Farm Mutual Automobile Insurance Company State Tracking Number:
Company Tracking Number:
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.003 Other
Product Name: Long Term Care Partnership
Project Name/Number: Partnership/

Filing at a Glance

Company: State Farm Mutual Automobile Insurance Company

Product Name: Long Term Care Partnership SERFF Tr Num: STFH-128148464 State: Arkansas
TOI: LTC03I Individual Long Term Care SERFF Status: Closed-Approved State Tr Num:
Sub-TOI: LTC03I.003 Other Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Donna Lambert
Authors: Barb Metz, Sandy Barnes, Disposition Date: 03/29/2012
Julia Weber, Regina King
Date Submitted: 03/29/2012 Disposition Status: Approved
Implementation Date Requested: On Approval Implementation Date: 03/29/2012
State Filing Description:

General Information

Project Name: Partnership Status of Filing in Domicile: Not Filed
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 03/29/2012
State Status Changed: 03/29/2012
Deemer Date: Created By: Regina King
Submitted By: Regina King Corresponding Filing Tracking Number:
Filing Description:
March 28, 2012

Jay Bradford, Commissioner
Arkansas Insurance Department
1200 W 3rd Street
Little Rock, AR 72201-1904

Re: NAIC # 176-25178

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Disposition

Disposition Date: 03/29/2012

Implementation Date: 03/29/2012

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	LTC Partnership Certification	Approved	Yes
Supporting Document	Statement of Variability	Approved	Yes
Form	Individual Long-Term Care Partnership Insurance Application	Approved	Yes
Form	Long-Term Care Partnership Rider	Approved	Yes
Form	Long-Term Care Partnership Disclosure Notice	Approved	Yes

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Form Schedule

Lead Form Number: 99717AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 03/29/2012	1004232 AR	Application/ Enrollment Form	Individual Long-Term Care Partnership Insurance Application	Initial		56.200	Bracket 1004232 AR App.pdf
Approved 03/29/2012	99717AR	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Long-Term Care Partnership Rider	Initial		42.400	LTC Partnership Program Rider 99717AR.pdf
Approved 03/29/2012	1004638	Other	Long-Term Care Partnership Disclosure Notice	Initial			Bracket AR Partnership Disclosure 1004638.pdf



State Farm Mutual Automobile Insurance Company
 One State Farm Plaza
 Bloomington, IL 61710-0001
 [866-855-1212]

Doc
 Type: **01**

Individual Long-Term Care Partnership Insurance Application

NEW	REINSTATEMENT APP	BENEFIT CHANGE (EXPLAIN)	POLICY NUMBER
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SECTION ONE Proposed Insured (One Applicant Per Application)

LAST NAME		FIRST NAME			MIDDLE INITIAL		
RESIDENCE ADDRESS				RESIDENCE ADDRESS			
CITY		STATE	ZIP CODE	COUNTY			
SOCIAL SECURITY NUMBER	SEX	BIRTH DATE MONTH-DAY-YEAR	AGE	MARITAL STATUS	HEIGHT	WEIGHT	U.S. CITIZEN? YES <input type="radio"/> NO <input type="radio"/>
OCCUPATION - GIVE SPECIFIC DUTIES						ARE YOU ACTIVELY WORKING? YES <input type="radio"/> NO <input type="radio"/>	

SECTION TWO Benefits Applied for

MAXIMUM DAILY BENEFIT AMOUNT (\$25 Increments) \$ _____	ELIMINATION PERIOD <input type="radio"/> 30 DAYS <input type="radio"/> 90 DAYS <input type="radio"/> 180 DAYS	MAXIMUM BENEFIT FACTOR <input type="radio"/> 2 YEARS <input type="radio"/> 3 YEARS <input type="radio"/> 5 YEARS <input type="radio"/> 10 YEARS	MODE	SFPP	A	SA	Q	PREMIUM
			(Check One)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$
								AMOUNT SUBMITTED
								\$

Based on your age select the coverage desired:

Ages 76 - 79 <input type="radio"/> Compound Automatic Increase Benefit <input type="radio"/> Simple Automatic Increase Benefit <input type="radio"/> No Automatic Increase Benefit	Ages 61 - 75 <input type="radio"/> Compound Automatic Increase Benefit <input type="radio"/> Simple Automatic Increase Benefit Ages 30 - 60 <input type="radio"/> Compound Automatic Increase Benefit
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Optional Benefit Rider

Nonforfeiture Benefit/
Shortened Benefit Period

Spousal Information (if applicable in your state marital/legally-sanctioned domestic partner or civil union partner)

If your spouse has or is applying for a State Farm® Long-Term Care policy, give name and/or policy number.

SECTION THREE If any question in Section Three is answered "YES", you are not eligible for coverage.

YES NO

1. Due to any present or past mental or physical disability, is any person or institution currently authorized to act on your behalf? YES NO
2. Are you confined to bed or home? YES NO
3. For any "yes" answers to the questions below, check all that apply:
 - a. Do you use a: walker wheelchair motorized cart quad (4-prong) cane YES NO
 - b. Do you use any medical appliance such as: catheter oxygen equipment dialysis machine YES NO
 - c. Do you require help or supervision, or are you limited in any way in performing the following daily activities:
 bathing mobility managing medications YES NO
 dressing toileting eating
 - d. Have you ever been diagnosed as having: YES NO
 Alzheimer's disease multiple sclerosis ALS (Lou Gehrig's disease)
 Dementia muscular dystrophy Huntington's disease
 memory loss Parkinson's disease Schizophrenia
 cystic fibrosis scleroderma multiple myeloma
 - e. Within the last 5 years, have you been diagnosed as having or have you received medical advice or treatment for:
 diabetes treated with insulin chronic liver disease cancer that has spread from the original site YES NO
 chronic kidney disease drug abuse
4. Within the last 3 years, have you been diagnosed as having or have you received medical advice or treatment for alcoholism? YES NO
5. Have you ever tested positive for exposure to HIV infection or have you ever been diagnosed or treated for acquired immune deficiency syndrome (AIDS)? YES NO

SECTION FOUR Explain any "YES" answers on the next page.

YES NO

6. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
 - a. Any disorder or disease of the brain or nervous system: (including but not limited to Alzheimer's disease, Amyotrophic Lateral Sclerosis, dementia, Huntington's Chorea, memory loss, multiple sclerosis, muscular dystrophy, myasthenia gravis, Parkinson's disease) YES NO
 - b. Any disorder or disease of the respiratory system: (including but not limited to Chronic Obstructive Pulmonary Disease or emphysema, asthma) YES NO
 - c. Any psychiatric or mental health disorder or disease: (including but not limited to depression, anxiety, bi-polar disorder) YES NO
 - d. Any cancer, tumor, cyst or nodule: (including but not limited to multiple myeloma; leukemia or lymphoma; cancer of breast, colon or prostate) YES NO
7. Are you receiving any type of disability benefits? YES NO
8. Have you received Medicare benefits prior to age 65? YES NO
9. Within the last 3 years have you used tobacco or any other nicotine products in any form? YES NO
10. Within the past 5 years have you been hospitalized; or advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)? YES NO

Explanations

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SECTION FIVE

List the name and address of your primary physician. Indicate date and reason(s) last seen.

PHYSICIAN NAME	
ADDRESS	
DATE LAST SEEN	REASON(S) SEEN

SECTION SIX Complete for ages 44 and under

List name and address of any doctor(s), other than listed above, seen in the last 12 months. Indicate date, reason seen, and findings.

PHYSICIAN NAME	
ADDRESS	
DATE LAST SEEN	REASON SEEN - FINDINGS

PHYSICIAN NAME	
ADDRESS	
DATE LAST SEEN	REASON SEEN - FINDINGS

SECTION SEVEN Other Insurance

YES NO

- 11. Do you now have in force or are you applying for any other long-term care, nursing home, or home health care policy, rider, or certificate (including a health care service contract or a health maintenance organization contract)? YES NO
- 12. Other than above, did you have a long-term care insurance policy, rider, or certificate in force during the last 12 months? YES NO
- 13. Are you covered by Medicaid? YES NO
- 14. Do you intend to replace any of your medical or health insurance coverage with this policy? YES NO

Agent: If yes, and the other coverage is in force, complete the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance.

List details below for any "YES" answers in questions 11, 12 and 13:

NAME AND ADDRESS OF COMPANY	LAPSED	WHEN? (MO-DAY-YEAR)	APPLIED FOR	IN FORCE	POLICY NUMBER, TYPE AND AMOUNT OF BENEFITS
	<input type="checkbox"/>		<input type="radio"/>	<input type="radio"/>	

NAME AND ADDRESS OF COMPANY	LAPSED	WHEN? (MO-DAY-YEAR)	APPLIED FOR	IN FORCE	POLICY NUMBER, TYPE AND AMOUNT OF BENEFITS
	<input type="checkbox"/>		<input type="radio"/>	<input type="radio"/>	

15. **Agent: List any other health insurance policies you have sold to the applicant as follows:**

a. List policies sold that are still in force. **(If none, indicate none.)**

b. List policies sold in the past five (5) years that are no longer in force. **(If none, indicate none.)**

SECTION EIGHT Protection Against Unintended Lapse

YOU HAVE THE RIGHT TO DESIGNATE A THIRD PARTY TO RECEIVE NOTICE OF OUR INTENT TO TERMINATE YOUR POLICY FOR NONPAYMENT OF PREMIUM.

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

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

FULL NAME				
ADDRESS				
CITY	STATE	ZIP	TELEPHONE NUMBER	

LONG-TERM CARE PARTNERSHIP PROGRAM RIDER

Anything to the contrary notwithstanding, this policy and attached riders, if any, is amended in the following respects.

POLICY DISCLOSURE FORM

IMPORTANT INFORMATION REGARDING YOUR POLICY'S LONG-TERM CARE INSURANCE PARTNERSHIP STATUS

This disclosure notice is issued in conjunction with Your Long-Term Care Insurance policy.

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

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

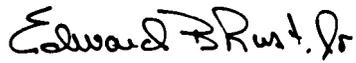
Partnership Policy Status. Your Long-Term Care Insurance policy is intended to qualify as a Partnership policy under the Arkansas Long-Term Care Partnership Program as of Your policy's effective date.

What Could Disqualify Your Policy as a Partnership Policy? If You make any changes to Your policy, such changes could affect whether Your policy continues to be a Partnership policy. **Before You make any changes, You should consult with State Farm Mutual Automobile Insurance Company to determine the effect of a proposed change.** In addition, if You move to a state that does not maintain a Partnership Program or does not recognize Your policy as a Partnership policy, You would not receive beneficial treatment of Your policy under the Medicaid program of that state. The information contained in this notice is based on current state and federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of Your policy under Arkansas' Medicaid program.

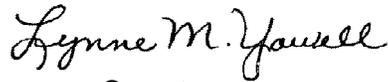
Additional Information. If You have questions regarding Your insurance policy, please contact State Farm Mutual Automobile Insurance Company. If You have questions regarding current laws governing Medicaid eligibility, You should contact the Arkansas Department of Human Services.

This rider shall become effective on the date specified in the Policy Schedule and shall terminate concurrently with the policy to which it is attached.

Issued by the STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, of Bloomington, Illinois



President



Secretary



State Farm Mutual Automobile Insurance Company

1 State Farm Plaza

Bloomington, IL 61710-0001

[866-855-1212]

SOLICITATION DISCLOSURE FORM

IMPORTANT CONSUMER INFORMATION REGARDING THE ARKANSAS LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM

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

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

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

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

If you apply and are approved for Long-Term Care Insurance coverage, State Farm Mutual Automobile Insurance Company will provide you with written documentation as to whether or not your policy qualifies as a Partnership policy.

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

Additional Information. If you have questions regarding the Long-Term Care insurance policies, please contact State Farm Mutual Automobile Insurance Company. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Arkansas Department of Human Services.

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Supporting Document Schedules

	Item Status:	Status
		Date:
Satisfied - Item: Flesch Certification	Approved	03/29/2012
Comments:		
Attachment:		
READABILITY SCORE AND CERTIFICATION FOR POLICY FORMS.pdf		

	Item Status:	Status
		Date:
Satisfied - Item: Application	Approved	03/29/2012
Comments:		
The application is a new form and has been placed under the form schedule tab for approval.		

	Item Status:	Status
		Date:
Satisfied - Item: Health - Actuarial Justification	Approved	03/29/2012
Comments:		
N/A		

	Item Status:	Status
		Date:
Satisfied - Item: Outline of Coverage	Approved	03/29/2012
Comments:		
This Outline of Coverage was approved March 1, 2012.		
Attachment:		
LTCI Outline of Coverage 1004060 AR.pdf		

	Item Status:	Status
		Date:
Satisfied - Item: LTC Partnership Certification	Approved	03/29/2012
Comments:		

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Attachment:

LTC Partnership Certification.pdf

	Item Status:	Status
Satisfied - Item: Statement of Variability	Approved	Date: 03/29/2012
Comments:		
Attachment:		
STATEMENT OF VARIABILITY AR.pdf		

READABILITY SCORE AND CERTIFICATION FOR POLICY FORMS

97062AR and 99717AR

The Flesch reading ease test score is as follows:

Policy Form Number	Policy Name	Flesch Score
1004232 AR	Individual Long-Term Care Partnership Insurance Application	56.2
99717AR	Long-Term Care Partnership Program Rider	42.4
Mandated language	Long-Term Care Partnership Disclosure Form	N/A

Forms 97062AR and 99717AR have been combined for a Flesch score of 42.4.

This meets the minimum reading ease test score required in Arkansas.

Signed Chris A. McNeilly

Chris A McNeilly, Assistant Secretary/Treasurer



State Farm Mutual Automobile Insurance Company
One State Farm Plaza, Bloomington, Illinois 61710-0001
866-855-1212

Retain this for your records.

Long-Term Care Insurance Policies, 97062 Series Outline of Coverage Form 97062AR, Form 97062SAR, Form 97062CAR

Notice to Buyer: This policy may not cover all of the costs associated with Long-Term Care incurred by you during the period of coverage. You are advised to review carefully all policy limitations.

Caution: The issuance of this Long-Term Care Insurance policy is based upon your responses to the questions on your application. A copy of your application will be attached to your policy. If your answers are incorrect or untrue, the company may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: State Farm Mutual Automobile Insurance Company, One State Farm Plaza, Bloomington, Illinois 61710-0001.

1. This policy is an individual policy of insurance.
2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual policy contains governing contractual provisions. This means that the policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY CAREFULLY!**
3. **FEDERAL TAX CONSEQUENCES.** This policy is intended to be a federally tax-qualified Long-Term Care Insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.
4. **TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED.**
 - A. **RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. State Farm Mutual Automobile Insurance Company cannot change any of the terms of your policy on its own, except that, in the future, **IT MAY INCREASE THE PREMIUM YOU PAY.**

B. WAIVER OF PREMIUM BENEFIT. We will waive premiums that become due after you are certified Chronically ILL and receive 90 days of eligible, covered, Qualified Long-Term Care services, so long as you:

1. Remain Chronically ILL; and
2. Continue to receive eligible, covered, Long-Term Care services.

The 90 days that care is provided do not need to be consecutive; however, this care cannot be separated by more than 15 consecutive days.

If you recover or are no longer receiving eligible, covered, Qualified Long-Term Care services or your Maximum Lifetime Benefit amount has been paid, you will need to resume paying your premium to keep your policy in force.

Days used to satisfy your Elimination Period can count toward the Waiver of Premium requirement. Payment under the Home Modification and Durable Medical Equipment Benefit, Medical Help System Benefit and Caregiver Training Benefit will not count toward the 90 days of care needed for the premium to be waived.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS. Any change will apply to all policies in the same class as yours in the state where the policy was issued. We will notify you in writing 60 days before your premium changes.

6. TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED. It is important that you understand your policy and are satisfied with it. Please read it carefully. If you are not satisfied with it for any reason, return it to us at our Home Office at One State Farm Plaza, Bloomington, Illinois 61710-0001 or our producer through whom it was purchased within 30 days after you receive it. We will refund any premium paid within 30 days of return directly to the payer and consider the policy never to have been issued.

The policy contains a provision providing for refund of unearned premium upon notice of your death, or if you exercise your right to request cancellation.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

Neither the State Farm Mutual Automobile Insurance Company nor its agents represent Medicare, the federal government or any state government.

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

This policy provides coverage in the form of reimbursement of expenses for eligible, covered, Qualified Long-Term Care services, subject to policy limitations, waiting periods, and coinsurance requirements.

9. BENEFITS PROVIDED BY THIS POLICY

A. BENEFIT LIMITS

Maximum Daily Benefit: \$ _____

Maximum Weekly Adult Day Care Benefit: \$ _____

Maximum Lifetime Benefit: \$ _____

The Maximum Lifetime Benefit is the total amount payable in the lifetime of your policy for all benefits. Your original Maximum Lifetime Benefit is shown on your Policy Schedule.

Elimination Period _____ Days

The Elimination Period is the number of days for which we will **NOT** pay benefits, that eligible, covered, Qualified Long-Term Care services are provided and charged for before benefits can be paid. The number of days of your Elimination Period are shown on your Policy Schedule and can be satisfied by any combination of days in an Alternate Care Facility, Long-Term Care Facility, and Home and Adult Day Care. Care does not need to be continuous but must be satisfied within a continuous 730 day (2 year) period. The Elimination Period has to be satisfied only one (1) time while this policy is in force.

B. INSTITUTIONAL BENEFITS

1. Alternate Care Facility Benefit

If you are certified Chronically ILL, each day you require and receive services in an Alternate Care Facility, benefits will be paid as described below. When eligible, covered, Qualified Long-Term Care services are provided in an Alternate Care Facility, we will pay the lesser of:

- a. The Maximum Daily Benefit; or
- b. The expenses you incur for eligible, covered, Qualified Long-Term Care services provided by an Alternate Care Facility.

2. Long-Term Care Facility Benefit

If you are certified Chronically ILL, each day you require and receive services in a Long-Term Care Facility, benefits will be paid as described below. When eligible, covered, Qualified Long-Term Care services are provided in a Long-Term Care Facility, we will pay the lesser of:

- a. The Maximum Daily Benefit; or

- b. The expenses you incur for eligible, covered, Qualified Long-Term Care services provided by a Long-Term Care Facility.

3. Bed Reservation Benefit

If you are certified Chronically ILL and a resident in an eligible Alternate Care Facility or Long-Term Care Facility and incur a room charge while you are temporarily absent, we will pay up to 30 days per calendar year to hold your room. The amount payable will be the lesser of:

- a. The Maximum Daily Benefit; or
- b. The expenses you incur to reserve your space in the facility.

Unused days in one calendar year cannot be carried over into the next calendar year.

C. NONINSTITUTIONAL BENEFITS

1. Home and Adult Day Care Benefit

If you are certified Chronically ILL and require and receive Home and Adult Day Care, benefits will be paid as described below. When eligible, covered, Qualified Long-Term Care services are provided in Your Home or Adult Day Care, we will pay, on a calendar week basis, the lesser of:

- a. Seven (7) times the Maximum Daily Benefit; or
- b. The expenses you incur for eligible, covered, Qualified Long-Term Care services provided in a calendar week by:

(1) A Home Health Care Agency; and/or

(2) Adult Day Care.

Home and Adult Day Care benefits will not be payable if you are receiving services as a resident in an Alternate Care Facility, Long-Term Care Facility, or hospital.

2. Home Modification and Durable Medical Equipment Benefit

If you have been certified Chronically ILL and the Licensed Health Care Practitioner has recommended that you need assistance provided in a Long-Term Care Facility, alternative options, such as Home Modification or purchase, rental, or lease of Durable Medical Equipment, may be available.

Home Modification and Durable Medical Equipment Benefits are available to enable you to remain in Your Home if the following requirements are met:

- a. The request is made by you or your Personal Representative; and
- b. Developed by or with a Licensed Health Care Practitioner; and
- c. Expected to enable you to remain in Your Home for at least 90 days after Home Modification is complete or Durable Medical Equipment is provided; and
- d. Approved, in writing, by you or your Personal Representative, the Licensed Health Care Practitioner, and us, before any activity is done to begin the modifications or equipment is obtained.

The Home Modification and Durable Medical Equipment Benefit maximum benefit is fifty (50) times the current Maximum Daily Benefit in effect on the day initial benefits under this provision are paid. As benefits are paid, the paid amount is subtracted from the total amount available under this benefit. The Maximum Lifetime Benefit amount is reduced by benefits paid under the Home Modification and Durable Medical Equipment provision.

This benefit will be paid in addition to Your Home and Adult Day Care Benefit or Alternate Plan of Care Benefit, if being utilized, providing it is in preparation for you to return to Your Home or enables you to remain in Your Home. Once the maximum benefit under the Home Modification and Durable Medical Equipment Benefit is exhausted, no further benefits will be available for the lifetime of the policy. Restoration of Benefits does not apply to this benefit.

Home Modifications may include, but are not limited to, widening doorways, building ramps, restructuring bathroom facilities to accommodate wheelchairs, etc. Home Modification does not include hot tubs, swimming pools and items similar in nature, home repair or maintenance, or other modifications that are made to increase the value of Your Home.

Durable Medical Equipment will need to stand repetitive use, be medical in nature, and not be needed or used in the absence of disease or impairment. Items may include, but are not limited to, wheelchairs, portable slings for lifting the body, or adaptive devices to assist with eating, dressing, etc. Durable Medical Equipment does not include prescription drugs, athletic equipment, equipment placed on or in your body, or items commonly found in a household, items primarily designed to enhance comfort or convenience are not eligible.

Benefits for Durable Medical Equipment considered eligible or covered by or paid by Medicare will not be duplicated or paid in any manner, including coinsurance and deductible amounts.

No benefits are eligible under the Home Modification and Durable Medical Equipment Benefit for services or items obtained prior to our approval of your request. If your request is approved, benefits will only be provided pursuant to this agreement.

Our approval of a Home Modification and Durable Medical Equipment request will not waive any of your or our rights under the policy.

You do not have to satisfy your Elimination Period for this benefit to apply; however, days that are paid will not apply toward your Elimination Period.

3. Respite Care Benefit

In addition to any benefits payable above, we will pay for up to 30 days of Respite Care per calendar year.

For each day of Respite Care, we will pay the lesser of:

- a. The Maximum Daily Benefit; or
- b. The expenses you incur for such care.

Unused days cannot be carried over into the next calendar year.

4. Medical Help System Benefit

If you are certified Chronically ILL, we will pay the expense you incur each month, not to exceed 25% of your Maximum Daily Benefit, toward the rental or lease of a Medical Help System installed in Your Home while the policy is in force. This amount is payable for a maximum of 12 months during the lifetime of your policy.

This benefit will be paid in addition to benefits provided for Home and Adult Day Care and services provided under an Alternate Plan of Care. Benefits for a Medical Help System are only payable if you are residing in Your Home.

The Medical Help System Benefit does not provide coverage for normal telephone services, mobile phones, pagers, home security systems, and other similar communication devices.

You do not have to satisfy your Elimination Period for this benefit to apply; however, days that are paid do not apply toward your Elimination Period.

5. Caregiver Training Benefit

If you require eligible, covered, Qualified Long-Term Care services, we will pay the expenses you incur for Caregiver Training, not to exceed five (5) times the Maximum Daily Benefit during any one Plan of Care.

This benefit will be paid in addition to your Maximum Daily Benefit.

You do not have to satisfy your Elimination Period for this benefit to apply; however, the days on which benefits are paid do not apply toward your Elimination Period.

This benefit is payable to enable you to remain in Your Home or return to Your Home, to be cared for by your Informal Caregiver. The Caregiver Training Benefit will not be provided to a person who will be paid as a caregiver.

D. ELIGIBILITY FOR PAYMENT OF BENEFITS

1. Activities of Daily Living: The Activities of Daily Living are:
 - a. Bathing. Washing yourself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
 - b. Continence. The ability to maintain control of bowel and bladder function; or, when unable to control bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
 - c. Dressing. Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
 - d. Eating. Feeding yourself by getting food into your body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
 - e. Toileting. Getting to and from, and off and on, the toilet, and performing associated personal hygiene.
 - f. Transferring. Moving into or out of a bed, chair, or wheelchair.
2. Alternate Care Facility: A facility in which Maintenance or Personal Care Services are provided and satisfies all the following requirements:
 - a. Licensed to operate as an Alternate Care Facility by the appropriate licensing agency in the state where you receive care, when a license is offered or available. If a license is not offered or available in the state where you receive care, the facility must satisfy all of the requirements listed below except for licensure to be eligible under the Alternate Care Facility benefit.
 - b. 24-hour trained staff available to provide assistance with Activities of Daily Living or Cognitive Supervision; and
 - c. Provide services in accordance with a Plan of Care developed by a physician; and
 - d. Provides three (3) meals per day, accommodating special dietary needs; and
 - e. Has formal arrangements for services with a physician or nurse to provide medical care in case of an emergency; and

- f. Has appropriate procedures and methods for the administration and handling of drugs and other prescribed treatments.

An Alternate Care Facility does not mean a hospital, clinic, boarding home, or a place that operates primarily for the treatment of alcoholism or drug addiction, individual residences or independent living units. However, with appropriate licensure, it may be a freestanding facility or a distinct part of a facility such as a ward, wing, or unit, or swing-bed of a hospital or institution, or part of a life-care community.

3. Chronically ILL: has the meaning prescribed for this term by 7702B(c)(2) of the Internal Revenue code of 1986, as amended. Under this provision, a Chronically ILL individual means any individual who has been certified by a licensed health care practitioner as:
 - a. Being unable to perform (without substantial assistance from another) at least two (2) Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
 - b. Requiring substantial supervision to protect the individual from threats to health and safety due to severe Cognitive Impairment.

A Chronically ILL individual shall not include an individual otherwise meeting these requirements unless within the preceding 12 month period a Licensed Health Care Practitioner has certified that the individual meets these requirements.

4. Cognitive Impairment: means a deficiency in an individual's short or long-term memory, orientation to person (who you are), place (your location) and time (day, date, and year), deductive or abstract reasoning or judgment as it relates to safety awareness.
5. Long-Term Care Facility: An inpatient facility for people who require constant nursing care, and have significant deficiencies with Activities of Daily Living or require 24-hour supervision due to a Cognitive Impairment, and satisfies all of the following requirements:
 - a. Licensed or Medicare certified to operate as a Long-Term Care Facility by the appropriate licensing agency in the state where you receive care, when a license is offered or available; and
 - b. Provides 24-hour per day care by or under the supervision of a registered, licensed practical, or licensed vocational nurse; and
 - c. Maintains daily records for all residents of the care and services provided.

A Long-Term Care Facility does not mean a hospital, clinic, boarding home, or a place that operates primarily for the treatment of alcoholism or drug addiction, individual residences or independent living units. However, with appropriate licensure, it may be a freestanding facility or a distinct part of a facility such as a ward, wing, or unit or swing-bed of a hospital or institution, or part of a life-care community.

6. **Qualified Long-Term Care Services:** means services that meet the requirements of 7702(c)(1) of the Internal Revenue Code of 1986, as amended as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation, and rehabilitative services, and Maintenance or Personal Care Services which are required by a Chronically ILL individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

E. RESTORATION OF BENEFITS

If your Maximum Lifetime Benefit is not exhausted, it will be fully restored to its original maximum as if no claim benefits have been paid, if:

1. You are no longer Chronically ILL; and
2. You have not required nor received Qualified Long-Term Care Services for 180 consecutive days.

There is no limit on the number of times Restoration of Benefits can occur, providing the requirements identified above are satisfied.

Restoration of Benefits does not apply to Home Modification and Durable Medical Equipment Benefit.

F. INFLATION PROTECTION BENEFITS (Choose One)

- Compound Automatic Increase Benefit: (Policy Form 97062CAR)** On the anniversary of your policy's Effective Date of Coverage, the benefits provided in your policy will increase in the following manner:

1. **Maximum Daily Benefit.** Your current Maximum Daily Benefit is the amount in effect on the most recent anniversary date of your policy. The amount will increase by 5% annually, on the anniversary date of your policy.
2. **Maximum Lifetime Benefit.** The following is added to the definition of Maximum Lifetime Benefit found in the policy:
 - a. The Maximum Lifetime Benefit on the current anniversary date is the Maximum Lifetime Benefit on the previous anniversary date, increased by 5% of the remaining Maximum Lifetime Benefit.
 - b. The remaining Maximum Lifetime Benefit is the Maximum Lifetime Benefit on the previous anniversary date less the total of all claims paid to the current anniversary date.
 - c. If your Maximum Lifetime Benefit has been exhausted, no further increase is available.

Annual increases occur regardless of whether benefits are currently being paid.

○ **Simple Automatic Increase Benefit: (Policy Form 97062SAR)** On the anniversary of your policy's Effective Date of Coverage, the benefits provided in your policy will increase in the following manner:

1. **Maximum Daily Benefit.** Your current Maximum Daily Benefit is the amount in effect on the most recent anniversary date of your policy. The amount will increase by a fixed 5% of your original Maximum Daily Benefit, shown on the Policy Schedule.
2. **Maximum Lifetime Benefit.** The following is added to the definition of Maximum Lifetime Benefit found in the policy:
 - a. The Maximum Lifetime Benefit on the current anniversary date is the Maximum Lifetime Benefit on the previous anniversary date, increased by an amount equal to the remaining Maximum Lifetime Benefit multiplied by the Increase Factor.
 - b. The remaining Maximum Lifetime Benefit is the Maximum Lifetime Benefit on the previous anniversary date less the total of all claims paid to the current anniversary date.
 - c. The Increase Factor is the proportionate increase in your daily benefit amount from the previous anniversary date to the current anniversary date.
 - d. If your Maximum Lifetime Benefit has been exhausted, no further increase is available.

Annual increases occur regardless of whether benefits are currently being paid.

○ **Future Purchase Option Benefit: (Policy Form 97062AR)** If you do not purchase a policy with the Simple Automatic Increase Benefit or the Compound Automatic Increase Benefit, on the anniversary of your policy's Effective Date of Coverage following your 45th, 50th, 55th, 60th, and 65th birthdays, you will be given the opportunity to increase your Maximum Daily Benefit by the amount shown on the Policy Schedule. This increase will be effective on your policy anniversary date. Application for the increase must be submitted within 60 days of notice.

This increase is not available if:

1. You are Chronically ILL; or
2. You have required or received eligible, covered, Qualified Long-Term Care services within the past 180 consecutive days.

Premiums for the increased benefit will be based on your age at the time of increase and the premium rates then in effect.

No Future Purchase Option or adjustment will be made while this policy is in effect under any nonforfeiture benefit.

G. OPTIONAL BENEFITS

Nonforfeiture Benefit/Shortened Benefit Rider Form 99591AR

Selected

Not Selected

The Nonforfeiture Benefit provides for continuation of coverage during your lifetime if you stop paying premiums. The benefits payable for a Long-Term Care Facility stay or home and community-based care which begin after the Nonforfeiture Date, as defined below, will be subject to the following limits:

1. The Maximum Daily Benefit amount will be the amount in effect on the Nonforfeiture Date.
2. The maximum amount we will pay for all covered care or services you receive after the Nonforfeiture Date is the greater of:
 - a. 100% of the sum of all premiums paid for the policy, including the premiums paid prior to any changes in benefits; or
 - b. 30 times the Maximum Daily Benefit in effect on the Nonforfeiture Date.

However, the total benefits payable under the policy, including this Nonforfeiture Benefit, will not exceed the Maximum Lifetime Benefit amount at the time of lapse. Benefits will be payable in accordance with all other terms and conditions of the policy.

10. LIMITATIONS AND EXCLUSIONS

- A. **Pre-existing Condition Limitation.** A health condition for which you received medical advice or treatment was recommended by or received from a provider of health care within the six (6) months preceding your Effective Date of Coverage.

We will not pay for a loss due to a Pre-existing Condition which you did not disclose in the application unless the loss begins more than six (6) months after the Effective Date of Coverage. However, providing incorrect information may cause your policy to be voided.

If this policy replaces another Long-Term Care Insurance policy, the six (6) month time period above is waived to the extent it has been satisfied under the replaced policy.

- B. **Noneligible Facilities/Providers.** Long-Term Care Facility does not mean Your Home, a hospital, clinic, boarding home or a place that operates primarily for the treatment of alcoholism or drug addiction. Unlicensed providers are not considered eligible under the policy provisions. However, care or services provided in or by these facilities/providers may be covered subject to the conditions of the Alternate Plan of Care benefit provision.

C. Exclusions/Exceptions. We will not pay benefits when:

1. You are entitled to, receive, are owed, or paid any benefit for a condition or impairment for which there is or has been a settlement related to any state or federal Workers' Compensation, Employer's Liability or Occupational/Disease Law, or any Motor Vehicle No-fault Law;
2. Your condition or impairment is the result of war or any act of war, declared or undeclared;
3. Charges are otherwise subject to coverage by Medicare and Medicare deductible/coinsurance amounts, including benefits paid by other government programs, as required by law, with the exception of Medicaid. However, eligible Qualified Long-Term Care Services may be applied to the Elimination Period;
4. No charge is normally made in the absence of insurance;
5. Services are provided outside of the United States of America or its territories or possessions;
6. Your condition or impairment is brought about as a result of your participation in a felony, riot or insurrection, or involvement in an illegal occupation;
7. Your condition or impairment is brought about as a result of attempted suicide, while sane or insane, or intentionally self-inflicted injury;
8. Your condition or impairment is brought about as a result of your alcoholism or drug addiction; or
9. Services are provided by your family member unless they are licensed as a physical, occupational, respiratory, or speech therapist, or a registered, licensed practical, or licensed vocational nurse, providing services in the same state as licensed and operating under the structure and limitation of their license.

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

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of Long-Term Care services will likely increase over time, you should consider whether and how the benefits of this policy may be adjusted.

See the accompanying charts on page 15, 16, and 17 which illustrates Maximum Daily Benefits with and without an automatic increase benefit. Benefits automatically increase each year; premiums do **not** change because of the automatic benefit increase. **However, we do have the right to change premium in the future as described in 4 and 5 above.**

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS. Your policy provides benefits, subject to all provisions of the policy, for Alzheimer's Disease or senile dementia, which are determined by clinical tests that reliably measure and produce clinical evidence.

13. PREMIUM

The total premium for this policy is \$ _____.

The portion of the premium for the Nonforfeiture Benefit/Shortened Benefit Rider, if selected, is \$ _____.

14. ADDITIONAL FEATURES

- A. Medical underwriting is used for this policy.

Your eligibility for coverage is based on the answers to the medical questions in the application.

- B. Unintentional Lapse Protection. You have the right to designate an individual in addition to yourself to receive notification when your policy will terminate because of nonpayment of premium.

We will notify the person you designate at least 30 days before the scheduled termination date of the policy, but not earlier than 30 days after the premium due date. The notice will be given by first class United States mail, postage prepaid. Notice will be deemed to have been given as of five (5) days after the date of mailing. On every renewal of your policy, you will be given the right to change the designated person.

Also, if the policy should terminate for nonpayment of premium because you suffered Cognitive Impairment or Functional Incapacity, or you would have otherwise qualified for benefits under the policy at the time of policy termination, we will reinstate the policy without requiring evidence of your insurability if you or your authorized representative request it within six (6) months following the termination of your policy for nonpayment of premium.

- C. Contingent Benefit Upon Lapse. If your policy lapses within 120 days of the due date of a substantial premium rate increase and you have rejected the offer of a Nonforfeiture Benefit/Shortened Benefit Rider which is available to you, then we will provide a Contingent Nonforfeiture Benefit to you effective from the policy issue date.

The contingent benefit provides for continuation of coverage during your lifetime if your policy lapses as a result of a substantial premium increase as outlined in the policy. The contingent benefit upon lapse shall be triggered every time we increase the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding a percentage of your initial annual premium. (See policy language for specific information.)

- D. Care Management. During your claim, we can, with your approval, provide you with access to a care manager, named at our discretion, who can work with you, your Personal Representative, and your Licensed Health Care Practitioner to create and monitor your Plan of Care. Assessments of your situation and evaluation of potential care resources may be provided during this period. Care Management Services will be provided at no cost to you and will not count against your Maximum Lifetime Benefit. You are not required to use this service or any provider located by this service.

E. Alternate Plan of Care Benefit. If you have been certified Chronically ILL and the Licensed Health Care Practitioner has recommended that you need assistance provided in a Long-Term Care Facility, alternative options may be available to you. For this Alternate Plan of Care Benefit to be considered, it must be a cost-effective alternative to benefits under your policy and be:

1. Requested by you or your Personal Representative; and
2. Developed by or with a Licensed Health Care Practitioner; and
3. Approved, in writing, by you or your Personal Representative, the Licensed Health Care Practitioner, and us, before implementation of any alternative arrangements.

No benefits are eligible for any Alternate Plan of Care services received prior to our receiving the agreements described above.

No benefits will be paid before the Elimination Period is satisfied; however, if approved, days of care may be applied to the Elimination Period.

Services provided by a Family Member are not reimbursable under this benefit.

Agreement to participate in an Alternate Plan of Care will not waive any of your or our rights under the policy.

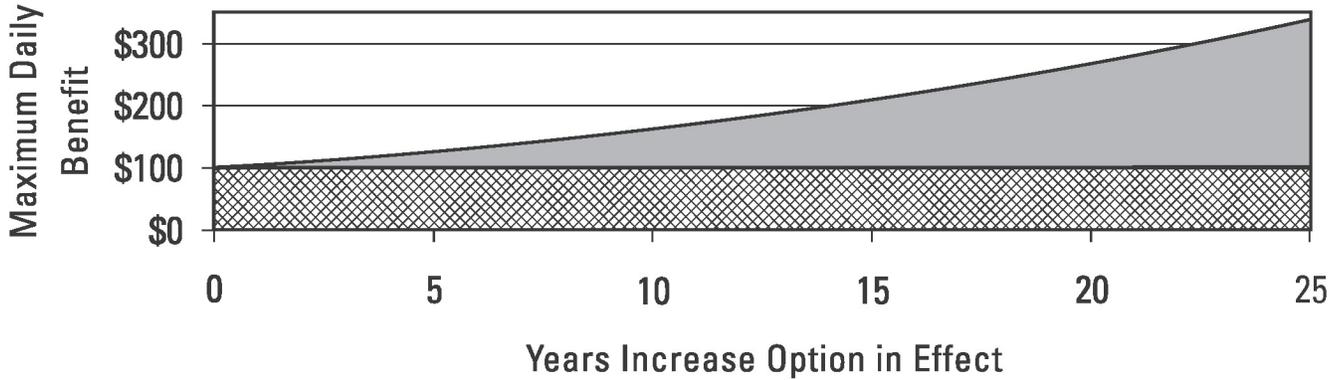
This alternative arrangement for care may identify specific treatments or locations for care to be provided. If an Alternate Plan of Care agreement is approved, benefits will only be provided per this agreement. The Medical Help Benefit, Caregiver Training, and Home Modification and Durable Medical Equipment Benefit may be utilized as specified to assist you to remain at home. We will pay the lesser of:

1. The Maximum Daily Benefit; or
2. The expense you incur under this agreement.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM TOLL-FREE AT 1-800-371-2782 IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY.

Growth of Payment Maximums Over Time

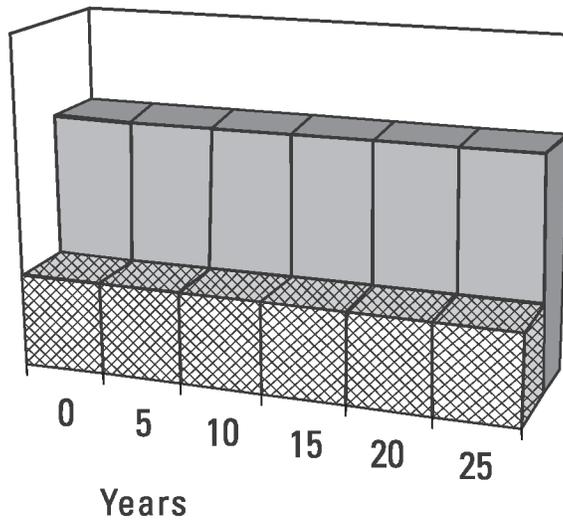
Compound Automatic Increase Benefit



Level Benefits
 Compound Automatic Increases

Relative Premium Costs

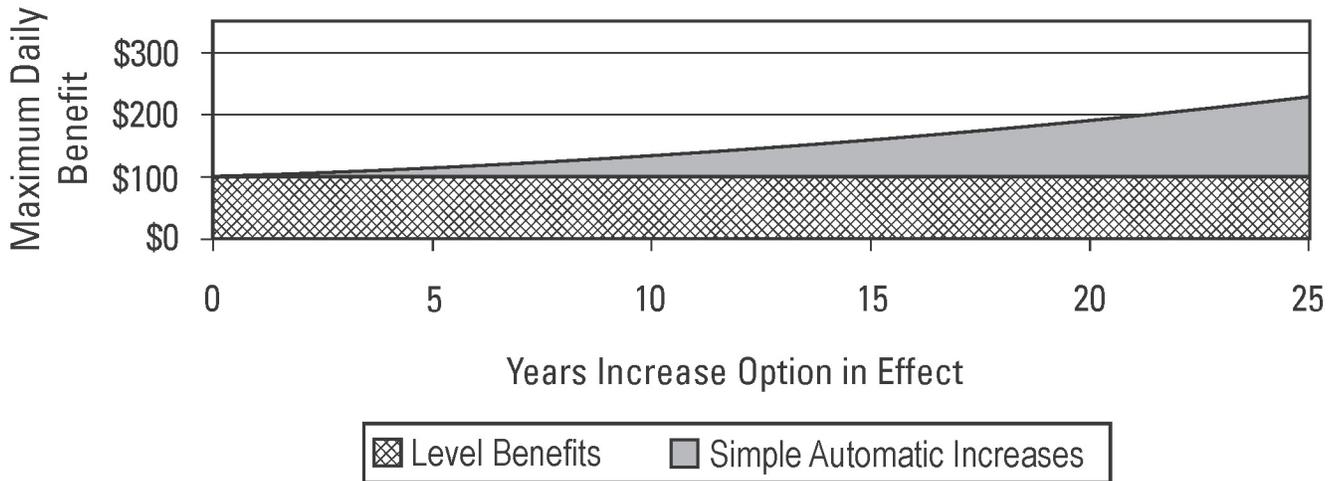
Compound Automatic Increase Benefit



Level Coverage
 Compound Automatic Increase Coverage

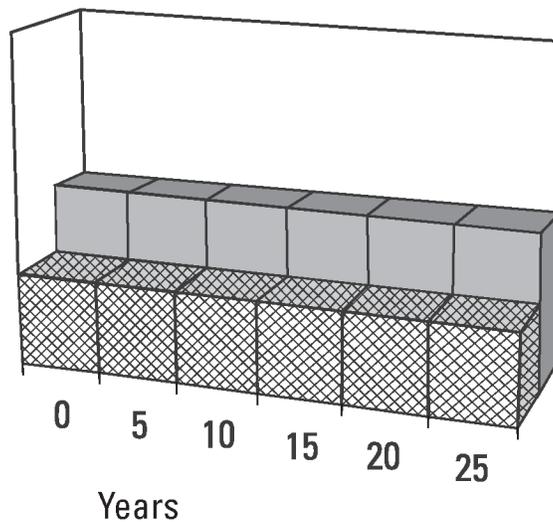
Growth of Payment Maximums Over Time

Simple Automatic Increase Benefit



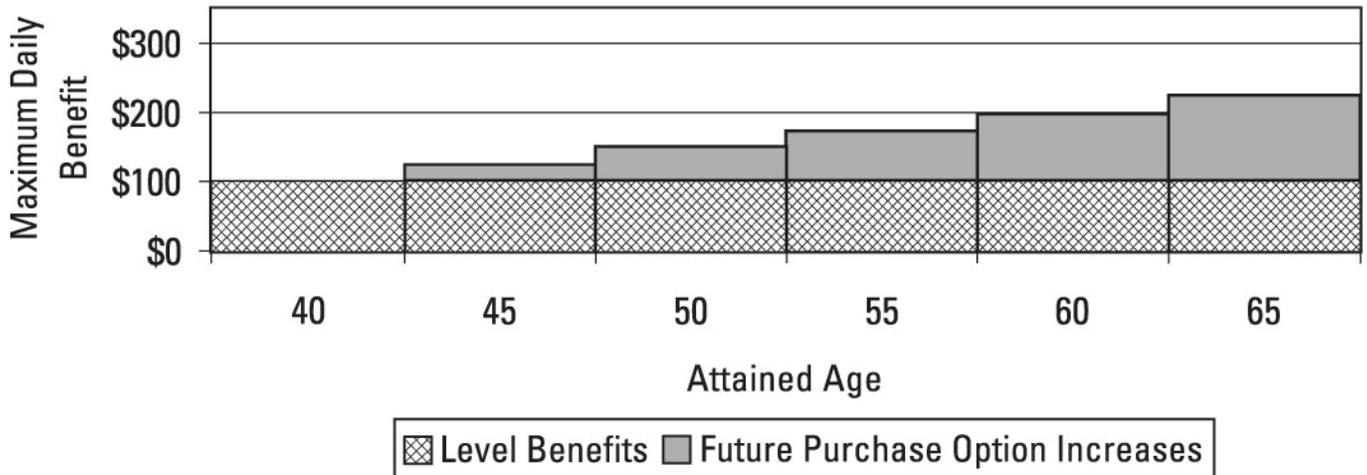
Relative Premium Costs

Simple Automatic Increase Benefit



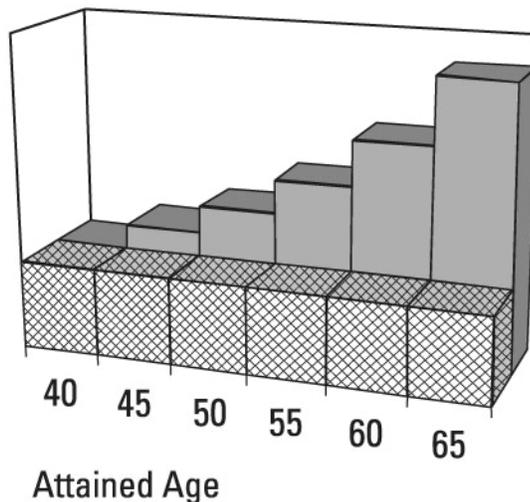
Growth of Payment Maximums Over Time

Future Purchase Option



Relative Premium Costs

Future Purchase Option



Level Coverage Future Purchase Option Increase Coverage

Level Coverage assumes Future Purchase Option is never elected. Future Purchase Option Increase Coverage assumes Future Purchase Option is exercised at each possible election date.

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

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

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

I. GENERAL INFORMATION

A. Name, address and telephone number of issuer:

State Farm Mutual Automobile Insurance Company
1 State Farm Plaza
Bloomington, IL 61710-0001

B. Name, address, telephone number, and email address (if available) of an employee of issuer who will be the contact person for information relating to this form:

Julia Weber
1 State Farm Plaza
Bloomington, IL 61710-0001 julia.weber.gwsx@statefarm.com

C. Policy form number(s) (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form (expand the space below as required):

1004232 AR
99717 AR
1004638

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

II. CERTIFICATIONS

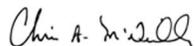
- A. I hereby certify that the policy forms listed above are in compliance with Rule 13 and Rule 94 and all other Arkansas statutes and rules regarding long-term care insurance.
- B. I hereby certify to the best of my knowledge and belief that all producers who sell, solicit or negotiate long-term care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

March 28, 2012

Date

Chris A. McNeilly

Name and title of officer of the Issuer



Signature of officer of the Issuer

STATEMENT OF VARIABILITY

Individual Long-Term Care Partnership Rider and Disclosure

SOLICITATION DISCLOSURE FORM 1004638

INDIVIDUAL LONG-TERM CARE PARTNERSHIP INSURANCE APPLICATION FORM 1004232 AR

[866-855-1212]: This is the general assistance number for questions regarding the policy or claims.