

Applying is easy!

Just follow these simple instructions. Send no money now.

1. Complete the Long-Form Application.
2. Fill in each section of the application carefully, answering each question completely. Be sure to include the name and Social Security Number of the employee.

In the "Statement of Insurability" section, there is a question about Medicaid eligibility. Medicaid is a program for persons who meet their state's criteria for poverty. It is not the same as Medicare, which is the program for persons over 65 and certain disabled persons.

Also the "Statement of Insurability" asks about any prescription drugs you are taking, even if the health problem is not shown elsewhere. The information on name and dosage can be found on the label of the medication container.
3. Select one Daily Maximum Benefit Amount
4. Double-check to make sure you've answered every question and have signed and dated your application in both Sections Six and Seven at the end. If your spouse is applying, he or she should complete, sign and date his or her own application.
5. Fold your completed application(s) and mail to CNA at:
**CNA Insurance
PO Box 946760
Maitland, FL 32794-6760**
Send no money now.
6. We may telephone you after we receive your application to make sure we understand the facts you've noted about your health. We are very grateful for your cooperation.
7. We will inform you by mail whether you have been accepted. If accepted, we will send your certificate and a bill for your premium.

Important Preliminary Information

To keep the Group Long-Term Care program affordable for all participants, there are some circumstances under which we do not offer coverage.

1. During the past 12 months have you consulted a physician, been diagnosed or treated for any of the following?
 - a. Cerebral vascular accident or stroke
 - b. Alzheimer's Disease, dementia, or change in cognitive functioning.
 - c. Parkinson's Disease, Multiple Sclerosis, Huntington's Disease, or Amyotrophic Lateral Sclerosis
 - d. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)
2. Are you currently residing in a nursing home?

If you answered "no" to all of the above, please complete the application. While coverage is not guaranteed, some medical conditions will not necessarily disqualify you for coverage.

Questions?

Just call a CNA customer service representative at

Toll-free 1-877-895-6761



Group Long-Term Care Long-Form Application

If any parts of Sections 1 through 7 are blank, your long-form application cannot be processed.

SECTION 1 – APPLICANT INFORMATION

Applicant's Name: First, Middle Initial, Last		Date of Birth / /	Sex (M or F)
Applicant's Address: Number and Street		Social Security Number: 3/4 3/4	
City	State	Zip Code	
Daytime Phone Number ()	Evening Phone Number ()		

SECTION 2 – BENEFIT SELECTIONS

Select ***ONE*** Daily Benefit / Lifetime Maximum:

- \$ 80 Daily Benefit / \$160,000 Lifetime Maximum
 \$120 Daily Benefit / \$240,000 Lifetime Maximum
 \$100 Daily Benefit / \$200,000 Lifetime Maximum
 \$140 Daily Benefit / \$240,000 Lifetime Maximum

SECTION 3 – ELIGIBILITY

- I certify that I am a:
- | | |
|---|--|
| <input type="checkbox"/> Employee's parent or parent-in-law | <input type="checkbox"/> Retiree |
| <input type="checkbox"/> Employee's grandparent or grandparent-in-law | <input type="checkbox"/> Spouse of a retiree |
| <input type="checkbox"/> Employee's child (25 years+) | |

Employee/Retiree Name	Social Security Number - - - - - - - - - -
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OVER, PLEASE

SECTION 4 – STATEMENT OF INSURABILITY

- | | YES | NO |
|---|---|--|
| 1. Height _____ ft. _____ in. Weight _____ lbs. | | |
| 2. At any time in the last five years have you applied for or received Social Security disability benefits or Medicaid? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. During the last seven years have you been diagnosed, received medical advice, or been treated by a member of the medical profession for any of the following: | | |
| a. Auto or Acquired Immune Disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Internal Lupus Erythematosus or any other connective tissue disease or disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Alzheimer's Disease, Dementia, or change in cognitive functioning _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Parkinson's Disease, Multiple Sclerosis, Huntington's Disease, or Amyotrophic Lateral Sclerosis _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Seizures, Epilepsy or any other Neurologic Disease or Disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Diabetes Mellitus, Glucose Intolerance, or Hyperglycemia _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Internal Cancer or Melanoma. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Disorder, Disease or Surgery of the Heart or Circulatory System _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Cerebral Vascular Accident, Stroke or Transient Ischemic Attack _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| k. High Blood Pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Osteoporosis _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Arthritis, or any other Bone, Spine, Joint or Muscular Disease, Disorder or Surgery _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Reproductive, Kidney or Urinary System Disease, Disorder or Surgery _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Liver, Digestive, Colon or Rectal Disease Disorder or Surgery _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| p. Alcoholism or Substance Abuse. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| q. Any Mental, Emotional or Nervous Disease or Disorder, Depression or Chemical Imbalance. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. During the past 12 months have you consulted a physician, been diagnosed or treated for any of the following? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, check those which apply:</i> | | |
| <input type="checkbox"/> dementia | <input type="checkbox"/> dizziness | <input type="checkbox"/> loss of appetite |
| <input type="checkbox"/> unstable gait | <input type="checkbox"/> falling | <input type="checkbox"/> deterioration of vision |
| <input type="checkbox"/> disorientation | <input type="checkbox"/> fainting | <input type="checkbox"/> bladder control |
| 5. At any time during the past 12 month have you needed assistance or supervision or were you limited in any way physically or cognitively from performing any of the following daily activities? | YES
<input type="checkbox"/> | NO
<input type="checkbox"/> |
| <i>If yes, check those which apply:</i> | | |
| <input type="checkbox"/> bathing | <input type="checkbox"/> dressing | <input type="checkbox"/> toileting |
| <input type="checkbox"/> eating | <input type="checkbox"/> managing medications | <input type="checkbox"/> housekeeping |
| | | <input type="checkbox"/> continence |
| | | <input type="checkbox"/> mobility |
| | | <input type="checkbox"/> preparing meals |
| 6. At any time during the past 12 months have you used any of the following medical devices? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, check those which apply:</i> | | |
| <input type="checkbox"/> cane | <input type="checkbox"/> walker | <input type="checkbox"/> wheelchair |
| | <input type="checkbox"/> oxygen equipment | <input type="checkbox"/> catheter |
| 7. Have you been confined in a long-term care facility or received home health care or adult day care services during the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you used any tobacco products at any time during the last three years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. During the past five years, have you received any medical advice, treatment or diagnosis for any condition other than those stated in questions 2 through 7? | <input type="checkbox"/> | <input type="checkbox"/> |

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YES NO

10. Are you taking any prescription drugs?

If yes, please provide the name and daily dosage below.

Drug Name	Daily Dosage	Taken for (diagnosis or condition)	Prescribing Doctor's Name

11. If you answered "Yes" to any part of questions 2 through 9 provide details below.

For more details attach a separate signed and dated sheet.

Question Number	Diagnosis	Date Treatment Began	Ongoing OR Date of Recovery/ Control	Name of Doctor or Facility

12. Please list all physicians which you have consulted or been treated by in the past five years.

For more details attach a separate signed and dated sheet.

Name of Doctor	Specialty	Phone Number	Address
Primary Care Physician			
All Other Physicians			

YES NO

13. Does someone else hold your power of attorney?

If yes, explain why, what type of power of attorney, and if that power of attorney is being actively used at this time. To provide more details, attach a separate sheet of paper which is signed and dated.

14. Do you currently have long-term care insurance in force or have you recently applied for such insurance?

YES NO

If yes, please list all such coverages in the space provided below. Indicate if you intend to replace any medical or health insurance coverage, including health care service contract or health maintenance organization with the insurance applied for with this application.

Company Name	Policy Number	Is coverage to be replaced?		When
		YES <input type="checkbox"/>	NO <input type="checkbox"/>	
		YES <input type="checkbox"/>	NO <input type="checkbox"/>	

OVER, PLEASE

SECTION 5 – PAYMENT METHOD

Direct Bill: Quarterly Semi-Annual Annual ~OR~ Monthly Electronic Funds Transfer

SECTION 6 – ALTERNATE BILLING DESIGNEE

I understand that I have the right to designate at least one person other than myself to receive notice before my coverage terminates for nonpayment of premium. I designate:

First Designee Name: _____

Home Address: _____
Number and Street

City _____ State _____ ZIP code _____

Second Designee Name: _____

Home Address: _____
Number and Street

City _____ State _____ ZIP code _____

OR

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

Applicant's Signature _____ **Date** ____ / ____ / ____

SECTION 7 – AUTHORIZATION

NOTICE: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may have violated the laws in his or her state.

I understand and agree that the statements in this application are complete and true to the best of my knowledge and belief and that they will form a part of the contract of insurance. I also understand and agree that the insurance for which I am applying, if issued, shall be based on these statements.

I authorize any insurance company, reinsuring company, insurance reporting agency, employer, the Veterans Administration, licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility having medical records or knowledge of me, or my health, to give to the Continental Casualty Company any such information, in order to evaluate my application for long-term care insurance. A photostatic copy of this authorization is as valid as the original.

This authorization shall remain in effect for two years and six months from the date shown below. I have read this authorization and understand I can receive a copy.

I certify that I have read, or had read to me, the completed application. All statements in this application are representations and not warranties. If this application is accepted, the insurance will take effect on the effective date shown on the schedule page attached to the certificate of coverage.

Caution Notice: If your answers on this application are incorrect or untrue, the Continental Casualty Company may have the right to deny benefits or rescind your coverage, subject to the incontestability provision in the policy.

Applicant's Signature _____ **Date** ____ / ____ / ____

Coverage is not guaranteed and is based on the information provided.