

Applying is easy!

Just follow these simple instructions. *Send no money now.*

Complete the **Short-Form Application** if you are an **employee** who is enrolling after the six-month enrollment period or the **spouse** of an employee who is enrolling at any time.

TIPS

1. Fill in each section of the application carefully, answering each question completely. If any parts are left blank, we cannot your application.
2. The employee and spouse should complete his or her own application.
3. Select the one Daily Maximum Benefit and Lifetime Maximum Benefit you prefer.

Then select the Inflation Protection Feature of your choice. Premiums for the plan options are in the plan booklet.

NOTE: The employee must enroll before the spouse may apply.
4. If you are an employee, complete Sections One, Two, Three, and Five. Then read and sign Sections Four and Six.
5. If you are a spouse, complete Sections One, Two, Three and Five. Be sure to include the employee's name and social security number in Section Three. Then read and sign Section Six. The employee must read and sign Section Four.
6. We will inform you by mail whether you have been accepted. If accepted, we will send your certificate via First Class Mail.
7. Premiums will be deducted from the employee's paycheck.
8. When completed, return your application to:
CNA Insurance
P.O. Box 946760
Maitland, FL 32794-9776

Questions?

**Just call a CNA customer service representative at
Toll-free 1-877-895-6761**



Group Long-Term Care Short-Form Application

If any parts of Sections 1 through 6 are blank, your short-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 – EMPLOYEE INFORMATION

I certify that I am the: Employee Spouse of an employee

Employee Name: First, Middle, Last	Employee Social Security Number
Date of Hire	Payroll Location

SECTION 4 – PAYMENT METHOD

I authorize **The Texas A&M University System** to make payroll deductions for the above specified coverage and release other necessary information to the administrators of this program.

Employee's Signature _____ Date ____/____/____

OVER, PLEASE

SECTION 5 – STATEMENT OF INSURABILITY

1. Height _____ ft. _____ in. Weight _____ lbs.
2. During the last seven (7) years have you been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or other immune system disorder?..... **YES** **NO**
3. During the last seven (7) years have you been diagnosed, received medical advice or treatment by a member of the medical profession for any of the following:
- a. Acquired Immune Deficiency Syndrome (AIDS) or any other Immune System Disorder.....
 - b. Alzheimer's Disease, Dementia or Change in Cognitive Functioning.....
 - c. Multiple Sclerosis, Huntington's Disease, Parkinson's Disease or Amyotrophic Lateral Sclerosis.....
 - d. Emphysema, Chronic Bronchitis or Asthma.....
 - e. Cancer which has spread or metastasized.....
 - f. Heart Disorder.....
 - g. Diabetes Mellitus, Glucose Intolerance or Hyperglycemia.....
 - h. Cerebral Vascular Accident, Stroke or Transient Ischemic Attack.....
 - i. Alcoholism or Substance Abuse.....
 - j. Bone or Joint Disease or Disorder requiring prescription medication or surgery.....
 - k. Mental, Emotional or Nervous Disease or Disorder, Depression or Chemical Imbalance.....
4. Have you used any tobacco products more than once a month at any time during the last three years?.....
5. At any time during the last two years have you needed assistance or supervision or were you limited in any way physically or cognitively from performing any of the daily activities of bathing, dressing, toileting, mobility, eating or managing medications?
6. At any time in the last seven years have you applied for or received Social Security disability benefits or Medicaid?
7. Do you currently have or have you had in the past 12 months any long-term care insurance in force other than Group Long-Term Care Insurance from Continental Casualty Company or have you applied for such insurance? If yes, what company and if the policy has lapsed, when did it lapse?
8. Do you intend to replace any medical or health insurance coverage, including a health care service contract or health maintenance organization, with insurance applied for with this application other than with Group Long Term Care from Continental Casualty Company?

SECTION 6 – 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 have 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.