



INDIVIDUAL

Long Term Care Insurance

APPLICATION

This policy for long term care insurance is intended to be a federally qualified long term care insurance policy and may qualify you for federal and state tax benefits.

THIS POLICY IS AN APPROVED LONG TERM CARE INSURANCE POLICY UNDER CALIFORNIA LAW AND REGULATIONS. THE BENEFITS PAYABLE BY THIS POLICY WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG TERM CARE. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE CALIFORNIA PARTNERSHIP FOR LONG TERM CARE, CALL THE HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM AT THE TOLL-FREE NUMBER, 1-800-434-0222.

underwritten by UnumProvident subsidiary
Unum Life Insurance Company of America
2211 Congress Street
Portland, ME 04122

Instructions for Completing the Long Term Care Application

Provide complete information in all sections of the application. Any changes made to the application must be initialed by the applicant.

If this is an application to reinstate a policy that has lapsed, and you were cognitively impaired or had a loss of functional capacity at the time of the lapse, you may have additional rights or time periods in which to apply. Please refer to your policy documents.

Please be sure the following sections are reviewed and/or completed by the applicant:

- ✓ Part 8 Protection Against Unintended Lapse
- ✓ Part 9 Acknowledgement
- ✓ Part 13 Signature
- ✓ Page 6 Personal Worksheet

I AM APPLYING FOR

- A New Policy A Change in Coverage A Reinstatement

BROKER/AGENT COMPLETES FOLLOWING SECTION

Instructions: If this offering is for modified underwriting coverage, please remove pages 2a, 2b and 2c from this application. All other information must be completed.

If the applicant is requesting coverage above the modified underwriting offer, pages 2a, 2b and 2c must be completed.

1. Special Offerings:

Conversion from Disability Income Policy: Policy # _____

Other: _____

2. Employer Programs:

Employer Sponsored (Direct Bill) Flex Bill (list bill) Modified Underwriting

Employer Name: _____

Employee Spouse Family Member

Other: _____

3. Organization Discounts:

Affinity Association Franchise Other

Name of Organization: _____

Comments: _____



INDIVIDUAL LONG TERM CARE INSURANCE APPLICATION

Unum Life Insurance Company of America
2211 Congress Street, Portland, Maine 04122

Any changes made to the application must be initialed by the Applicant

Part 1: Personal Information	
a. Name (Last, First, Middle): _____	b. Social Security Number: _____
c. <input type="checkbox"/> Home <input type="checkbox"/> Work Address: _____ _____ City: _____ State: _____ Zip Code: _____	d. Date of Birth: _____ (mo/day/year) Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
e. Telephone Number: (____) _____ Best time to Contact: _____	f. Do You Work at Least 30 Hours/Week? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Hire/Eligibility: _____ (complete if applying through Employer offer)
g. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed Is Your Spouse Applying for Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse's Name: _____	

Part 2: Statement of Health Part A		
Do you use a:		
<input type="checkbox"/> Yes <input type="checkbox"/> No Wheelchair	<input type="checkbox"/> Yes <input type="checkbox"/> No Walker	<input type="checkbox"/> Yes <input type="checkbox"/> No Quad Cane
<input type="checkbox"/> Yes <input type="checkbox"/> No Crutches	<input type="checkbox"/> Yes <input type="checkbox"/> No Hospital Bed	<input type="checkbox"/> Yes <input type="checkbox"/> No Dialysis Machine
<input type="checkbox"/> Yes <input type="checkbox"/> No Oxygen	<input type="checkbox"/> Yes <input type="checkbox"/> No Stairlift	<input type="checkbox"/> Yes <input type="checkbox"/> No Hoyer Lift

Part 2: Statement of Health Part B		
Do you currently need or receive help in doing any of the following:		
<input type="checkbox"/> Yes <input type="checkbox"/> No Bathing	<input type="checkbox"/> Yes <input type="checkbox"/> No Eating	<input type="checkbox"/> Yes <input type="checkbox"/> No Dressing
<input type="checkbox"/> Yes <input type="checkbox"/> No Toileting	<input type="checkbox"/> Yes <input type="checkbox"/> No Transferring	<input type="checkbox"/> Yes <input type="checkbox"/> No Maintaining Continence

If you answered "Yes" to any question in Part 2 A or B, DO NOT SUBMIT THIS APPLICATION.

Part 3: Insurance History (Required by Law)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	3a. Do you have another long term care insurance policy in force, including health care service contract, or health maintenance organization contract?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3b. Have you had another long term care insurance policy in force during the last 12 months? If so, with which company: _____ If it has lapsed, when did it lapse? _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	3c. Are you covered by Medicaid (not Medicare)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3d. Are you receiving Disability, Worker's Compensation, or Social Security Disability Benefits?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3e. Do you intend to replace any of your medical or health coverage with the coverage applied for?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3f. Have you activated a Power of Attorney authorizing another individual to manage your personal affairs? Why _____

Part 4: Choice of Contract	4a. <input type="checkbox"/> Tax Qualified	
Plan Design	Advantage I Only	Advantage Plus Only
4b. Monthly Benefit:	Nursing Facility \$ _____ (Increments of \$100) From \$1,000 to \$6,000	Long Term Care Facility \$ _____ (Increments of \$100) From \$1,000 to \$8,000
4c. Home Care Coverage Options:	<input type="checkbox"/> Home Care Home & Community-Based Care <input type="checkbox"/> Home Care Home, Community-Based & Immediate Family Care	<input type="checkbox"/> Home Care Home & Community-Based Care <input type="checkbox"/> Home Care Home, Community-Based & Immediate Family Care
4d. Home Care Percent of Monthly Benefit:	<input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%	<input type="checkbox"/> 60% <input type="checkbox"/> 80% <input type="checkbox"/> 100%
4e. Elimination Periods (in Days):	<input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 180 <input type="checkbox"/> 365	<input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 180 <input type="checkbox"/> 365 <input type="checkbox"/> 730
4f. Benefit Periods (in Years):	<input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> Lifetime	<input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> Lifetime
4g. Benefit Increase Options:	<u>Benefit Increase Protection</u> <input type="checkbox"/> None <input type="checkbox"/> 5% Simple <input type="checkbox"/> 2x <input type="checkbox"/> No Cap <input type="checkbox"/> 5% Compound 2x <u>Inflation Protection</u> <input type="checkbox"/> None <input type="checkbox"/> 5% Compound No Cap	<u>Benefit Increase Protection</u> <input type="checkbox"/> None <input type="checkbox"/> 5% Simple <input type="checkbox"/> 2x <input type="checkbox"/> No Cap <input type="checkbox"/> 5% Compound 2x <u>Inflation Protection</u> <input type="checkbox"/> None <input type="checkbox"/> 5% Compound No Cap
4h. Non-Forfeiture:	<input type="checkbox"/> None <input type="checkbox"/> Shortened Benefit Period	<input type="checkbox"/> None <input type="checkbox"/> Shortened Benefit Period
4i. Additional Provisions:	None Available	<input type="checkbox"/> Survivorship Waiver <input type="checkbox"/> Restoration of Benefits

Part 5: Policy Administration

5a. Premium Payment Interval: Annual Semi-Annual Quarterly Monthly

5b. Accelerated Payment Option (APO): 10 Year To age 65

5c. Billing Discount: 2 Year Prepayment Discount (Not available with APO)

5d. Method of Billing: Flex bill (List) Direct bill Other _____

5e. Send Bills to: Applicant Employer Other _____

Premium Billing Name and Address (if different than Part 1c): _____

Billing Phone Number: (_____) _____

5f. Is advanced payment made with this application? Yes No

Modal Premium Amount: \$ _____ Annual Premium Amount: \$ _____

5g. Dating Requests: Date to Save Age Special Policy Date _____ Other _____

Corrections and Amendments (Home Office use Only):

Part 6: Medical Profile					
		6a. Your Height:_____ Your Weight:_____			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	6b. Have you had a weight gain of 10 or more pounds in the last 12 months?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	6c. Have you had a weight loss of 10 or more pounds in the last 12 months?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	6d. Was the weight change due to a medical condition?			
In the next 6 months do you plan:					
<input type="checkbox"/> Yes	<input type="checkbox"/> No	6e. to be hospitalized?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	6f. to have surgery?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	6g. to have any diagnostic tests (e.g. EKG, MRI, x-ray)?			
In the last 12 months have you:					
<input type="checkbox"/> Yes	<input type="checkbox"/> No	6h. experienced episodes of falling, fainting, dizziness or imbalance?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	6i. used tobacco products (smoked, chewed, or used a nicotine delivery system), including pipes and cigars?			
Within the past five (5) years, have you been diagnosed with, treated or consulted with a licensed physician or been referred to another licensed physician for any of the following conditions? If you answer "Yes" to any of the following conditions, Do not submit this application. If not please continue.					
<input type="checkbox"/> Yes <input type="checkbox"/> No	Ambulation Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Ataxia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiomyopathy
<input type="checkbox"/> Yes <input type="checkbox"/> No	Catheter use	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cerebral Palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Obstructive Pulmonary Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cirrhosis of the Liver	<input type="checkbox"/> Yes <input type="checkbox"/> No	Confusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Crohn's Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No	Defibrillator use	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dementia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Abuse
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hairy Cell Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hodgkin's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Huntington's Chorea
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hydrocephalus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence, bowel or bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Memory Loss
<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Retardation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Myeloma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis
<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Myasthenia Gravis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Organ Transplant (except cornea)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Organic Brain Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ostomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paraplegia
<input type="checkbox"/> Yes <input type="checkbox"/> No	Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poliomyelitis (Polio)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Polycythemia Vera	<input type="checkbox"/> Yes <input type="checkbox"/> No	Progressive Muscular Atrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Post Polio Syndrome
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Quadriplegia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Schizophrenia
<input type="checkbox"/> Yes <input type="checkbox"/> No	Scleroderma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sjogren's Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	Systemic Lupus Erythematosus
<input type="checkbox"/> Yes <input type="checkbox"/> No	Temporal Arteritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thrombocytopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wilson's Disease

Within the past five (5) years, have you been diagnosed with, treated or consulted with a licensed physician or been referred to another licensed physician for any of the following conditions? If you answer “Yes” to any of the following conditions, please provide the Physician information on page 2c.

<input type="checkbox"/> Yes <input type="checkbox"/> No	Amputation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aneurysm
<input type="checkbox"/> Yes <input type="checkbox"/> No	Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arrhythmia/ Irregular Heart Beat
<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma/ Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Atrial Fibrillation
<input type="checkbox"/> Yes <input type="checkbox"/> No	Back Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Barrett’s Esophagus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer
<input type="checkbox"/> Yes <input type="checkbox"/> No	Carotid Artery Disease/ Stenosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Fatigue Syndrome
<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Colitis/Irritable Bowel Syndrome/Ulcerative Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congestive Heart Failure
<input type="checkbox"/> Yes <input type="checkbox"/> No	Coronary Heart/Artery Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes
<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocarditis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy/Seizures
<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures, including compression fractures of the spine
<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack (Myocardial Infarction)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hip Fractures/ Disorders/ Replacement
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hyperglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia
<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease/ Renal Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Knee Replacement
<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoarthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paget’s Disease of Bone
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Peripheral Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostatic Hypertrophy, Benign (BPH)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Polymyalgia Rheumatica	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sarcoidosis
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal Stenosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Steroid Therapy
<input type="checkbox"/> Yes <input type="checkbox"/> No	Thrombophlebitis/ Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Valvular Heart Disease		

Primary Physician’s Name:	Date of Last Physical Exam: Month Day Year
Primary Physician’s Address:	Primary Physician’s Telephone Number: ()

If you checked "Yes" to any of the questions in Part 6, please list all medications prescribed and provide the appropriate details as requested below (include both prescribed and over the counter medications).

Physician (Name & Specialty):	Telephone Number:
Clinic/Office Name:	()
Address (Street, City, State, Zip Code):	
Medication(s) you are taking for the condition checked in Medical Profile - Part 6:	Condition you are taking the medication for:
Date you last visited this Physician:	

Physician (Name & Specialty):	Telephone Number:
Clinic/Office Name:	()
Address (Street, City, State, Zip Code):	
Medication(s) you are taking for the condition checked in Medical Profile - Part 6:	Condition you are taking the medication for:
Date you last visited this Physician:	

Physician (Name & Specialty):	Telephone Number:
Clinic/Office Name:	()
Address (Street, City, State, Zip Code):	
Medication(s) you are taking for the condition checked in Medical Profile - Part 6:	Condition you are taking the medication for:
Date you last visited this Physician:	

Physician (Name & Specialty):	Telephone Number:
Clinic/Office Name:	()
Address (Street, City, State, Zip Code):	
Medication(s) you are taking for the condition checked in Medical Profile - Part 6:	Condition you are taking the medication for:
Date you last visited this Physician:	

To Be Completed by All Advantage Plus Applicants (Not applicable to Advantage I)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Have you used tobacco products (smoked, chewed, or used a nicotine delivery system) including cigars or pipes within the last twelve months?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Do you use mechanical devices, such as a wheelchair, walker, quad cane, crutches, hospital bed, dialysis machine, oxygen or stairlift?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Do you need assistance with personal care including use of the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry or light housekeeping?
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Is your height and weight outside our Preferred range (see page 17 of this application)?

If you answered No to all of these questions, you qualify for a 10% Preferred Discount

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Part 7: Authorization for Automatic Payments (Monthly Bank Draft)

Authorization and Agreement for Automatic Payments drawn by and payable to Unum Life Insurance Company of America. I authorize the bank indicated below to pay and charge my account debit entries, including checks, drafts, and other orders by electronic or paper means, made by and payable to Unum Life Insurance Company of America. I have attached a copy of a voided check, reflecting my account number, from the bank authorized to pay and charge my account debit entries.

Applicants' Name: _____

Name of Bank: _____

Bank Address: _____

Name(s) of Depositor(s): _____

Account Number: _____ Signature (s): _____

Please attach void check to this Page

Part 8: Protection Against Unintended Lapse

I understand that I have the right to designate up to three person(s), other than myself, to receive Notice of Lapse/Termination of this insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

I ELECT to, I ELECT NOT to designate a person(s) to receive such notice

Name: _____ Address: _____

Telephone Number: _____

Name: _____ Address: _____

Telephone Number: _____

Name: _____ Address: _____

Telephone Number: _____

Part 9: Acknowledgment

Please advise if you have received the following documents with this application:

- Outline of Coverage Yes No
- HICAP Notice (Item 13 in the Outline of Coverage) Yes No
- A Consumer's Guide to Long Term Care Yes No
- Things You Should Know Before You Buy Long Term Care Yes No
- Long Term Care Insurance Personal Worksheet Yes No
- Notice to Applicant Regarding Replacement of Accident and Sickness, Nursing Home or Long Term Care Insurance Yes No

I have reviewed the Outline of Coverage and the graphs that compare benefits and premiums of this policy with and without inflation protection. I have reviewed the Capped and Uncapped Compound and Simple inflation coverage and

→ I Accept Reject Inflation Protection.

I have reviewed the policy with and without Non-Forfeiture Benefit as described therein.

→ I Accept Reject the Non-Forfeiture Benefit.

I understand that if no advance payment is made with the application, any subsequent change in health status prior to the Date of Issue will affect the application process.

Part 10: Agreement

I have read this application and I understand that: Unum Life Insurance Company of America (Unum) will rely on the information provided in this application and any supplemental application, medical exams or tests and other questionnaires to determine whether to provide the coverage I have requested. All these documents shall form a part of my contract of insurance and any coverage based on such information is contestable in accordance with the provisions of the Policy.

No agent, broker, medical examiner or other person, except an authorized employee of Unum, may change or waive questions asked or answers given in this application or in my medical examination, determine if I am eligible for coverage, promise that I will be issued coverage, or change or waive any rights or requirements of Unum.

I agree that payment of premium is my responsibility. If any other person collects, pays or forwards any part of the premium for this coverage, he/she acts as my agent and not an agent of Unum. If Unum does not receive premium as due, the policy will lapse in accordance with the provisions of the policy.

If I make an advance payment (prepaid premium) with this Application, insurance will be effective only as provided by the terms of the Conditional Receipt for Advance Payment.

If I make no advance payment with this Application, I understand the policy will not be effective until a policy has been delivered to me and I have paid the first premium.

If a policy is issued, the Effective Date will be the issue date as stated in the policy.

Part 11: Broker/Agent Certification (Must be completed by Broker/Agent, except where coverage is sold without Broker/Agent.)

I certify that I have asked the applicant all the questions on this Application and that the information recorded in this Application and Broker's Certification accurately reflects the information supplied by the proposed insured.

To the best of my knowledge, replacement of other insurance is is not involved in this transaction. Listed below are all other health insurance policies I have (a) sold to the Applicant which are still in force; and (b) sold to the Applicant in the last five years which are no longer in force.

Company	Type of Policy	Effective Date	In Force?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

This Application was obtained:

via the mail in person over the telephone

Other (please explain)

Personal Worksheet

A rate guide is available, that compares the policies sold by different insurers, the benefits provided in those policies, sample premiums, and the history of rate increases, if any, for those policies. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free number (1-800-434-0222) or by accessing the Department of Insurance's Internet web site (www.insurance.ca.gov).

People buy long term care insurance for a variety of reasons. These reasons include avoiding spending assets for long term care, making sure there are choices regarding type of care received, protecting family members from having to pay for care, or decreasing the chances of going on Medicaid.

However, long term care insurance can be expensive and may not be appropriate for everyone. State law requires the insurance company to ask you to complete this worksheet to help you and the insurance company determine whether or not you should buy this policy.

Premium

The premium for the coverage you are considering will be \$_____ per year.

The company reserves the right to change the premiums for this policy in the future. To do so, the company must change the premiums for all similar policies issued in your state for this policy form. Unum has not increased or requested increases in premium for any of its long term care policies issued in California or any other policy issued in the United States.

The company has sold long term care insurance since 1988.

Have you considered whether you could afford to keep this policy if the premiums were raised in the future?

Income

Where will you get the money to pay each year's premium?

Income Savings Family Members Other _____

What is your annual income? **(Check One)**

Under \$10,000 \$10 - 50,000 Over \$50,000

How do you expect your income to change over the next 10 years? **(Check One)**

No Change Increase Decrease

If you will be paying premiums with money received only from your income, a rule of thumb is that you may not be able to afford this policy if the premium will be more than 7% of your income.

Savings and Investments

Not counting your home, what is the approximate value of all of your assets? **(Check One)**

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

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

Stay about the same Increase Decrease

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

Disclosure Statement

I. Applicant (Check One)

- a) The information provided above accurately describes my financial situation;
OR
- b) I choose not to complete this information;

Signed: _____ **Date:** _____
(Applicant)

II. Agent:

I explained to the Applicant the importance of completing this information.

Signed: _____ **Date:** _____
(Agent)

III. Applicant (Sign below - if applicable):

My agent has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.

Signed: _____ **Date:** _____
(Applicant)

The company may contact you to verify your answers.

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<p>Conditional Receipt (Pre-Payment)</p>	<p>Applicant Copy Conditional Receipt/Prepayment Agreement Unum Life Insurance Company of America 2211 Congress Street, Portland, ME 04122</p>
<p>If money is received with the application, complete this section (to be completed by the applicant).</p> <p>I acknowledge that I have been given a Conditional Receipt for pre-payment. I have read it and understand and agree to its provisions.</p> <hr/> <p>Signature of Applicant</p> <hr/> <p>Date</p>	<p>Received: \$ _____</p> <p>From: _____</p> <p>Date: _____</p> <p>The undersigned acknowledges receipt of the amount stated above and paid with this application, said application being for insurance from Unum Life Insurance Company of America in the form or forms and with benefit limits as set out below, and said amount being received subject to the following conditions and provisions:</p> <p>If the Company is satisfied that on the date of this receipt the applicant proposed for coverage is insurable as standard risk in accordance with the Company's rules and practices for the plan and amounts applied for, the application will be approved; otherwise the application will be disapproved.</p> <p>If the application is approved, insurance issued pursuant thereto shall be effective from the date of the receipt, and (a) if the amount acknowledged by this receipt is sufficient to pay the full premium for the initial term, the insurance shall be in force for said term, or (b) if the amount is insufficient to pay the full premium of the initial term, the insurance shall be in force only for a period equal to such proportionate part of the initial term as the money paid bears to the full premium for the initial term.</p> <p>If said application is not approved, the Company shall have no liability under this receipt or under said application except for the return of the amount paid with said application.</p> <p>All premium checks must be made payable to Unum Life Insurance Company of America. Do not make check payable to the agent or leave the payee blank.</p> <p>Broker/Agent (acknowledging receipt of payment):</p> <hr/>

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Replacement Notice – Company Copy	Replacement Notice – Applicant Copy
<p>NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE. Save this notice! It may be important to you in the future.</p>	<p>NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE. Save this notice! It may be important to you in the future.</p>
<p>According to your application, you intend to lapse or otherwise terminate existing accident and sickness, long term care, or nursing home insurance and replace it with coverage to be issued by Unum Life Insurance Company of America. Your new coverage provides thirty (30) days within which you may decide, without cost, whether you desire to keep the coverage. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new coverage.</p> <ol style="list-style-type: none"> (1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new coverage. This could result in denial or delay in payment of new benefits under the new coverage, whereas a similar claim might have been payable under your present coverage. (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage. (3) If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded. <p>The above "Notice to Applicant" was delivered to me on:</p> <p>Date: _____</p> <p>Applicant's Signature: _____</p>	<p>According to your application, you intend to lapse or otherwise terminate existing accident and sickness, long term care, or nursing home insurance and replace it with coverage to be issued by Unum Life Insurance Company of America. Your new coverage provides thirty (30) days within which you may decide, without cost, whether you desire to keep the coverage. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new coverage.</p> <ol style="list-style-type: none"> (1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new coverage. This could result in denial or delay in payment of new benefits under the new coverage, whereas a similar claim might have been payable under your present coverage. (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage. (3) If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

COMPARISON TO YOUR CURRENT COVERAGE: I have reviewed your current long term care coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:.

- Additional or different benefits (please specify);
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- Other (please specify):

COMPARISON TO YOUR CURRENT COVERAGE: I have reviewed your current long term care coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:.

- Additional or different benefits (please specify);
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- Other (please specify):

Signature of Agent and Name of Insurer:

Applicant's Signature:

Date: _____

Signature of Agent and Name of Insurer:

Date: _____

Applicant Should Retain a Copy of This Notice

APPLICANT RETAINS THIS PAGE

Things You Should Know

Things You Should Know Before You Buy Long Term Care

- | | |
|---------------------------------|---|
| Long Term Care Insurance | <ul style="list-style-type: none">• A long term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.• You should not buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.• The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs. |
| Medicare | <ul style="list-style-type: none">• Medicare does not pay for most of long term care. |
| Medicaid | <ul style="list-style-type: none">• Medicaid will generally pay for long term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.• Many people become eligible for Medicaid after they have used up their own financial resources by paying for long term care services.• When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance and some of your joint assets.• Your choice of long term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local and state Medicaid agency. |
| Shopper's Guide | <ul style="list-style-type: none">• Make sure the insurance company or agent gives you a copy of a booklet called the "Guide to Long Term Care". Read it carefully. If you have decided to apply for long term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy. |
| Counseling | <ul style="list-style-type: none">• Free counseling and additional information about long term care insurance are available through your state's insurance counseling program. Contact your state department on aging for more information about the senior health insurance counseling program in your state. |

MEDICARE NOTICES

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE
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(For long term care policies providing both nursing home and non-institutional coverage)

Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.

This is long term care insurance that provides benefits for covered nursing home and home care services.

In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.

This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about long term care insurance, review the Shopper's Guide to Long Term Care Insurance, available from the insurance company.

For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE
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(For long term care policies providing nursing home only coverage)

Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.

This insurance provides benefits primarily for covered nursing home services.

In some situations Medicare pays for short periods of skilled nursing home care and hospice care.

This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplemental insurance provides benefits for most nursing home expenses.

Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about long term care insurance, review the Shopper's Guide to Long Term Care Insurance, available from the insurance company.

For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

APPLICANT RETAINS THIS PAGE

Disclosure

Notice of Insurance Information Practices

Thank you for applying to Unum. As part of our normal underwriting procedure, we need to obtain information to determine an Applicant's eligibility for insurance. Much of that information will come from you, however, we often obtain additional information or verify information through other sources.

Collection

Your application, including the medical questionnaire and any exams, is our main source of information. However, Unum may need to obtain additional information from other sources about your age, physical condition, occupation, other insurance coverage, health history, avocations, general reputation and lifestyle.

Unum may obtain this information from physicians, hospitals, clinics or other medical professionals or medical care facilities. We may collect information in person, by telephone, or by exchanges of correspondence.

Disclosures

Unum will not disclose to others the information which we obtain about you, without your prior authorization, except as necessary to conduct our business (and then only if disclosure is permitted by law).

For example, if necessary, Unum may disclose information to:

- persons and organizations that perform insurance, or business or professional services for us;
- other insurance companies to which you have applied for coverage or benefits;
- other insurance companies, agents, or insurance support organizations to help detect or prevent insurance fraud or misrepresentation;
- a medical professional or facility so it can properly notify you of a medical condition of which you may not be aware;
- our reinsurers;
- insurance departments or commissions in connection with audits or examinations of our company;
- law enforcement agencies to help prevent or prosecute fraud or to alert them that unlawful activity may have occurred; or
- a research or actuarial organization.

These are disclosures that Unum is permitted to make - not disclosures that we make often. In fact most disclosures made by us are to identify you for collection of information, for reinsurance or other services, or to help detect or prevent fraud and misrepresentation.

Access to Information

You have a right to recorded personal information about you which is in Unum's files and is reasonably locatable. To ensure security of information in our files, we will require positive identification before we allow access to that information. To obtain access to recorded personal information about you, send a signed, written request to the address on the front page of this Application. Give your full name, address, telephone number, and policy number if a policy has been issued.

Within 30 business days after we receive your request, we will inform you of the nature and substance of the information in our files which is reasonably locatable and retrievable. We will also tell you to whom we have disclosed this information within the last two years. If you wish we can show you the information at our Home Office or we will mail copies to you. However, we reserve the right to disclose medical information only through a medical professional chosen by you. You may have to pay a reasonable charge to cover the cost of the copies.

Correction of Information

If you believe any of Unum's information is not correct, please notify us and explain why you believe it is inaccurate or incomplete. We will review it. If we agree with you, we will correct the information and notify any person designated by you to whom we have disclosed the information within the preceding two years.

If we disagree with you, we will tell you that we will not make the requested change. Then you may submit to us information and your reasons for disagreeing with our decision not to change the information. We will then furnish your statement to any person designated by you to whom we disclosed the information in the prior two years and to anyone else who may receive the information from us in the future.

Height and Weight Charts			
Females ages 18 and Over			
Height	Preferred Range	Height	Standard Range
4' – 8"	94 – 163	4' – 8"	164-191
9"	96 – 166	9"	167-195
10"	97 – 170	10"	171-199
11"	99 – 174	11"	175-203
5' – 0"	102 – 178	5' – 0"	179-208
1"	104 – 182	1"	183-213
2"	107 – 186	2"	187-218
3"	110 – 191	3"	192-223
4"	112 – 196	4"	197-229
5"	115 – 200	5"	201-234
6"	118 – 205	6"	206-239
7"	120 – 210	7"	211-245
8"	125 – 215	8"	216-251
9"	127 – 221	9"	222-257
10"	131 – 228	10"	229-264
11"	135 – 236	11"	237-272
6' – 0"	139 – 244	6' – 0"	245-282
1"	143 – 252	1"	253-291
2"	148 – 260	2"	261-300
3"	152 – 268	3"	269-309
4"	156 – 276	4"	277-318
Males ages 18 and Over			
Height	Preferred Range	Height	Standard Range
5' – 0"	111 – 180	5' – 0"	181-213
1"	114 – 184	1"	185-217
2"	116 – 188	2"	189-222
3"	120 – 193	3"	194-227
4"	123 – 198	4"	199-232
5"	126 – 203	5"	204-238
6"	130 – 208	6"	209-244
7"	133 – 214	7"	215-250
8"	136 – 220	8"	221-257
9"	140 – 226	9"	227-264
10"	144 – 232	10"	233-271
11"	148 – 238	11"	239-278
6' – 0"	152 – 244	6' – 0"	245-285
1"	155 – 251	1"	252-292
2"	160 – 258	2"	259-299
3"	164 – 265	3"	266-307
4"	169 – 272	4"	273-315
5"	173 – 279	5"	280-323
6"	178 – 286	6"	287-331
7"	183 – 293	7"	294-339
8"	188 – 300	8"	301-347

Preferred Discount only available with Preferred Weight Range. Note: An applicant weighing more than the weight, indicated in the Standard Weight column, is uninsurable.

FOR BROKER/AGENT USE ONLY

For commission purposes, please indicate the individual name or corporate entity (insurance agency) responsible for receiving commissions on this policy, **directly from UnumProvident**. Also, please indicate the UnumProvident producer number and or the Social Security Number or Tax Identification number.

Commissions are being paid to: (Individual or Corporation)	UnumProvident Producer Number and/or Tax ID	Split%	Send correspondence to: (primary indicated)
1.		_____ %	
2.		_____ %	
3.		_____ %	
4.		_____ %	
5.		_____ %	

Any changes to the above form (white-outs, cross-outs, etc.) will require a broker/agent verification form.

UnumProvident Contracted Affiliation – (To be completed by Field Office or General Agent.)

UnumProvident Marketing Partner (i.e.; SGA, MGA, Co-Marketing, etc.)

Print or Stamp Name: _____ **Date:** _____