Employer Group Discount

Carrier	Prudential LTC3	John Hancock Corp Choice	John Hancock Corp Solutions	MetLife	Genworth	Med America
CASE DISCOUNT	5% ESP Employees, Spouses, Qualified Adults and other eligible Family Members Parents, in-laws, aunts, uncles, siblings, grandparents, granparents-in-law, children 18 and older. (*10% Discount available NY & NJ)*	5% Discount, **Simplified or Guaranteed Issue Available** - based on Hancock's decision. FULL UW: Spouses, Qualified Adults and other eligible Family Members	5% Discount Simplified Underwriting --- **Not avail in NY & CA**	10% Discount (Simplified uw for eligible EEs), 5% (modified uw for Spouses, Domestic Partners, Adult Children, Parents, Step-parents, In-Laws, Grandparents, Step-Grandparents)	5% Discount	10% for all Participants
Case Design	Up to $300 Daily, Calendar Day to 365 EP, up to 150% Home Care (with Daily Benefit up to $200), up to 6 year benefit period; Daily, Monthly, Flex Cash or Cash; All inflation otions -- Riders Avail but may vary by state	Up to $300 Daily, 6 year benefit, GPO or Compound, No Simple Inflation	LEADING EDGE Simplified UW: up to $300 Daily , $9000 Monthly, 5yr benefit, inflation and riders. Full UW: Any Leading Edge Choices	Up to $300 Daily, 5 year benefit period, Calendar Day, All inflation otions . All benefits available for modified underwriting	Any plan designs are available - full underwriting	Multiple Options available (see MedAm attachment)
COMMISSION IMPACT	ESP Commission Reduced to 50% / 5% (*In NY & NJ 47.5% / 2%*) ---- Commissions further reduced for Limited Pay Cases (10-Pay and Pay to 65)	ER Pay: no reduction. Commission Reduced to 45% on Voluntary Paid	Commission Reduced to 45% on Voluntary Paid	No Commission Reduction on 10+ lives Reduction on 3 -9 live plans based on group's market segment, eligible population and plan type.	Commission Reduced to 40%	Commission Reduced to: 45% (ages 18 - 64) and 35% (ages 65 - 85) Limited Pay Options (to 65 and 10-Pay) are further reduced
CASE SIZE REQUIREMENT - INITIAL	ER Group of 2-6 lives: like Affiliation 5% Discount Only, no minimum lives requirement, full Underwriting, direct bill ----- ER Groups of 7+ : 7 minimum lives (Spouses/Partners do not count), Simplified Avail	25 Paid For by ER or 200 Voluntary Paid. All EEs - not Partners (Some wiggle-room on case-by-case basis)	7 ER Paid or 10 Voluntary Paid (of company of at least 100 EEs)	3 applications received together (bundled) within 1st 30 days - group suspended if not 3 pending or approved apps in 30 days (for 3 to 9 or 10+ ee cases)	First 4 Apps bundled together (can be combination of ER, EE, spouse)	10 Employees and up ---- need min 10 applications from 10 actively-at-work EEs (Care Partners don't count)
UNDERWRITING	Simplified Ages 18-65, 25 hours per week; Spouses: work 25 hours a week, ER Pay $250 annually or 25%	Simplified UW (GSI with good demographics)	Simplified UW	Simplified or Modified UW available (preferred avail w/ modified)	Full Underwriting	Simplified UW for eligible EEs during open enrollment , Standard UW for all others
ENROLLMENT PERIOD	60 Days	30 Days	60 Days	30 Days (new hires will be eligible)	First 4 must be submitted together	90 Days
Employer Sponsor Endorsement Letter Needed	Signed Employer Auth Form	Yes	Yes	Yes	Business Profile Form	Yes - ER Agreement Form
Agent Required Forms	Yes for ESP, approval form needed Call LTC (212) 697-2025 X309	Yes Call LTC (212) 697-2025 X309	Yes Call LTC (212) 697-2025 X309	Yes Call LTC (212) 697-2025 X309	Yes Call LTC (212) 697-2025 X309	Yes Call LTC (212) 697-2025 X309
SPOUSAL / QA DISCOUNT	*In NY:* 25% Both Spouses 10% One Spouse ------- *Out of NY* : 30% Both Spouses 15% One Spouse NY Discount capped at 35% ---------- Preferred Health (Spouse/Partner with FULL UW) loses the ESP group discount	Blended partner rates approx 17%	15% Partner/Marital Discount avail. (or) 30% Partner/Marital both both approved NY 10% / 20% Total Max 43.5% (NY 33%)	30% Spousal (both apply & accepted) 15% Marital (spouse does not apply or is declined) 15% Residential (same household and meet eligibilty) Max 33.5% (Full UW) 24% (Simplified)	40% Joint Married CT 30% max 25% couples in NY (to 35% cap)	Blended Care Partner Discount: Approx. 34% discount in all states except NY and CT. In CT it is about 25% discount and in NY about a 17% discount (regardless of whether partner applies)
PREFER HEALTH DISCOUNT	Preferred Health Discount *not* available for EEs even if Fully Underwritten - Spouse/Partner preferred class avail w/ Full UW	Preferred not available unless full underwriting - price based off demographics of group	Some industries able to receive preferred health discount of 15% (see JH Attachment)	No Preferred Health Discount for Simplified UW 10% Preferred Health Discount available for Full/ Modified Underwriting for qualified participants	Preferred Avail (w Multi-life plus and no tobacco 3 years, Preferred and PHI waived)	No Preferred Health Discount available
DISCOUNT LIMIT	No caps except NY - 35%	43% (Except NY where limit is 33%)	43% (Except NY where limit is 33%)	35% (Full UW)* 24% (Simplified)	35% cap in NY	No Discount Limits
Billing	Direct Bill	Payroll Electronic Billing Only (EE) Direct Bill Partners Family, etc.	Direct Bill or List Bill avail.	List Bill (Emp & Spouse -- monthly), Direct Bill or 3rd Party Billing Avail. -- Applicant chooses option.	List Bill or Direct Bill Avail. (on emp sponsor form)	Direct Bill & List Bill

February, 2010

Association / Affiliation Discount

Carrier	Prudential LTC3	John Hancock	MetLife	Genworth	Med America
CASE DISCOUNT	5% Discount for Association Members, Spouses, Qualified Adults and other eligible Family Members Parents, in-laws, aunts, uncles, siblings, grandparents, granparents-in-law, children 18 and older.	5% Discount	5% Discount	NOT AVAIL	10% for all eligibles (Affiliation members, Care Partners of Members, Family -- defined as Children/Stepchildren, Adopted children, Parents, In-laws, Grandparents, Grand-in-laws, Siblings)
Case Design	Any plans and riders approved in the state	Any plans ok -- (ER can't pay for more than 50% of premium in NY)	Any plans and riders approved in the state		All Simplicity ii plans available
COMMISSION IMPACT	Commission Reduced to 50% / 5% ---- Commissions further reduced for Limited Pay Cases (10-Pay and Pay to 65)	Commission reduced to 52.5% / 3.5% ---- No reduction for Leading Edge	No Commission Reduction on 10+ lives Reduction on 3 -9 live plans		Commission Reduced to: 45% (ages 18 - 64) and 35% (ages 65 - 85)
CASE SIZE REQUIREMENT - INITIAL	No Minimum	3 lives within 90 days (can be spouses)	3 lives within 30 Days (modified uw) - must have 3 pending or approved apps pr group will be suspended		1 Participant of group of 5 members or greater
UNDERWRITING	Full Underwriting	Full Underwriting	Modified UW		Full Underwriting
ENROLLMENT PERIOD	No Defined Enrollment Period	90 Days	After initial Open Enrollment Period, new Employees must enroll within 12 months		No Defined Enrollment Period
Sponsor Endorsement Letter Needed	Sponsor Letter Of Acknowlegement	Yes	Yes		No
Agent Required Forms	Yes Call LTC (212) 697-2025 X309	Yes Call LTC (212) 697-2025 X309	Yes Call LTC (212) 697-2025 X309		Yes Call LTC (212) 697-2025 X309
SPOUSAL / QA DISCOUNT	*In NY:* 25% Both Spouses 10% One Spouse *Out of NY:* 30% Both Spouses 15% One Spouse NY Discount Capped at 35%. Preferred Health (Spouse/Partner) (Full UW) loses the ESP group discount	15% Partner/Marital Discount avail. (or) 30% Partner/Marital both approved NY 10% / 20% Total Max 43.5% (NY 33%)	30% Spousal (both apply & accepted) 15% Marital Max 33.5% (Full UW) 24% (Simplified) * Availability may vary by state		1. 20% Single Married * 2. 40% Joint Married * * Vary by state: NY 10% / 20%, CT 15% / 30%
PREFER HEALTH DISCOUNT	Preferred Health Discount Avail	Available (see max discounts available above)	No Preferred Health Discount for Simplified UW 10% Preferred Health Discount available for Full/ Modified Underwriting.		15% Preferred Health Discount available to all participants
DISCOUNT LIMIT	No caps except NY - 35%	43% (Except NY where limit is 33%)	35% (Full UW)* 24% (Simplified)		No Discount Caps
Billing	Direct Bill	Direct Bill or List Bill avail.	List Bill (Emp & Spouse -- monthly), Direct Bill or 3rd Party Billing Avail. -- Applicant chooses option.		Direct Bill

Employer Simplified Knockout Questions

MetLife NY Knockout Questions | **Height & Weight? No** | Sposes simplified if ER pay 10+ lives

MetLife

PART B INSURABILITY QUESTIONS

SIMPLIFIED UNDERWRITING – Answer questions in Parts B and C, skip Part D (not applicable to Simplified Underwriting) and continue to Part E.
MODIFIED UNDERWRITING – Answer questions in all sections.

To the best of your knowledge and belief:	APPLICANT 1	APPLICANT 2
1. Have you had, do you currently have, have you ever been medically diagnosed as having or have you been treated for: **Circle all that apply** • Stroke (CVA) • Multiple Transient Ischemic Attacks (TIA's) • TIA within 5 years • Alzheimer's Disease • Dementia • Mental Retardation • Schizophrenia • Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) • Muscular Dystrophy • Multiple Sclerosis • Parkinson's Disease • Diabetes with amputation or complications affecting the kidney • Cancer that has spread to another area of your body including nodes; or cancer diagnosed or treated in the past 2 years (except basal cell cancer, squamous cell cancer of the skin or early stage breast or prostate cancer). • Organ Transplant	☐Yes ☐No	☐Yes ☐No
2. Have you ever been treated for or medically diagnosed as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), any AIDS related condition(s)? **This does not include any prior HIV test results.**	☐Yes ☐No	☐Yes ☐No
3. Do you currently reside in, or have you been advised to enter, or are you planning to enter a nursing home, assisted living facility or residential care facility or are you currently receiving home health care services or attending Adult Day Care?	☐Yes ☐No	☐Yes ☐No
4. Do you require human help or supervision for any of the following?: • bathing • dressing • eating • walking • toileting • transferring from bed or chair • controlling bowel or bladder	☐Yes ☐No	☐Yes ☐No
5. Do you currently use any of the following?: • dialysis • oxygen • wheelchair • walker • quad cane • crutches	☐Yes ☐No	☐Yes ☐No

SPOUSE OR DOMESTIC PARTNER OF EMPLOYEES ONLY

Complete this section if: You are part of a Simplified Underwriting group, and your Spouse's or Domestic Partner's employer is paying the premium.

Do you currently need or receive help with any of the following activities because you are unable to perform them yourself? ☐Yes ☐No

• taking medications • shopping • meal preparation • managing finances

IF "YES" please explain:

This information will be reviewed to determine if the coverage you selected can be approved. We may need to contact you for additional information.

MAIL THIS PAGE TO METLIFE

LTC3-ML-APP-NY 3

MetLife nonNY Knockout Questions | **Height & Weight? Yes if yes to any of the following** | Sposes simplified if ER pay 10+ lives

PART C INSURABILITY QUESTIONS

If you have any doubt about your answers, ask your doctor.

SIMPLIFIED UNDERWRITING – Answer questions in Part C. If all answers are **NO**, skip Part D and continue to Part E. If you answer **YES** to question 6, you must answer all of the questions in Part D and continue the application.

MODIFIED UNDERWRITING – Answer questions in all sections.

1. Have you ever been specifically diagnosed or treated by any medical professional for any of the following conditions:

YES	NO		YES	NO
❑	❑	Stroke (CVA)	❑	❑
❑	❑	Multiple Transient Ischemic Attacks (TIA's)	❑	❑
❑	❑	TIA within the past 5 years	❑	❑
❑	❑	Alzheimer's disease	❑	❑
❑	❑	Dementia / Organic brain syndrome	❑	❑
❑	❑	Memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication	❑	❑
❑	❑	Mental retardation	❑	❑
❑	❑	Schizophrenia	❑	❑
❑	❑	Amyotrophic Lateral Sclerosis (ALS)	❑	❑
		Muscular dystrophy	❑	❑
		Multiple sclerosis	❑	❑
		Parkinson's disease	❑	❑
		Huntington's chorea	❑	❑
		Cancer that has spread to another area of your body, including nodes; or cancer diagnosed or treated within the past 12 months (except basal or squamous cell of the skin)	❑	❑
		Diabetes with complications (e.g. amputation, kidney disease, eye disease, nerve disease); and/or diabetes combined with heart attack, bypass surgery, angina and/or TIA	❑	❑
		Organ transplant completed or medically advised	❑	❑

2. Have you been medically diagnosed as having or have you been treated by any medical professional for AIDS (Acquired Immune Deficiency Syndrome)/AIDS related conditions?	❑	❑
3. Do you require supervision or human assistance with: bathing; dressing; eating; walking; getting in/out of bed or a chair; use of toilet; or bowel/bladder control?	❑	❑
4. Do you use or have you been advised to use any of the following medical equipment: wheelchair; motorized scooter; walker; stair lift; quad cane; crutches; dialysis; or oxygen (except for sleep apnea)?	❑	❑
5. Do you currently reside in, or have you been advised to enter or use: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?	❑	❑
6. **Within the past 2 years,** have you had an application for MetLife Long-Term Care Insurance declined, postponed or rated less than standard? IF YES please answer all the questions in Part D. We will review your information and determine if you can be approved for coverage. We may need to contact you for additional information.	❑	❑

SPOUSE OR DOMESTIC PARTNER OF EMPLOYEES ONLY

Complete this section if: You are part of a Simplified Underwriting group, you are under age 66, and your Spouse or Domestic Partner's employer is paying the premium.

7. Do you need or receive help with any of the following activities because you are unable to perform them yourself: shopping, paying bills, meal preparation, transportation, laundry, or taking your medication? IF YES please explain: _____ This information will be reviewed to determine if the coverage you selected can be approved. We may need to contact you for additional information.	❑	❑

PART D HEALTH QUESTIONS (Provide additional information in the DETAILS section on page 5, if needed.)

SKIP PART D IF SIMPLIFIED UNDERWRITING

Primary Care Physician (with most of your records)

Physician _____ Phone Number ( ) _____ Date Last Seen _____
Address _____ City _____ State _____ Zip _____

All Physician Specialists (excluding podiatrists, dentists) seen within the past 5 years

Physician _____ Phone Number ( ) _____ Date Last Seen _____
Address _____ City _____ State _____ Zip _____

Physician _____ Phone Number ( ) _____ Date Last Seen _____
Address _____ City _____ State _____ Zip _____

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Employer Simplified Knockout Questions

Pru Knockout Qs (not NY) **Height & Weight? No**

MEDICAL HISTORY – PART 1 INSURABILITY PROFILE			Indicate Yes or No
☐ Yes	☐ No	1	Do you use a: ☐ Walker ☐ Oxygen ☐ Respirator ☐ Kidney Dialysis ☐ Wheelchair?
☐ Yes	☐ No	2	Within **the past 12 months** have you: ☐ Used Adult Day Care ☐ Needed Home Health Care
☐ Yes	☐ No		Been medically advised to enter or been confined to: ☐ A Nursing Home ☐ An Assisted Living Facility ☐ Other Long Term Care Facility
☐ Yes	☐ No	3	Do you currently need assistance or supervision by another person in performing any of the following activities: ☐ Bathing ☐ Eating ☐ Toileting ☐ Bowel or Bladder Control ☐ Moving In and Out of Bed or Chair ☐ Dressing ☐ Taking your Medication
		4	Have you had, do you currently have, or have you ever been diagnosed as having any of the following medical conditions:
☐ Yes	☐ No	a	Organic Brain Syndrome, Dementia, Senility, Confusion, Memory Loss, Alzheimer's Disease, or Schizophrenia?
☐ Yes	☐ No	b	Metastatic Cancer (cancer that has spread from the original site or location)?
☐ Yes	☐ No	c	Multiple Sclerosis (MS) Muscular Dystrophy, Multiple Transient Ischemic Attacks (TIA), Parkinson's Disease, Amyotrophic Lateral Sclerosis (ALS), Stroke, Cerebrovascular Accident (CVA), or Huntington's Disease?
☐ Yes	☐ No	d	Diabetes with heart, circulatory, or kidney complications?
☐ Yes	☐ No	5	Have you had, do you currently have, or have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)?

Attention Agent: The above conditions are uninsurable.

Employer Simplified Knockout Questions

Pru NY Knockouts **Height & Weight? No**

MEDICAL HISTORY – PART 1 INSURABILITY PROFILE — Indicate yes or no

☐ Yes ☐ No 1 Do you use a: ☐ Walker ☐ Oxygen ☐ Respirator ☐ Kidney Dialysis ☐ Wheelchair?

☐ Yes ☐ No 2 Within **the past 12 months** have you: ☐ Used Adult Day Care ☐ Needed Home Health Care

☐ Yes ☐ No Been medically advised to enter or been confined to:
☐ A Nursing Home ☐ An Assisted Living Facility ☐ Other Long Term Care Facility

☐ Yes ☐ No 3 Do you currently need assistance or supervision by another person in performing any of the following activities:
☐ Bathing ☐ Eating ☐ Toileting ☐ Bowel or Bladder Control
☐ Moving In and Out of Bed or Chair ☐ Dressing ☐ Taking your Medication

4 Have you ever been medically diagnosed as having any of the following medical conditions:

☐ Yes ☐ No a Organic Brain Syndrome, Dementia, Senility, Confusion, Memory Loss, Alzheimer's Disease, or Schizophrenia?

☐ Yes ☐ No b Metastatic Cancer (cancer that has spread from the original site or location)?

☐ Yes ☐ No c Multiple Sclerosis (MS) Muscular Dystrophy, Multiple Transient Ischemic Attacks (TIA), Parkinson's Disease, Amyotrophic Lateral Sclerosis (ALS), Stroke Cerebrovascular Accident (CVA), or Huntington's Disease?

☐ Yes ☐ No d Diabetes with heart, circulatory, or kidney complications?

☐ Yes ☐ No e Acquired Immune Deficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) Infection?

Attention Producer: The above conditions are uninsurable.

Hancock Knockouts **Height & Weight? Yes**

PART 3 INSURABILITY QUESTIONS

SIMPLIFIED UNDERWRITING PROGRAM – If you are part of the Simplified Underwriting Program please complete Section A and skip to Part 4. If you are part of the full underwriting program please complete all Parts of the application.

Section A

- **Please check "yes" or "no" to each question. If "yes", circle all diagnoses or conditions that apply.**
- **If you answer "yes" to any question 1-6, then we suggest you do not submit an application. We will be unable to offer you coverage.**

	Applicant A	Applicant B
1 Do you have or have you ever been diagnosed for: • Alzheimer's Disease • Memory Loss • Paralysis • ALS (Lou Gehrig's Disease) • Mental Retardation • Post Polio Paralytic Syndrome • Cirrhosis • Metastatic Cancer • Chronic Kidney Failure • Multiple Sclerosis • Schizophrenia • Dementia • Muscular Dystrophy • Scleroderma • Diabetes –treated with greater than 49 units of insulin or with amputation or ongoing complications affecting the kidney • Neurological Conditions affecting the Brain or Spinal Cord • Systemic Lupus Erythematosus • Organic Brain Syndrome • Stroke/CVA • Parkinson's Disease • TIA's 2 or more	❑ Yes ❑ No	❑ Yes ❑ No
2 Do you currently require human assistance or supervision in any of the following activities: eating; dressing; toileting; transferring from bed to chair; walking; maintaining continence; or bathing?	❑ Yes ❑ No	❑ Yes ❑ No
3 Do currently reside in, have you been advised to enter, or are you planning to enter a nursing home, assisted living facility or other custodial facility, or are you currently receiving home health care services or attending adult day care?	❑ Yes ❑ No	❑ Yes ❑ No
4 Do you currently use one of the following medical devices: wheelchair; walker; hospital bed; quad cane; oxygen; stairlift; or dialysis?	❑ Yes ❑ No	❑ Yes ❑ No
5 Have you been diagnosed or treated by a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex?	❑ Yes ❑ No	❑ Yes ❑ No
6 Are you currently receiving Social Security Disability, Worker's Compensation or Long Term Disability Benefits?	❑ Yes ❑ No	❑ Yes ❑ No

Section B *If you are part of the Simplified Underwriting Program please skip to Part 4.*

MEDICAL HISTORY	Applicant A	Applicant B
1 Have you consulted with your Primary Care Physician within the last 18 months?	❑ Yes ❑ No	❑ Yes ❑ No

Applicant A: Primary Care Physician Name:	**Applicant B:** Primary Care Physician Name:
Address:	Address:
City, State, Zip Code:	City, State, Zip Code:
Tel. #:	Tel. #:
Date Last Seen:	Date Last Seen:

Employer Simplified Knockout Questions

MedAmerica Knockouts | **Height & Weight? Yes**

V. INSURABILITY PROFILE-MUST BE COMPLETED BY ALL APPLICANTS:
Continue Completing the Insurability Profile Unless You are Directed to STOP-
Please read the Stop Instructions Carefully.

SPEEDApp

INSTRUCTIONS: You must answer each question by **checking YES or NO.**

1. **Have you ever received Medical Advice, Consultation, or Treatment for any of the following conditions:** ☐ YES ☐ NO
- Alzheimer's Disease, Lewy Body Disease, Dementia, Any Memory Problems, Psychosis, Schizophrenia, Mental Retardation
- Amyotrophic Lateral Sclerosis (ALS), Myasthenia Gravis, Multiple Sclerosis, Parkinson's Disease/Parkinsonism
- Post-Polio Syndrome, Demyelinating Disease, Other Neurological Conditions affecting the brain or spinal cord
- Lupus (SLE), Mixed Connective Tissue Disease, Scleroderma, Muscular Dystrophy, Other Muscular Conditions Causing Limits
- Kidney Disease, Polycystic Kidney Disease, Liver Cirrhosis, Hepatitis, Hemachromatosis
- Amputation-Due to Disease, Double Heart Valve Replacement , Organ or Bone Marrow Transplants
- Brain or Spinal Tumors-benign or malignant, Multiple Myeloma
- Peripheral Vascular Disease **and** Smoking, Peripheral Vascular Disease **and** Diabetes, Skin Ulcers **and** Diabetes
- 2 or more Strokes or Transient Ischemic Attacks(TIAs), Single Stroke OR TIA **and** Diabetes
- AIDS- You need not answer "yes" if you have only tested positive for Human Immunodeficiency Virus (HIV). In addition, you need not answer "yes" if you do not have, or have never been tested for HIV or AIDS. You are obligated to answer "yes" if you have actually been diagnosed as having AIDS

2. **In the past year** have you needed assistance or supervision in performing activities of daily living*, used any Medical Equipment**, or received nursing home care, home health care, assisted living care, or adult day care services? ☐ YES ☐ NO

*Activities of Daily Living Include Walking, Dressing, Eating, Toileting, Taking Medications, Getting In and Out of Bed, Bowel and Bladder Control

**Medical Equipment Includes Wheelchair, Walker, Motorized Scooter, Quad Cane, Canadian Crutches, Catheters, Ventilators, Oxygen, Stairlift, or Home Intravenous Medications.

STOP! IF questions 1 OR 2 are "Yes," we cannot offer coverage at this time. Do not Submit the Application.

3. **In the past 2 years have you consulted with a medical professional, had surgery for, been hospitalized for, had therapy or rehabilitation services for, or taken any medication for any of the following?** ☐ YES ☐ NO
- Arthritis with Multiple Joint Replacements or Causing Limitations
- Cancer
- Cardiomyopathy or Congestive Heart Failure
- Chronic Blood Disorders
- Chronic Muscular or Neurological Conditions
- Vascular Disease or other Circulatory Disease
- Diabetes
- Drug/Substance Abuse
- Bowel or Bladder Problems
- Falls, Fractures, or Compression Fractures
- Joint Deformities
- Lung Disorders such as COPD or Emphysema
- Manic-Depression
- Stroke/TIA/Amaurosis Fugax- Single Episode

4. **In the past year** have you been hospitalized overnight, been advised to have surgery, received rehabilitative services including physical or occupational therapy, OR have you received disability income or worker's compensation? ☐ YES ☐ NO

STOP! IF You are Applying During Open Enrollment AND You are An Actively at Work Employee of the Group

☛ GO TO SECTION VI: Authorization to Obtain Protected Health Information ☚

V. Insurability Profile (Continued) List ALL Current Medications ☐ No Medications

Medication	Dosage (x/day)	Reason Taking	#Months On Med

STOP!
IF You are applying During Open Enrollment AND You are an Actively at Work Care Partner of an Employee
OR You are Age 71 or Younger Purchasing a $100,000 or $200,000 Cash Benefit Account

☛ GO TO SECTION VI: Authorization to Obtain Protected Health Information ☚

MedAmericaAttachment

MedAmerica Employer Group Discount Protgram Benefits Options

The section below summarizes the benefits available under the Simplicity® Employer Program. Applicants choose a Cash Benefit Account and one Monthly Cash Benefit that is right for them. If they wish to increase Facility Benefits, they then choose the corresponding Enhanced Facility Benefit from the same row. All riders available, and may vary by state.

CASH BENEFIT ACCOUNT		OPTIONAL: Select the EFB amount that corresponds with your chosen Monthly Cash Benefit.
$100,000 (2 options)		
MONTHLY CASH BENEFIT →	Choose: a. $1,500 • b.$3,000	ENHANCED FACILITY BENEFIT → a. $2,000 • b. $4,000
$200,000 (4 options)		(OPTIONAL)
MONTHLY CASH BENEFIT →	Choose: a. $1,500 • c. $4,500	ENHANCED FACILITY BENEFIT → a. $2,000 • c. $6,000
	b. $3,000 • d. $6,000	b. $4,000 • d. $8,000
$300,000 (3 options)		(OPTIONAL)
MONTHLY CASH BENEFIT →	Choose: a. $3,000	ENHANCED FACILITY BENEFIT → a. $4,000
	b. $4,500	b. $6,000
	c. $6,000	c. $8,000
$500,000 (2 options)		(OPTIONAL)
MONTHLY CASH BENEFIT →	Choose: a. $4,500	ENHANCED FACILITY BENEFIT → a. $6,000
	b. $6,000	b. $8,000