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 <u>Not</u> 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%)	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 (Spousse/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%	30% Spousal (both apply & accepted) 15% Marital (spouse does not apply or is declined) 15% Residential (same household and meet eligibilty)	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 <i>not</i> 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	Total Max 43.5% (NY 33%) Some industries able to receive preferred health discount of 15% (see JH Attachment)	Max 33.5% (Full UW) 24% (Simplified) 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 June, 2009

MetLife NY Knockout Questions

Height & Weight? No

Sposes simplified if ER pay 10+ lives

MetLife

PART B

To the best of your knowledge and belief

INSURABILITY QUESTIONS

APPLICANT 1 APPLICANT 2

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.

				1070 PB 100 B 100 B 1	
I.		urrently have, have you even have you been treated for: (- Amyotrophic Lateral Sclerosis (Lon Gohrig's Discose) - Muscular Dystrophy - Multiple Sclerosis - Parkinson's Discose - Diabetes with ampu- tation or complications affecting the kidney		□Yes □Ne	□Ves □Ne
2.	(Acquired Immune Def	sted for or medically diagno ficiency Syndrome), ARC (A tion(s)? This does not incl	AIDS Related Complex).	□Yes □Ne	□Yes □No
	planning to enter a murs	in, or have you been advise ing home, assisted living fa- currently receiving home he re?	cility or residential	□Yes □No	□Yes □Nu
	· bathing · dressing ·	help or supervision for any e eating • walking • todeti or chair • controlling howe	ng	□Yes □No	□Yes □No
	Do you currently use ar dialysis oxygen •	ny of the following?: wheelchair • walker • qua	nd came • crutches	□Yes □No	□Yes □No
S	POUSE OR DOMESTIC PAR	THER OF EMPLOYEES ONLY			
C		a are part of a Simplified Un ployer is paying the premiun		Spouse's or Dom	estic Partner's
	o you currently need or re scause you are unable to p	eceive help with any of the fe perform them yourself?	offlowing activities	□Yes □N	0
	taking medications • s	shopping • meal preparation	n • managing finances		
,					
	IF "YES" please explain:				

MAIL THIS PAGE TO METLIFE

LTC3-ML-APP-NY

MetLife nonNY **Knockout Questions** Height & Weight? Yes if yes to any of the following

Sposes simplified if ER pay 10+ lives

U

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NO

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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 YES NO

1 52	NO		325 ST 101 ST
0		Stroke (CVA)	Muscular dystrophy
Ū.		Multiple Transient Ischemic Attacks (TIA's)	Multiple sclerosis
0	0	TIA within the past 5 years	Parkinson's disease
Ū.		Alzheimer's disease	Huntington's chorea
0	0	Dementia / Organic brain syndrome	Cancer that has spread to another area of your
0		Memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication	body, including nodes; or cancer diagnosed or treated within the past 12 months (except basal or squamous cell of the skin)
	(U)	Mental retardation	Diabetes with complications (e.g. amputation,
		Schizophrenia	kidney disease, eye disease, nerve disease); and/ or diabetes combined with heart attack, bypass surgery, angina and/or TIA.
		Arryotrophic Lateral Sclerosis (ALS)	Organ transplant completed or medically advised
		en medically diagnosed as having or have you b mune Deficiency Synchome/VAIDS related conditions	een treated by any medical professional for AIDS
		re supervision or human assistance with: bathing of toilet; or bowel/bladder control?	dressing; eating; walking; getting in/out of bed or
		or have you been advised to use any of the follower; stair lift; quad cane; crutches; dialysis; or oxyg	owing medical equipment: wheelchair; motorized gen (except for sleep apnea)?
5. Do y	ou curre dential c	ently reside in, or have you been advised to enter are facility; adult day care; any other type of long-	or use: a nursing home; an assisted living facility; term care facility; or home health care services?
or ra	ated less		Life Long-Term Care Insurance declined, postponed tions in Part D. We will review your information and o contact you for additional information.
		OMESTIC PARTNER OF EMPLOYEES ONLY section if: You are part of a Simplified Underwrit	ting group, you are under age 66, and your Spouse

		Memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication	treated within the past 12 months (except basal or squamous cell of the skin)		
	(D)	Mental retardation	Diabetes with complications (e.g. amputation,		
	0	Schizophrenia	kidney disease, eye disease, nerve disease); and/ or diabetes combined with heart attack, bypass surgery, angina and/or TIA		
		Amyotrophic Lateral Sclerosis (ALS)	Organ transplant completed or medically advised	.0	0
2. Hav (Acc	e you be quired Im	en medically diagnosed as having or have you b mune Deficiency Syndrome/VAIDS related conditions	een treated by any medical professional for AIDS ?	0	0
		re supervision or human assistance with: bathing; of toilet; or bowel/bladder control?	dressing; eating; walking; getting in/out of bed or	0	0
4. Do 5000	you use oter; wall	or have you been advised to use any of the folk ser; stair lift; quad cane; crutches; dialysis; or oxyg	owing medical equipment: wheelchair; motorized en (except for sleep apnea)?	п	0
5. Do resi	you curre dential c	ently reside in, or have you been advised to enter are facility; adult day care; any other type of long-	or use: a nursing home; an assisted living facility; term care facility; or home health care services?	o	0
or ra	ated less		Life Long-Term Care Insurance declined, postponed ions in Part D. We will review your information and o contact you for additional information.	٥	0
Comp	lete this	or Domestic Partner's employer is pay			
		or receive help with any of the following activities sying bills, meal preparation, transportation, laund	because you are unable to perform them yourself: iry, or taking your medication?		0

contact you for additional information.	The contract of the contract o	0.07429030001733003003003044900	
PART D HEALTH QUESTIONS	(Provide additional information in the DETAILS:	section on page 5, if needed.)	
SKIP PART D IF SIMPLIFIED UNDERWRIT Primary Care Physician (with most of yo	100		
Physician	Phone Number ()	Date Last Seen	-
Address	City	State Zip	
All Physician Specialists (excluding pod	iatrists, dentists) seen within the past 5 yea	iPS	
Physician	Phone Number ()	Date Last Seen	-
Address	City	State Zip	
Physician	Phone Number ()	Date Last Seen	
4.11	400	Co	

IF YES please explain:
This information will be reviewed to determine if the coverage you selected can be approved. We may need to

VIPZAPP-ML-NJ 3

Employer Simplified Knockout Questions

vvisco-	- C. S S.	RY - 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 F	ome 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 ☐ Bathing ☐ Eating ☐ Toileting ☐ Bowel or Bladder Control ☐ Moving In and Out of Bed or Chair ☐ Dressing ☐ Taking your Medicat	0.55
		4 Have you had, do you currently have, or have you ever been diagnosed as having medical conditions:	any of the following
] Yes	□ No .	a Organic Brain Syndrome, Dementia, Senility, Confusion, Memory Loss, Alzheimer	's Disease, or Schizophrenia?
1 Yes	□ No	b Metastatic Cancer (cancer that has spread from the original site or location)?	
] Yes	□ No	 Multiple Sclerosis (MS) Muscular Dystrophy, Multiple Transient Ischemic Attacks Amyotrophic Lateral Sclerosis (ALS), Stroke, Cerebrovascular Accident (CVA), or Research 	#1.14##################################
] 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 Syndrome (AIDS)?	Acquired Immune Deficiency
		Attention Agent: The above conditions are uninsurable.	

Employer Simplified Knockout Questions

DICA	L HISTOR	RY -	PART 1	INSUR	ABILIT	PROFILE			Ind	icate ye	S 01 NO
] Yes	□ No	1	Do you us	ea: [⊐ Walker	□ 0xygen	☐ Respirator ☐ Kid	nev Dialysis	☐ Wheel	ichair?	
1 Yes	□ No		. San except to			ere soco uz na	☐ Used Adult Day Care				
) Yes	□ No		Been med	lically ac	tvised to e	nter or been	500 CT 18835 F-1201-1000 F-2				
1 Yes	□ No	3	Do you cu □ Bathing	rrently r	need assis	tance or supe Tolleting	ervision by another person	in performing	any of the	e following	activities;
							□ Dressing □ Taking as having any of the follor	your Medicati wing medical o			
Yes Yes	□ No						lity, Confusion, Memory Lo ad from the original site or		s Disease,	or Schizop	hrenia?
ı Yes	□ No		Multiple S	icierosis	(MS) Mus	cular Dystrop	hy, Multiple Transient Isch	emic Attacks (sase,
] Yes	□ No	a					ke Cerebrovascular Accide y complications?	ent (CVA), or Hi	untington s	s Litsease /	
	□ No						AIOS), or Human Immunod	laticiance Visus	/LINA Indo	etion?	
			Attention	Produc	er: The al	bove conditi	ons are uninsurable.				
	lication.	u skij) to Part	ч. п у	ou are p	art or the it	Il underwriting progra	am piease c	ompiete	all Faits	or the
5	Section	A	• If	oply. you an:	swer "yes	" to any qu	each question. If "yes estion 1-5, then we sug		-		
,	Section	Α	• If	oply. you an:	swer "yes		estion 1-6, then we sug		not submi	it an appli	
1 Do	you have c	or have	• If W	oply. you an: re will b	swer "yes e unable iagnosed	o" to any qu to offer you	estion 1-6, then we sug coverage.	gest you do n	not submi	it an appli	cation.
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1 Doy . A . A . C . C . C . C . C . G . G . G . G . G	you have of Alzheimer's ALS (Lou G Disease) Cirrhosis Chronic Kid Dementia Disbetes -t greater than insulin or w	or have s Diseasehrig's dney Fa treated n 49 u ith am compli	e you ever use s silure with nits of putation cations	poply. you am: 'e will b been d Mee Mee Mu Mu Ner Spi Org	e unable iagnosed mory Loss ntal Retar tastatic Ca tiple Scle soular Dy urological acting the nal Cord	"to any quito offer you for: dation ancer rosis strophy Conditions Brain or	estion 1-6, then we sug- coverage. Paralysis Post Polio Paralytic Syndrome Schizophrenia Scieroderma Systemic Lupus Erythematosus Stroke/CVA	gest you do r Applica	not submi	App	licant B
11 Do	you have of Alzheimer's Alzheimer's Alz (Lou Gibsease) Circhosis Chronic Kid Dementia Diabetes -t greater that insulin or wor ongoing affecting the you currentivities: eati	or have a Disease seeing: they Fi complete and 49 unith am complete inthy recomplete inthy recomplete	e you ever sees allure with nits of putation cations ay quire humanssing, toil	poly. you an: le will b Mer Mer Mu Mu Mu Ner Affe Spi Parr an assisteting: tr	isgnosed in a control of the control	"to any quito offer you for: k dation ancer rosis strophy Conditions Brain or 1 Syndrome Disease supervision in	estion 1-6, then we sug- coverage. Paralysis Post Polio Paralytic Syndrome Schizophrenia Scieroderma Systemic Lupus Erythematosus Stroke/CVA	Applica	int A	App	licant B
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1 Do	you have of Alzheimer's Obsease) Cirrhosis Chronic Kid Dementia Diabetes -t greater than insulin or w or angoing the vyou current inities; eati antening or currently n ursing home	or have a Disease Sehrigi they F treated or 49 ur th am comple e kidni or time me, ass as hea	e you ever see a with nits of putations exerce, or ba in, have you sisted living the care see e one of the	poply. you and been d Mee Mee Mee Mu Mu Ner affe Spi Par assiss sletting; ou been d par forces ou been	awer "yes e unable lagnosed la	to any quito offer you for: deficin ancer rosis strophy Conditions Brain or syndrome bisease supervision in grow bed to o enter, or a custodial facing adult day on the call devices.	Paralysis Post Polio Paralysis Post Polio Paralysic Syndrome Schizophrenia Scleroderma Systemic Lupus Erythematosus Stroke/CVA TIA's 2 or more any of the following chair, walking: re you planning to enter lifty, or are you currently	Applica Applica	int A	App O Yes O Yes	Blicant B
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MedAmerica Knockouts

Height & Weight? Yes

STRUCTIONS: You must answ	wer each question by checking	YES or NO.	
Have you ever received Me- Alzheimer's Disease, Lewy Bo Amytophic Lateral Scienceis Post-Polio Syndrome, Demyel Lupus (SLE), Mixed Connectii Kidney Disease, Polycystic Ki Amputation-Due to Disease, I Brain or Spinal Tumors-bengi Peripheral Vascular Disease 2 2 or more Strokes or Transien AIDS-You need not answer 1	dical Advice, Consultation, or ody Disease, Dementia, Any Mei (ALS), Myasthenia Gravis, Multis linating Disease, Other Neurolog we Tissue Disease, Scienoderma dney Disease, Liver Cirrhosis, H bouble Heart Valve Reptacemen or malignant, Multiple Myelom; and Smoking, Peripheral Vasculat t Ischemic Attacks (TIAs), Single yes' if you have only tested posi-	Treatment for any of the following conditions: mory Problems, Psychosis, Schizophrenia, Mental Re ple Scienceis, Parkinson's Disease/Parkinsonism pleat Conditions affecting the brain or spinal cord in Muscular Dystrophy, Other Muscular Conditions Cel- legatitis, Hernachronistosis if , Organ or Bone Marrow Transplants as Disease and Diabetes, Skin Ulcers and Diabetes	using Limits ition, you need not
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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. **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 CASH BENEFIT ACCOUNT \$200,000 (4 options) (OPTIONAL) **ENHANCED FACILITY BENEFIT -**➤ a. \$2,000 · c. \$6,000 MONTHLY CASH BENEFIT ► Choose: a. \$1,500 • c. \$4,500 b. \$4,000 · d. \$8,000 b. \$3,000 · d. \$6,000 (OPTIONAL) \$300,000 (3 options) MONTHLY CASH BENEFIT a. \$4,000 Choose: a. \$3,000 ENHANCED FACILITY BENEFIT b. \$4,500 b. \$6,000 c. \$6,000 c. \$8,000 \$500,000 (2 options) (OPTIONAL) MONTHLY CASH BENEFIT -➤ Choose: a. \$4,500 ➤ a. \$6,000 **ENHANCED FACILITY BENEFIT** b. \$6,000 b. \$8,000