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MY



The Prudential  
Insurance Company  
of America

Long-Term Care  
Insurance



## AFFILIATION APPLICATION

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# NY

- GRP113810
- GRP113811 3.5
- GRP113394
- GRP113392
- GRP113124
- GRP113582
- GRP114688
- GRP112648
- GRP112991
- GRP113773 3.5
- GRP112855

**NOTE: You must also include:**

**New York**

**Shoppers Guide ORD99020**

**Medicare Shoppers Guide (over age 65) ORD99019**



**INSURANCE HISTORY**

Indicate yes or no

**If coverage is being replaced, please submit a completed Replacement Notice.**

- 1 Are you covered by Medicaid or Medi-Cal (not Medicare)?  Yes  No
- 2 Do you have other long term care or accident and sickness insurance in force (including policies, certificates, health care service contracts, or health maintenance organization contracts)?  Yes  No
- 3 Did you have other long term care insurance in force during **the last 12 months**?  Yes  No
- 4 Do you intend to replace any of your medical health insurance with this insurance?  Yes  No

**IF YOU ANSWERED YES TO QUESTIONS 2, 3, OR 4 OF THIS SECTION, PLEASE PROVIDE THE FOLLOWING INFORMATION**

<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="text"/>	<input type="text"/>	Intend to replace? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did insurance lapse? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
	Type of Coverage	Policy #			If yes give date
<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="text"/>	<input type="text"/>	Intend to replace? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did insurance lapse? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
	Type of Coverage	Policy #			If yes give date

Full name and address of insurance company

**MEDICAL HISTORY – PART 1 INSURABILITY PROFILE**

Indicate yes or no

- 1 Have you had, do you currently have, or have you ever been diagnosed as having any of the following medical conditions:
  - a Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig’s Disease)?  Yes  No
  - b Alzheimer’s Disease, Chronic Memory Loss, frequent or persistent forgetfulness, senility, dementia, or Organic Brain Syndrome?  Yes  No
  - c Chronic Obstructive Pulmonary Disease (COPD) or Emphysema **in combination with:** Current Smoking; Congestive Heart Failure (CHF); Asthma; or Chronic Bronchitis?  Yes  No
  - d Congestive Heart Failure **in combination with:** Current Smoking, Angina or Heart Surgery; Asthma or Chronic Bronchitis; Diabetes; or Tuberculosis?  Yes  No
  - e Congestive Heart Failure, diagnosed or symptomatic, within **the past 12 months**?  Yes  No
  - f Metastatic Cancer (Cancer that has spread from the original site or location)?  Yes  No
  - g Stroke or Cerebrovascular Accident (CVA)?  Yes  No
  - h Liver Cirrhosis?  Yes  No
  - i Multiple Sclerosis (MS), Muscular Dystrophy, Parkinson’s Disease?  Yes  No
  - j Transient Ischemic Attack (TIA) within **the past 5 years**; multiple TIA’s; or TIA in combination with Diabetes or any Heart Surgery?  Yes  No
  - k Within **the past 6 months**, have you had open heart surgery, spine surgery, back surgery?  Yes  No
- 2 Have you ever been diagnosed as having AIDS, or AIDS Related Complex (ARC)?  Yes  No
- 3 Within **the past 48 months** have you had cancer of the:  Yes  No
  - Bone  Brain  Esophagus  Liver  Lung  Ovary  Pancreas  Stomach
- 4 Do you use a four pronged cane, kidney dialysis, motorized scooter, oxygen, respirator, walker, wheelchair?  Yes  No
- 5 Within **the past 12 months** have you:  Yes  No
  - Used adult day care  Needed home health care
  - Been medically advised to enter or been confined to:  A nursing home  An assisted living facility  Other long term care facility
- 6 Do you currently need assistance or supervision by another person in performing any of the following activities:  Yes  No
  - Bathing  Eating  Toileting  Dressing  Bowel or Bladder Control  Moving in and out of bed or chair
  - Taking your medication

**If you answered “Yes” to any question in this insurability profile, we recommend that you do not submit this Application.**

**MEDICAL HISTORY – PART 2 PERSONAL PROFILE**

Please provide the requested information about yourself.

- 1a 

<input type="text"/>	<input type="text"/>
Height	Weight
Ft./In.	Lbs.

 1b Have you had any change in weight in the last 12 months?  
 Gain \_\_\_\_\_ lbs.  Loss \_\_\_\_\_ lbs.  N/A
- 2a Are you retired?  Yes  No 2b If yes, what was your occupation? \_\_\_\_\_
- 3a Are you currently employed?  Yes  No 3b If yes, what occupation? \_\_\_\_\_
- 3c Is the work  Full-time or  Part-time?  Inside the home or  Outside the home?
- 4 Please list any activities in which you regularly participate outside your home. (For example, vigorous exercise, walking, gardening.) \_\_\_\_\_

- 5a Have you smoked or used tobacco products within the past three years?  Yes  No  
5b Do you use more than 1 (one) pack of tobacco products per day?  Yes  No
- 6a Do you drive an automobile?  Yes  No 6b If yes, approximate number of miles driven each year? \_\_\_\_\_
- 7 With whom do you live?  No one  Spouse/Domestic Partner  Other \_\_\_\_\_
- 8 Are you pregnant?  Yes  No
- 9a Are you living in a retirement community?  Yes  No
- 9b If yes, please list any services you currently receive (For example, housecleaning, laundry, meals, medications.) \_\_\_\_\_

- 10 Are you currently receiving any Disability benefits or have you during the past 1 year?  Yes  No  
Please check all that apply:  Disability Income Insurance  State or Federal Workers Compensation  
 State Insurance Program  Social Security  
 Occupational Disease Law  Employer's Liability Insurance

11 Have two or more years passed since you received any treatment or examination by **any** health care professional?  Yes  No

12 Who is your Primary Care Doctor with most of your medical records?

<input type="text"/>	<input type="text"/>	<input type="text"/>
Name	Phone	
<input type="text"/>	<input type="text"/>	
Street Address	Apt. No.	
<input type="text"/>	<input type="text"/>	<input type="text"/>
City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Date last seen		

Reason(s) last seen \_\_\_\_\_

**MEDICAL HISTORY – PART 3 HEALTH PROFILE**

Please answer every question in this section by indicating “Yes” or “No”

- In the **past 12 months**, have you had an application rejected for long term care, nursing home care, or other health insurance?  Yes  No
- Within the **past 5 years, (10 years for cancer)**, have you received any medical advice, examination, or treatment from a health care professional; taken any medications; or been medically diagnosed for:

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition			
a	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular or circulatory disorder including congestive heart failure (CHF), peripheral vascular disease, heart attack, chest pain, angina, high blood pressure or irregular heart beat	h	<input type="checkbox"/>	<input type="checkbox"/>	Asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, shortness of breath	o	<input type="checkbox"/>	<input type="checkbox"/>	Fracture
b	<input type="checkbox"/>	<input type="checkbox"/>	Cancer or non-cancerous tumors	i	<input type="checkbox"/>	<input type="checkbox"/>	Brain disorder, convulsions, epilepsy or seizures, dizziness or balance problems, fainting spells or black outs	p	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis
c	<input type="checkbox"/>	<input type="checkbox"/>	Hodgkin’s Disease, Lymphoma, Leukemia, other blood disorder	j	<input type="checkbox"/>	<input type="checkbox"/>	Depression, anxiety, mental, emotional or nervous disorder, or confusion, or memory loss	q	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
d	<input type="checkbox"/>	<input type="checkbox"/>	Skin ulcers	k	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	r	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis, weakness or numbness of the extremities
e	<input type="checkbox"/>	<input type="checkbox"/>	Non-insulin dependent diabetes	l	<input type="checkbox"/>	<input type="checkbox"/>	Visual disturbances	s	<input type="checkbox"/>	<input type="checkbox"/>	Replacement of the hip, knee or other joint
f	<input type="checkbox"/>	<input type="checkbox"/>	Insulin dependent diabetes # of units per day _____	m	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	t	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis, Lupus, Scleroderma or other connective tissue disease
g	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	n	<input type="checkbox"/>	<input type="checkbox"/>	Disabling back or spine injury	u	<input type="checkbox"/>	<input type="checkbox"/>	Other conditions causing crippling or limited motion or requiring use of an adaptive device, chronic pain or fatigue, or Fibromyalgia

- Within the **past three years**, have you been medically advised to enter or been confined to a hospital or other health care facility?  
 Yes  No
- Within the **past three years**, have you:  been confined to a nursing home, assisted living facility, or long term care facility?  
 been medically advised to have surgery which has not been performed?  
 received home health care?  used adult day care?  None
- Within the **past five years**, have you been advised to limit, reduce, discontinue or seek counseling for the use of alcohol or drugs?  Yes  No
- Within the **past five years**, have you received any medical advice, examination or treatment from a health care professional for any reason not previously stated?  Yes  No

In the space below you **MUST** provide details for any “Yes” answers to questions 1 through 6.

If needed, complete the additional medical information page that is provided.

Refers to number/letter above \_\_\_\_\_ Diagnosis date \_\_\_\_\_ Treatment date last seen \_\_\_\_\_

Reason Consulted/treated \_\_\_\_\_

Check here if treated by primary care physician (PCP). If not treated by PCP, give name, address, and phone for other treating professional

Refers to number/letter above \_\_\_\_\_ Diagnosis date \_\_\_\_\_ Treatment date last seen \_\_\_\_\_

Reason Consulted/treated \_\_\_\_\_

Check here if treated by primary care physician (PCP). If not treated by PCP, give name, address, and phone for other treating professional

Refers to number/letter above \_\_\_\_\_ Diagnosis date \_\_\_\_\_ Treatment date last seen \_\_\_\_\_

Reason Consulted/treated \_\_\_\_\_

Check here if treated by primary care physician (PCP). If not treated by PCP, give name, address, and phone for other treating professional

**MEDICAL HISTORY – PART 4 MEDICATIONS**

**1 Please provide the requested information. Are you currently taking any drugs or medications?**  **Yes**  **No**

If yes, provide the information requested in the space below. If needed, complete the Additional Medical Information Page that is provided.

a Drug or Medication \_\_\_\_\_ Dosage \_\_\_\_\_ How long been taking? \_\_\_\_\_

Reason for taking \_\_\_\_\_

Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

\_\_\_\_\_  
\_\_\_\_\_

b Drug or Medication \_\_\_\_\_ Dosage \_\_\_\_\_ How long been taking? \_\_\_\_\_

Reason for taking \_\_\_\_\_

Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

\_\_\_\_\_  
\_\_\_\_\_

c Drug or Medication \_\_\_\_\_ Dosage \_\_\_\_\_ How long been taking? \_\_\_\_\_

Reason for taking \_\_\_\_\_

Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

\_\_\_\_\_  
\_\_\_\_\_

d Drug or Medication \_\_\_\_\_ Dosage \_\_\_\_\_ How long been taking? \_\_\_\_\_

Reason for taking \_\_\_\_\_

Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

\_\_\_\_\_  
\_\_\_\_\_

e Drug or Medication \_\_\_\_\_ Dosage \_\_\_\_\_ How long been taking? \_\_\_\_\_

Reason for taking \_\_\_\_\_

Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

\_\_\_\_\_  
\_\_\_\_\_

f Drug or Medication \_\_\_\_\_ Dosage \_\_\_\_\_ How long been taking? \_\_\_\_\_

Reason for taking \_\_\_\_\_

Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

\_\_\_\_\_  
\_\_\_\_\_

g Drug or Medication \_\_\_\_\_ Dosage \_\_\_\_\_ How long been taking? \_\_\_\_\_

Reason for taking \_\_\_\_\_

Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

\_\_\_\_\_  
\_\_\_\_\_

**If you are taking more than 7 medications, please list them on the “Additional Medical Information Page.”**



**NOTIFICATION OF UNINTENTIONAL LAPSE**

You can provide Prudential with the name of a friend or relative to notify if your Policy should lapse because the premium is not paid when due. This designation does not constitute an acceptance of liability by the person named. Prudential will notify you each year of your right to designate or change the existing designation for this purpose.

**ONLY COMPLETE THE APPROPRIATE SECTION: NAME A DESIGNEE OR WAIVER OF NOTIFICATION.**

**Check here ONLY to name a designee, and provide the requested information about that person:**

First Name	M.I.	Last Name
Street Address		Apt. No.
City	State	Zip Code

**Check here only if you do not wish to name a person for this purpose and sign below.**

**WAIVER OF NOTIFICATION OPTION:**

I understand that I have the right to name at least one person other than myself to receive notice of lapse of termination of my long term care insurance policy for non-payment of premium. I understand that notice will not be given until thirty-one days after the premium is due and not paid.

**By my signature, I elect NOT to name any person to receive such notice.**

**X** \_\_\_\_\_ Applicant Signature 





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THE PRUDENTIAL  
INSURANCE COMPANY  
OF AMERICA

LONG-TERM CARE  
CUSTOMER  
SERVICE CENTER

PO BOX 8519  
PHILADELPHIA PA 19176-8519  
1.800.732.0416

## FEDERAL HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

“We” refers to The Prudential Insurance Company of America in its capacity as a provider of Group and Individual Long Term Care insurance. “You” or “yours” refers to any individual covered by a Long Term Care insurance policy issued by The Prudential Insurance Company of America.

Federal law—means the Health Insurance Portability and Accountability Act and related privacy rules—requires The Prudential Insurance Company of America to keep your health information private. We are not allowed to use or disclose it unless we receive your permission or unless permitted by law. Federal law requires us to give you this Notice of our legal duties and privacy practices. This Notice is to inform you of uses and disclosures of your health information that we may make. It also informs you of your rights and our duties with regard to this health information.

We must follow the terms of this Notice. We do reserve the right to change the terms of this Notice and make the new Notice provisions apply to all the health information we keep. This includes health information we had prior to any change in this Notice. We must promptly change this Notice when there is a material change to our uses or disclosures, your rights, our duties and other related circumstances. We will mail you any such revised Notice, unless you have agreed to receive Notices electronically. To receive such Notices by E-mail, you should tell the contact listed at the end of this Notice.

## USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Federal law permits us to use and disclose protected health information for purposes of treatment, payment and health care operations as those terms are defined under federal law. As an insurer, we do not provide treatment, but we may use and disclose protected health information for payment purposes, such as in connection with the payment of an insurance claim. We may also use and disclose protected health information for our health care operations such as when we decide to give you insurance or when we renew or replace your insurance. We will also comply with any state or federal law that is more restrictive as to our uses and disclosures of protected health information.

There are also times when federal law permits or requires us to use or disclose your information without your written permission.

Additionally, where appropriate, we may disclose protected health information to a group health plan or plan sponsor in accordance with federal law.

### PERMITTED DISCLOSURES

We may not make all of the uses and disclosures listed here, but federal law permits use or disclosure of your information without your permission when:

- We disclose your information to you.
- To third party non-Prudential business associates that perform services for us or on our behalf, such as vendors.
- Where disclosure is required by law.
- To a public health authority authorized by law to collect or receive your information to prevent or control disease, injury or disability or when reviewing reports of child abuse or for the conduct of other authorized public health activities and responsibilities.
- To a governmental authority when we reasonably believe you may be a victim of abuse, neglect or domestic violence where the governmental authority is allowed by law to have such information.
- To a health oversight agency for such activities.
- For judicial and administrative proceedings.
- To a law enforcement official for a law enforcement purpose.
- To a medical examiner for the purpose of identifying a deceased person, determining the cause of death, or other duties authorized by law.
- To organ donor organizations in order to aid in such donations.
- For certain research purposes authorized by and subject to federal law.
- To avert a serious threat to health or safety.
- To government officials regarding military personnel and certain domestic and foreign government officials for certain functions authorized by federal law.
- To comply with workers’ compensation and other similar programs.
- To make certain marketing communications and for certain fundraising purposes.

## REQUIRED DISCLOSURES

We are required to disclose your information when required by the Secretary of the Department of Health and Human Services to make sure we comply with federal law.

We are also required, with certain exceptions, to provide you with access to inspect and obtain a copy of your information that we keep. See “Your Right To Inspect and Copy Protected Health Information” below.

### NEED FOR AUTHORIZATION:

We will not make any uses or disclosures other than those mentioned above without your permission. You may withdraw such permission in writing. Your withdrawal will not be effective 1) if we took action relying on your permission before it was withdrawn, or 2) if we obtained your permission as a condition of issuing you insurance, and the law allows us to contest a claim under the policy or the policy itself. To withdraw your authorization, please write the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

### INDIVIDUAL RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

**FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO REQUEST RESTRICTIONS:** You have the right to request that restrictions be placed on certain uses and disclosures of your information. We are not required to agree. If we do agree, we may not use or disclose any of your information except where you need emergency treatment. We may end an agreement to restrict as allowed by federal law. If you wish additional information, you should write to the contact listed at the end of this Notice.

**FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO ALTERNATIVE CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION:** If you choose to have your information sent to you by a means of your choice or to an address of your choice, we will do so if the request is reasonable. You must clearly state that disclosure of all or any part of your information could endanger you if not sent per your choice. Any such request should be sent in writing to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

**FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO INSPECT AND COPY PROTECTED HEALTH INFORMATION:** You have the right to inspect and copy your information, except for any psychotherapy notes, certain information relating to civil, criminal, or administrative proceedings, and certain information prohibited by law from disclosure. We are allowed by law to deny access in some cases, and subject to certain procedures. Any request should be sent in writing to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

**FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO AMEND PROTECTED HEALTH INFORMATION:** You have the right to request that we amend your information kept in our records. We are allowed to deny your request if we did not create the information in the record. We will review your request and respond to you in writing. All requests should be in writing and sent to the contact listed at the end of this Notice. All requests should provide needed details, including your name, address, insurance policy number, and the reason you think your information needs to be changed. If you wish additional information, you should write to the contact listed at the end of this Notice.

**FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO AN ACCOUNTING:** You have the right to receive an accounting from us of disclosures of your information made for up to the six (6) years prior to your request. This right does not apply to: disclosures made to carry out treatment, payment, or health care operations; disclosures made with your permission; disclosures made for police purposes; disclosures allowed by law; or disclosures made before April 14, 2003. Any request should be sent to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

**FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO A PAPER COPY OF THIS NOTICE:** You have the right, even if you have agreed to receive notice by E-mail, to get a paper copy of this Notice. All requests should be in writing and sent to the contact listed at the end of this Notice.

**FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO FILE A COMPLAINT:** If you believe your privacy rights have been violated, you have the right to complain to us by writing to the contact listed at the end of this Notice or to the federal Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, Washington, DC 20201. Federal law prohibits retaliation against you for filing such a complaint. The contact listed at the end of this Notice is also available to provide you information regarding questions you have or other information concerning this Notice.

### WHEN YOU CONTACT US IN WRITING, YOU SHOULD INCLUDE YOUR NAME, ADDRESS, AND POLICY NUMBER

#### THE CONTACT TO WHOM YOU SHOULD ADDRESS YOUR COMPLAINT IS:

The Prudential Insurance Company of America

Privacy Contact

Long Term Care Customer Service Center

PO Box 8519

Philadelphia, PA 19101

Telephone Number: 800-732-0416

**The effective date of this notice is March 1, 2005.**



THE PRUDENTIAL  
INSURANCE COMPANY  
OF AMERICA

LONG-TERM CARE  
CUSTOMER  
SERVICE CENTER

PO BOX 8519  
PHILADELPHIA PA 19176-8519  
1.800.732.0416

**AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION**

**Attn: Underwriting**

**THIS AUTHORIZATION IS INTENDED TO COMPLY WITH THE HIPAA PRIVACY RULE**

First Name	M.I.	Last Name
Name of Applicant (please print)		
Date of Birth		
	Social Security #	Policy #

I authorize any health plan, doctor, health care professional, hospital, clinic, laboratory, medical facility, pharmacy benefit manager, retail pharmacy, clearinghouse, data warehouse or other organization that maintains pharmacy data, MIB, Inc. formerly known as Medical Information Bureau, or other health care provider that has provided treatment or services to me or on my behalf ("My Providers"), and any other medical or insurance organization, institution or professional, to disclose my entire medical record and any other health information concerning me, without restriction, to The Prudential Insurance Company of America and its agents, employees and representatives ("Prudential"). This includes medical records and information on diagnoses and/or treatment relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted disease, mental illness, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with My Providers to restrict my protected health information and, for purposes of this authorization, I instruct any of the above providers or entities to release and disclose the entire medical record for me without restriction, including without limitation any restrictions on healthcare items or services for which a healthcare provider has been paid out of pocket in full.

This information is to be disclosed under this Authorization so that Prudential may do the following, with respect to long term care insurance I am applying for: underwrite or make rating determinations, evaluate and determine my eligibility for long term care insurance, or conduct other legally permissible activities related to my application or coverage.

This authorization shall remain in force for 24 months following the date of my signature below, unless state law imposes a shorter time. A copy of this authorization is as valid as the original. I understand I have the right to withdraw this authorization in writing, at any time, by sending a written request to: The Prudential Insurance Company of America, Privacy Contact, P.O. Box 70194, Philadelphia, PA 19176-0194. I understand that a withdrawal is not effective if any of My Providers has relied on this authorization or to the extent that Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be re-disclosed, to the extent allowable under federal law and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization, Prudential may not be able to process my application or, if coverage has been issued, may not be able to make any benefit payments. I understand that Prudential will provide me with a copy of this authorization.

**X** \_\_\_\_\_ Date  
Signature of Applicant or Personal Representative

**X** \_\_\_\_\_  
Description of Personal Representative's Authority or Relationship to Applicant

**PLEASE SIGN AND RETURN THIS COPY**

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First Name	M.I.	Last Name
Name of Applicant (please print)		
Date of Birth		
	Social Security #	Policy #

I authorize any health plan, doctor, health care professional, hospital, clinic, laboratory, medical facility, pharmacy benefit manager, retail pharmacy, clearinghouse, data warehouse or other organization that maintains pharmacy data, MIB, Inc. formerly known as Medical Information Bureau, or other health care provider that has provided treatment or services to me or on my behalf ("My Providers"), and any other medical or insurance organization, institution or professional, to disclose my entire medical record and any other health information concerning me, without restriction, to The Prudential Insurance Company of America and its agents, employees and representatives ("Prudential"). This includes medical records and information on diagnoses and/or treatment relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted disease, mental illness, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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**X** \_\_\_\_\_ Date  
Signature of Applicant or Personal Representative

**X** \_\_\_\_\_  
Description of Personal Representative's Authority or Relationship to Applicant

**KEEP FOR YOUR RECORDS**

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**PRODUCER'S STATEMENT**

Please print all information except where signatures are required. Use black ink. Read all questions carefully. Please provide complete details to avoid delays in processing.

Applicant's First Name      M.I.      Applicant's Last Name

- 1 Did you personally interview the Applicant face-to-face and witness his or her signature? [ ] Yes [ ] No
2 Does the Applicant appear to be in good health? [ ] Yes [ ] No
3 Did you observe any physical or mental impairments with regard to walking, talking, or any form of tremor? [ ] Yes [ ] No
If yes, please describe

- 4 Has the Applicant purchased any other health insurance policy from you during the past 5 years? [ ] Yes [ ] No
If Yes, provide the information below:

Table with 3 columns: COMPANY, POLICY NUMBER, CURRENT STATUS (IF TERMINATED, INDICATE YEAR). Includes checkboxes for In force and terminated.

- 5 Indicate Rating Class quoted for this Applicant: [ ] Preferred [ ] Standard I [ ] Standard II [ ] Standard III
6 I received the initial, modal premium, in full where permitted by law, with the Application and provided to the Applicant as receipt of \$ \_\_\_\_\_, a Premium Receipt. [ ] Yes [ ] No

7 Special requests, remarks and instructions: \_\_\_\_\_

BY MY SIGNATURE ON THIS FORM:

- [ ] I have reviewed the Applicant's current insurance coverage, financial needs, and resources and certify that this purchase is suitable for the Applicant.
[ ] I understand that Medical Underwriting will determine the appropriate rate class.
[ ] I certify I have personally seen the Applicant and have accurately recorded information supplied to me by the Applicant at the time application was made.
[ ] I certify that I comply with applicable Long Term Care insurance licensing requirements in the Applicant's state of residence as shown on the application.
[ ] I certify that I have delivered the Outline of Coverage to the Applicant at the time of first solicitation.
[ ] The applicant understands that I will be paid a commission from the sale of this policy, and may also receive performance based compensation.

Signature lines for Producer's Signature, Date, Print Name, Contract Number, State of Licensure, License Number, Full Address, Phone Number.





THE PRUDENTIAL  
INSURANCE COMPANY  
OF AMERICA

LONG-TERM CARE  
CUSTOMER  
SERVICE CENTER

PO BOX 8519  
PHILADELPHIA PA 19176-8519  
1.800.732.0416

## LONG-TERM CARE NOTICE

Thank you for choosing The Prudential Insurance Company of America (Prudential) for your insurance needs. Before we can issue coverage we must review your application/enrollment form. To do this, we need to collect and evaluate personal information about you. This notice is being provided to inform you of certain information practices Prudential engages in, and your rights, with regard to your personal information. We would like you to know that:

- Personal information may be collected from persons other than yourself or other individuals, if applicable, proposed for coverage;
- This personal information as well as other personal or privileged information subsequently collected by us may in certain circumstances be disclosed to third parties without authorization;
- You have a right of access and correction with respect to personal information we collect about you; and
- Upon request from you, we will provide you with a more detailed notice of our information practices and your rights with respect to such information. Should you wish to receive this notice, please contact:

The Prudential Insurance Company of America  
Long-Term Care Customer Service Center  
Attention: Privacy Contact  
P.O. Box 8519  
Philadelphia, PA 19101

Information regarding your insurability will be treated as confidential. Prudential or its reinsurers may, however, make a brief report thereon to the MIB, Inc. formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

Prudential, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

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## FOR NEW YORK RESIDENTS ONLY

### Estimated Average New York State Nursing Home Rates<sup>1</sup>

These estimates are based on nursing home cost reports for the year 2007. It is important to note that these are average nursing home rates and nursing home rates can be significantly higher, depending on the type of facility you would prefer.

<b>Western Region — Buffalo</b> (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming)	\$244 / day	\$89,016 / year
<b>Western Region — Rochester</b> (Chemung, Livingston, Monroe, Ontario, Seneca, Schuyler, Steuben, Yates, Wayne)	\$287 / day	\$104,640 / year
<b>Central Region</b> (Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins)	\$228 / day	\$83,256 / year
<b>Northeastern Region</b> (Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington)	\$255 / day	\$93,192 / year
<b>Northern Metropolitan</b> (Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester)	\$310 / day	\$113,268 / year
<b>New York City</b> (Bronx, Kings, New York, Queens, Richmond)	\$323 / day	\$118,056 / year
<b>Long Island</b> (Nassau, Suffolk)	\$357 / day	\$130,224 / year

<sup>1</sup> [www.nyspltc.org/rates.htm](http://www.nyspltc.org/rates.htm)

The long-term care insurance coverage is issued by The Prudential Insurance Company of America, a Prudential Financial company, 751 Broad Street, Newark, NJ 07102. The Booklet-Certificate contains all details, including any policy exclusions, limitations and restrictions, which may apply. Contract Series: 83500.

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LONG-TERM CARE  
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1.800.732.0416

**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.**

According to the information you have furnished on your Application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with a franchise long-term care insurance policy to be issued by The Prudential Insurance Company of America. Your new Policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the Policy. 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 Policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

**STATEMENT TO APPLICANT BY AGENT:**

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

- 1 This Policy has no exclusion for pre-existing conditions. This means that health conditions which you may presently have are fully and immediately covered under the new Policy.
- 2 State law provides that your replacement Policy or certificate may not contain new pre-existing conditions or probationary periods. The Policy you are applying for has no such pre-existing conditions or probationary periods.
- 3 If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agents regarding the proposed replacement of your present policy. 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.
- 4 If, after due consideration, you still wish to terminate your present policy 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 Policy 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.

**X**

\_\_\_\_\_  
Signature of Agent, Broker or Other Representative

\_\_\_\_\_  
Applicant's Signature  
The above "Notice to Applicant"  
was delivered to me on:

\_\_\_\_\_  
Name of Agent (please type or print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address of Agent (please type or print)

**PLEASE SIGN AND RETURN THIS COPY WITH YOUR APPLICATION**

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You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

**STATEMENT TO APPLICANT BY AGENT:**

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

- 1 This Policy has no exclusion for pre-existing conditions. This means that health conditions which you may presently have are fully and immediately covered under the new Policy.
- 2 State law provides that your replacement Policy or certificate may not contain new pre-existing conditions or probationary periods. The Policy you are applying for has no such pre-existing conditions or probationary periods.
- 3 If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agents regarding the proposed replacement of your present policy. 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.
- 4 If, after due consideration, you still wish to terminate your present policy 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 Policy 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.

**X**

\_\_\_\_\_  
Signature of Agent, Broker or Other Representative

\_\_\_\_\_  
Applicant's Signature  
The above "Notice to Applicant"  
was delivered to me on:

\_\_\_\_\_  
Name of Agent (please type or print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address of Agent (please type or print)

**RETAIN THIS COPY FOR YOUR RECORDS**

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**AFFIDAVIT OF DOMESTIC PARTNERSHIP**

Each of the undersigned attest that we satisfy the definition of Domestic Partnership as set forth below.

1. "Domestic Partnership" is defined as follows:

A Domestic Partnership consists of the subscriber and one other person of the same or opposite sex. Such persons must satisfy all of the following requirements:

- a. They have a single dedicated relationship of at least 6 months duration and intend to remain in the relationship indefinitely;
- b. They share the same permanent residence and have done so for at least 6 months;
- c. They are not related by blood or a degree of closeness, which would prohibit marriage in the law of the state in which they reside;
- d. Each is at least 18 years of age;
- e. Each is mentally competent to consent to contract;
- f. Neither is currently married to or legally separated from another person under either statutory or common law;
- g. Neither has been registered as a member of another Domestic Partnership within the last six months.
- h. They are financially interdependent and have furnished at least two of the following documents evidencing such financial interdependence:
  - i) joint ownership of real property or a common leasehold interest in real property;
  - ii) common ownership of an automobile;
  - iii) joint bank account;
  - iv) a will which designates the other as primary beneficiary;
  - v) a beneficiary designation form for a retirement plan or life insurance policy signed and completed to the effect that one Domestic Partner is beneficiary of the other; or
  - vi) if the Domestic Partners reside in a state which provides for registration of Domestic Partners, they have so registered and furnished evidence of such registration.

Date: \_\_\_\_\_

By: \_\_\_\_\_  
Signature of Subscriber

\_\_\_\_\_  
Printed Name

Date: \_\_\_\_\_

By: \_\_\_\_\_  
Signature of Domestic Partner of Subscriber

\_\_\_\_\_  
Printed Name

SUBSCRIBED AND SWORN TO ME

This \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_\_.

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PO BOX 8519  
PHILADELPHIA PA 19176-8579  
1.800.732.0416

## LONG-TERM CARE INSURANCE OUTLINE OF COVERAGE

### POLICY NUMBER GRP 113772

The following applies to applicants who must answer medical questions in order to qualify for the Long Term Care Insurance.

**Caution:** *The issuance of this long term care insurance Policy is based upon your responses to the questions on your Application. A copy of your Application will be included with your Policy when issued. If your answers are incorrect or untrue, or you fail to include all material medical information requested, Prudential may have the right to deny benefits or rescind your Policy, subject to the Incontestability provision. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: Prudential Long Term Care Customer Service Center, P. O. Box 8519, Philadelphia, PA 19176.*

**Notice to buyer: This Policy may not cover all of the costs associated with longterm care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.**

- 1 This Policy is a franchise policy of insurance.
- 2 **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the Policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY CAREFULLY!**
- 3 **FEDERAL TAX CONSEQUENCES. This Policy is intended to be a federally taxqualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.**
- 4 **TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

**RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of your Policy, to continue this Policy as long as you pay your premiums on time. Prudential cannot change any of the terms of your Policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

This Policy contains a Waiver of Premium provision. After you meet the Benefit Eligibility Criteria and satisfy the required Calendar Day Elimination Period, the premiums for your Policy will be waived, subject to the terms and conditions of Your Policy. The Sponsor may end its sponsorship of Prudential's Long Term Care Insurance policy. If this occurs, the Policy will remain in force, subject to the terms of paragraph one of this provision. Termination of sponsorship does not affect your rights and obligations under the Policy. These features are described in full detail in the Policy.

- 5 **TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS. PRUDENTIAL MAY CHANGE THE PREMIUM YOU PAY, BUT ONLY IF THE CHANGE APPLIES TO ALL INSURED'S WITHIN YOUR CLASS.**
- 6 **TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED.**

**30-Day Right to Review Policy:** If you decide you do not want this Long Term Care Policy, you may return it within 30 days of receipt. Your Policy will be canceled as of the Effective Date and any premium paid will be returned to you.

**Pro-Rata Refund of Unearned Premium:** Upon proper notification of your death or cancellation of this Policy, Prudential will refund on a pro-rata basis any part of the premium for you which applies to the period after death or cancellation.

**Refund of Premium Upon Death:** This is an optional benefit available for additional premium. Upon proper notification of death while the policy was in-force, the premiums paid less claims paid may be refunded to your estate.

- 7 THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from Prudential. Neither Prudential nor its agents represent Medicare, the federal government or any state government.
- 8 LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home. This Policy provides coverage in the form of reimbursement benefits based on actual charges incurred, up to the applicable Daily Benefit you choose, for covered long term care expenses. Benefits are subject to policy limitations, the applicable Calendar Day Elimination Period and Calendar Year and Lifetime Benefits and the Lifetime Maximum. In some cases, if you have chosen the Cash Alternative benefit, or, for additional premium, the optional Cash Benefit Rider or Flexible Cash Benefit Rider, some benefits will be payable on an indemnity basis, subject to applicable terms and conditions of coverage.
- 9 BENEFITS PROVIDED BY THIS POLICY. After you have been certified as having a Chronic Illness or Disability, this Policy pays benefits for Eligible Charges incurred by you for the following:

**Facility Care, which includes:**

- |  |                 |
|--|-----------------|
| Nursing Home Care                          | Bed Reservation |
| Adult Foster Home Care                     | Hospice Care    |
| Care in an Assisted Living Facility        | Respite Care    |
| Care in a Residential Health Care Facility |                 |

**Home Care, which includes:**

- Home Health Care
- Adult Day Care
- Homemaker Services
- Personal Care

**Home Support Services, which includes:**

- Assistive Devices or Technology
- Caregiver Training
- Durable Medical Equipment
- Emergency Medical Response System
- Home Modifications
- Transportation Services

- Alternate Plan of Care
- Information Services including Private Care Consultant benefits
- International Coverage
- Restoration of Benefits
- Waiver of Premium

Benefits paid for Eligible Charges count towards fulfillment of your Lifetime Maximum, unless otherwise stated in the Policy. The actual amount paid depends on the Daily Benefit you have chosen.

**Facility Care Daily Benefit for Nursing Home, Adult Foster Home or Board and Care Facility, Assisted Living Facility or Residential Health Care, Bed Reservation, Hospice Care and Respite Care:**

\$ \_\_\_\_\_ (\$10 increments)

**Home Care Factor of the Facility Care Daily Benefit, for Home Health Care, Adult Day Care, Homemaker Services and Personal Care:**

- 50%     75%     100%     150%

Lifetime Maximum:     2 years     3 years     4 years     5 years     6 years     10 years     Unlimited

**Calendar Day Elimination Period:** \_\_\_\_\_ Number of Days

**Calendar Day Elimination Period.** The Elimination Period must be satisfied once during your lifetime before benefits are paid. Prudential will begin to count days to satisfy your Elimination Period with the date you are certified by a Licensed Health Care Practitioner, within the last 12 months, as having a Chronic Illness or Disability. Each day your Chronic Illness or Disability continues counts in satisfaction of this Elimination Period.

**Eligibility for Payment of Benefits.** Before incurring Eligible Charges and submitting a claim, your condition must first be assessed and certified by a Licensed Health Care Practitioner as a Chronic Illness or Disability. A Chronic Illness or Disability is one that meets either definition below.

- 1) A loss of the ability to perform, without Substantial Assistance, at least two Activities of Daily Living due to a loss of functional capacity. This inability must be expected to continue for at least 90 consecutive days. This expectation is not a waiting period. Activities of Daily Living are Bathing, Contenance, Dressing, Eating, Toileting and Transferring.
- 2) A severe Cognitive Impairment that requires Substantial Supervision to protect you from threats to health and safety.

A Plan of Care must then be developed by a Licensed Health Care Practitioner.

**Activities of Daily Living** are defined as follows.

**Bathing** - Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

**Contenance** - The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

**Dressing** - Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

**Eating** - Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously.

**Toileting** - Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

**Transferring** - Moving into or out of a bed, chair or wheelchair.

**Severe Cognitive Impairment** is defined as follows. A loss or deterioration in intellectual capacity that is:

- 1) Comparable to (and includes) Alzheimer's Disease and similar forms of irreversible dementia, and
- 2) Measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term or long term memory, orientation as to people, places, or time and deductive or abstract reasoning.

Prudential will arrange for a Licensed Health Care Practitioner to assess you or you may select your own Licensed Health Care Practitioner. The assessment will be based on objective standards of measurement. After your Chronic Illness or Disability is certified, Prudential will determine if you are eligible for benefits. If you are eligible, you will need a Plan of Care. Your Plan of Care will be used to determine benefits based on the benefit options in your Policy.

**OPTIONAL RIDERS AVAILABLE TO YOU. If you choose an optional rider and pay the required premium, your Policy will change as indicated by the terms of the Rider.**

**LTC Insurance Rider – Cash Benefit Rider:** If you elect payment under this Rider at the time of claim, Prudential will pay a monthly benefit payment to you while you are Chronically Ill. This Cash Benefit replaces benefits payable for Eligible Charges. Charges for Qualified Long Term Care services do NOT need to be incurred. The Cash Benefit payment is equal to the number of days in the month when you are Chronically Ill, times the Home Care Daily Benefit.

**LTC Insurance Rider – Flexible Cash Benefit Rider:** If you elect this benefit payment option at time of claim, Prudential will pay you a portion of your Home Care benefits in cash, in lieu of being reimbursed for Eligible Charges. If you elect this payment option, it applies to the entire month and may not be revoked for that month.

Prudential will pay you a cash benefit for each day in the month you are certified as being Chronically Ill. This Flexible Cash Benefit payment is equal to the number of days during the month you are certified as being Chronically Ill, after you satisfy the Elimination Period, times 50% of the Home Care Daily Benefit.

In addition to the cash portion, you may also be reimbursed for Eligible Charges incurred for Home Care in the same calendar month you elect to receive the cash portion. 50% of the Home Care Daily Benefit is available to reimburse you for Eligible Charges you incur for Home Care. Eligible Charges for Home Care will be reimbursed if you are certified as being Chronically Ill, satisfy your Elimination Period and provide standard Proof of Loss.

**LTC Insurance Rider – Monthly Benefit Rider:** Prudential will pay benefits for Eligible Charges for Home Care received during a calendar month, subject to the Monthly Benefit, instead of the Home Care Daily Benefit. The Monthly Benefit is equal to the number of days in the month times the Home Care Daily Benefit.

**LTC Insurance Rider – Joint Waiver Of Premiums Benefit:** Premiums will be waived for your Policy and the Prudential Long Term Care Insurance Policy issued to your Spouse or Domestic Partner. Prudential will waive premiums if you meet the Benefit Eligibility Criteria and the Elimination Period is satisfied. Both policies must meet these two conditions. They must be issued at the same time or within 6 months of the earliest to be issued. They must be in effect on the date you are certified as Chronically Ill.

**LTC Insurance Rider – Survivor Waiver Of Premiums Benefit:** Prudential will waive premiums for your Policy in the event your Spouse or Domestic Partner dies. For waiver of premiums to begin, all of the following conditions must be met.

- 1) A Prudential Long Term Care Insurance Policy must be in effect for both you and your spouse or Domestic Partner.
- 2) Both policies and the Rider must be in effect for at least 10 years.
- 3) Both policies and the Rider must be in effect at the time of death.
- 4) Long Term Care Insurance benefits have not been paid under either policy prior to the death of your spouse or Domestic Partner.

**LTC Insurance Rider – Shared Cared Rider:** Prudential will allow your designated Shared Care Partner to access benefits available under your Policy once his or her Policy's Lifetime Maximum is exhausted. Additionally, if your Shared Care Partner dies, we will increase your Lifetime Maximum by the amount of the deceased Shared Care Partner's remaining Lifetime Maximum, if any.

However, in order to receive benefits the following conditions must be met.

- 1) Your Shared Care Partner also has the Shared Care Rider in effect and you are the designated Shared Care Partner on his or her Policy.
- 2) You and your Shared Care Partner must have and maintain identical Policy Benefits, including Optional Benefit Riders.
- 3) You and your Shared Care Partner must have elected and maintain the same Premium Payment Option.
- 4) You keep this Rider in force.

**LTC Insurance Rider – Waiver of the Elimination Period for Home Care:** The requirement to satisfy your Elimination Period before receiving benefits will be waived if you are receiving eligible Home Care services. You must be certified as having a Chronic Illness or Disability and are receiving eligible services for Home Care.

#### 10 LIMITATIONS AND EXCLUSIONS. **Charges Not Covered.**

- a) Illness, treatment or medical conditions arising out of
  - 1) War or an act of war, whether declared or undeclared, while you are insured; or
  - 2) Your participation in a felony, riot or insurrection; or
  - 3) Alcoholism and drug addiction.
- b) Treatment provided in a government facility, unless payment of the charge is required by law or services provided by any law or governmental plan under which you are covered. This does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.
- c) Charges for services or supplies for which no charge would be made in the absence of insurance.
- d) Charges for care or treatment provided outside the United States except as described in the International Coverage benefit.

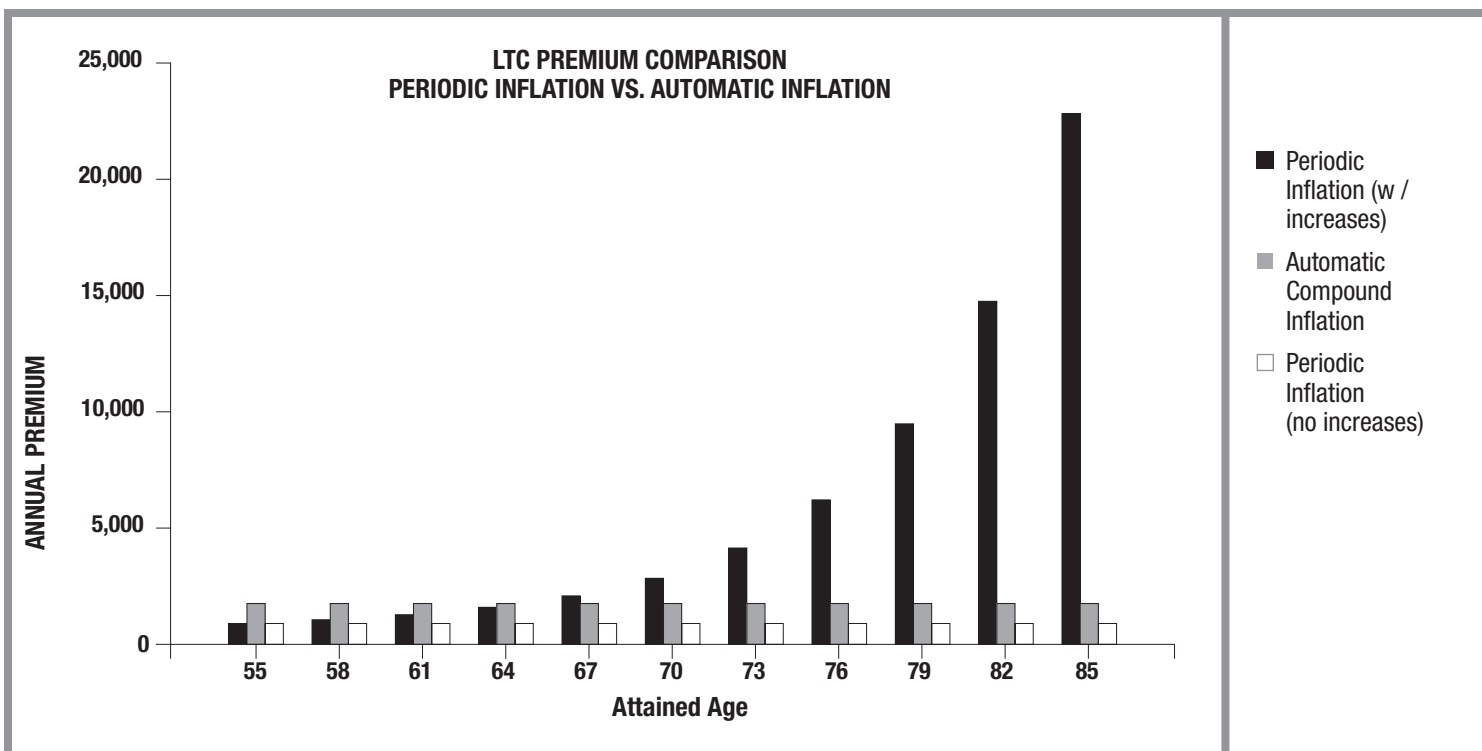
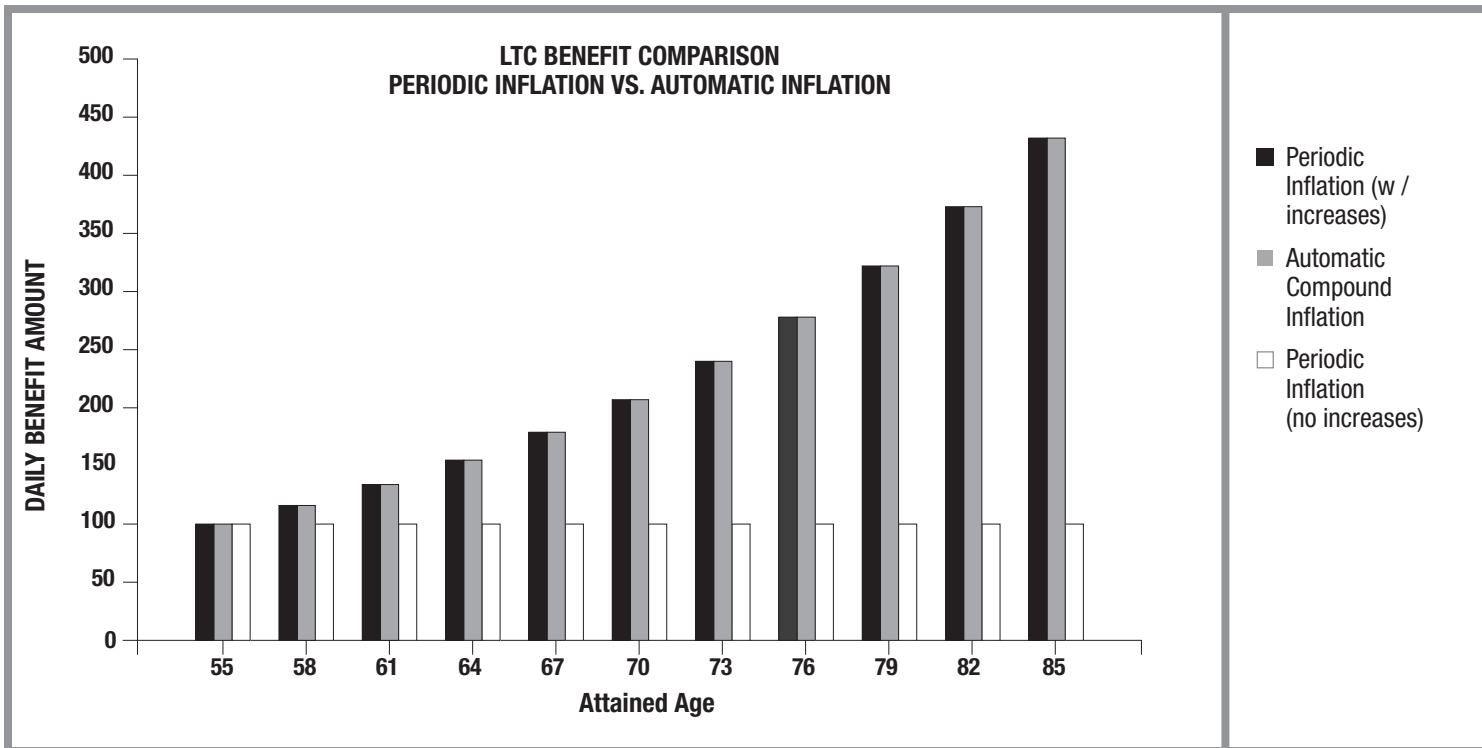
Benefits under your Policy are not payable for expenses for Qualified Long Term Care Services to the extent that such expenses are reimbursable under Medicare; or such expenses would be reimbursable under Medicare but for the application of a deductible or coinsurance amount.

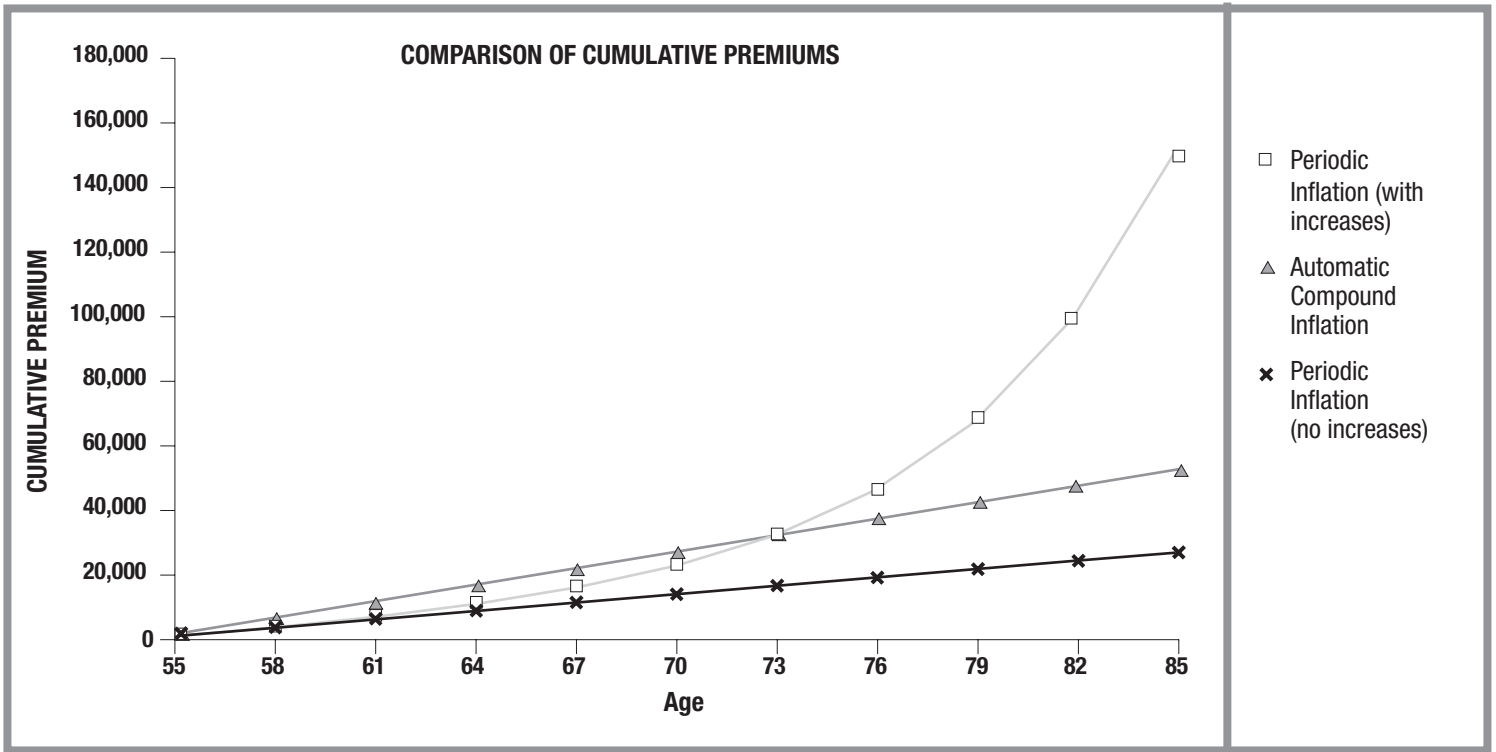
Benefits under your Policy may be reduced if we also pay benefits for Qualified Long Term Care Services under any other Prudential Individual Long Term Care Insurance Policy

#### **THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.**

11 RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this Policy may be adjusted. Benefit levels will not increase over time under the Policy, unless you purchase an optional Inflation Rider.

The following is a hypothetical graphic comparison of the benefit and premium levels of a Policy that increases benefits over the period of coverage with a Policy that does not increase benefits. The graphic comparison shows benefit and premium levels over a thirty year period. The example is based on a \$100 Facility Daily Benefit purchased by a 55 year old.





**OPTIONAL INFLATION RIDERS.** If you choose an Optional Inflation Rider and pay the required premium, your Policy will change as indicated by the terms of the Rider.

**LTC Insurance Rider – Guarantee Purchase Option Benefit.** At least every three years on your Rider’s anniversary, while your coverage is in effect, Prudential will increase your Policy Benefits. You will be notified of this increase at least 60 days prior to your Policy Anniversary. You will not have to provide proof of good health to receive this increase.

With each increase, your Policy Benefits that provide coverage for Eligible Charges up to a specified dollar amount per day, per Calendar Year or per lifetime will be increased by 5% compounded annually over the three-year period.

**LTC Insurance Rider – Automatic Compound Inflation Benefit – No Maximum.** A 5% increase to your benefit levels will occur each year that your Inflation Rider is in force. The increase will occur even if you are receiving benefits.

**LTC Insurance Rider – Automatic Compound Inflation Benefit – 2X Maximum.** A 5% increase to your benefit levels will occur each year that your Inflation Rider is in force. These increases will occur until your Facility Daily Benefit and Home Care Daily Benefit in effect on the original Effective Date of this Rider have doubled. The increase will occur even if you are receiving benefits.

**LTC Insurance Rider – Automatic Simple Inflation Benefit –** A 5% increase to your benefit levels will occur each year that your Inflation Rider is in force. The increased amount will be the same each year if your benefit levels do not change as a result of your request. The increase will occur even if you are receiving benefits.

**LTC Insurance Rider – 2% Automatic Compound Inflation Benefit.** A 2% increase to your benefit levels will occur each year that your Inflation Rider is in force. The increase will occur even if you are receiving benefits.

**LTC Insurance Rider – 3% Automatic Compound Inflation Benefit.** A 3% increase to your benefit levels will occur each year that your Inflation Rider is in force. The increase will occur even if you are receiving benefits.

**LTC Insurance Rider – 4% Automatic Compound Inflation Benefit.** A 4% increase to your benefit levels will occur each year that your Inflation Rider is in force. The increase will occur even if you are receiving benefits.

12 ALZHEIMER’S DISEASE AND OTHER ORGANIC BRAIN DISORDERS. The Policy provides coverage for insureds clinically diagnosed as having Alzheimer’s disease or related degenerative and dementing illnesses.

13 **PREMIUM.** The total annual premium for the Policy and options you have selected will be \$\_\_\_\_\_. Please see the last page of this Outline of Coverage for a complete listing of the features and premium for the options you have selected.

14 **ADDITIONAL FEATURES.**

**Medical Underwriting.** Medical underwriting is used to determine your eligibility for the Policy. To apply for coverage under the Policy, you must complete an Application. Satisfactory evidence of good health is required for all applicants in order to be eligible for this Policy. Individuals over the age of 79 are not eligible.

**Protection Against Unintentional Lapse.** You have the right to designate a person to receive notice that your Policy is about to lapse or terminate for nonpayment of premium. Unless you have chosen not to do so, your Application shows the name and address of the person you have designated to receive this notice. You may change this written designation at any time.

**Reinstatement.** If you fail to pay your premium and your Policy lapses for this reason, you may be eligible to reinstate your Policy. You may make a request for reinstatement within 90 days from the date the last notice of unpaid premium is given. If, due to your Chronic Illness or Disability, you fail to pay your premium and your Policy lapses for this reason, you may be eligible to reinstate your Policy. You or your representative may request reinstatement within five months of the date premiums were due.

**Non-Forfeiture Benefit.** For additional premium, you may purchase an Optional Rider to add a provision to your Policy that extends coverage for a shortened benefit period if your Policy ends due to non-payment of premium. Benefits will be payable based on the Facility and Home Care Daily Benefits in effect on the date your coverage would otherwise have ended. However, there will be a reduced Lifetime Maximum. The reduced Lifetime Maximum will be equal to the greater of 1) 30 times the Facility Care Daily Benefit in effect at the time your Policy ends, up to the Lifetime Maximum in effect on the date your Policy would otherwise have ended or 2) The total amount of premiums paid for your Policy, and any optional Riders, less the sum of all benefits paid on your behalf, while your Policy is in effect.

15 **CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY.**

16 **SENIOR COUNSELING PROGRAMS.** Please refer to *A Shopper's Guide To Long Term Care Insurance* contained in your enrollment material for the telephone number of the Senior Counseling Program in your state.

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