LifeSecure Insurance Company
Application for Long Term Care Insurance

FOR ADDITIONAL INFORMATION ABOUT LONG TERM CARE COVERAGE, WRITE TO: OFFICE OF FINANCIAL AND INSURANCE SERVICES, P.O. BOX 30220, LANSING, MI 48909, OR CALL THE AREA AGENCY ON AGING IN YOUR COMMUNITY.

LS-0200 ST 05/08

SECTION A: Initial Insurability Screen

Please answer all 5 questions BEFORE you continue with this Application.

1. Within the *past 12 months*, have you used or been advised by a healthcare professional to use any of the following? ☐ yes ☐ no
   - Home Health Care, Adult Day Care, or care in a Nursing Home, Assisted Living Facility, or any other Long Term Care Facility; or
   - A walker, wheelchair, quad cane, motorized scooter, hospital bed, or oxygen equipment?

2. Do you require human assistance or supervision in order to perform any of the following activities: ☐ yes ☐ no
   bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control?

3. Do you have or have you *ever* been diagnosed or treated by a healthcare professional as having any of the following: ☐ yes ☐ no
   - Amyotrophic Lateral Sclerosis (ALS also called Lou Gehrig's disease)
   - Alzheimer's Disease
   - Dementia
   - Frequent or persistent forgetfulness or memory loss
   - Mild Cognitive Impairment
   - Organic Brain Syndrome
   - Senility
   - Multiple Sclerosis (MS)
   - Muscular Dystrophy
   - Parkinson's Disease
   - Cystic Fibrosis
   - Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test
   - Metastatic Cancer (cancer that has spread from its original site)
   - Diabetes with a history of Transient Ischemic Attack (TIA) or Stroke
   - Huntington's Chorea
   - Cirrhosis of the Liver

4. In the *past two years*, have you been diagnosed or treated by a healthcare professional as having any of the following? ☐ yes ☐ no
   - Hydrocephalus
   - Stroke
   - Transient Ischemic Attack (TIA)
   - Type I (Juvenile) Diabetes
   - Uncontrolled Type II Diabetes
   - Drug Abuse
   - Hemophilia
   - Scleroderma
   - Other Degenerative Neuromuscular Disease

5. Are you *currently* receiving Social Security Disability Income Benefits or other disability insurance benefits? ☐ yes ☐ no

If you answered "**Yes**" to any part of any question in Section A, **PLEASE DO NOT CONTINUE**.
We regret that we cannot offer you long term care insurance coverage.
If your circumstances change, you may consider reapplying at a future time.

If you answered "**No**" to all questions in Section A, please **CONTINUE**.

SECTION B: Applicant Information

Print clearly - Use black or blue ink

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. (check one)

Name (First) (MI) (Last)

Street Address Apt. #

City **State** **Zip Code**

Date of Birth **Social Security Number** (or Tax ID Number)

☐ Male ☐ Female
Gender

☐ Single ☐ Married ☐ Domestic Partner
Marital Status

Work Phone Number **Home Phone Number**

____ a.m. ____ p.m. ☐ Home ☐ Work
Best Time/Place to Call

Group Number (if applicable)

E-mail Address **Employee Number** (if applicable)

If your application is approved and coverage is issued, would you prefer to receive future communications in ☐ hard-copy format via U.S. mail **OR** ☐ electronically via e-mail (pdf)?

SECTION C: Spouse or Domestic Partner Information

Please complete the information below whether or not your spouse or domestic partner is applying. You may qualify for a couple's discount.

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. (check one)

Name (First) (MI) (Last)

Social Security Number (or Tax ID Number)

Is your spouse or domestic partner also applying for coverage? ☐ yes ☐ no

SECTION D: Personal Physician Information

Please provide the following information about your personal physician, sometimes called your Primary Care Doctor (i.e., the physician with most of your medical records).

Physician's Name (First) (MI) (Last) (Suffix)

Street Address

Suite #

City **State** **Zip Code**

Office Phone Number

Have you seen this physician in the last two years? ☐ yes ☐ no

Date of last visit: _____

Reason for visit: _____

SECTION E: Medical History

If you need more space to explain any answer below, please attach an additional sheet of paper.

1. In the *past 3 years*, have you received medical advice or treatment, been diagnosed by or consulted with a healthcare professional for any of the following conditions (check all that apply or NONE OF THE ABOVE).

- ☐ 1. Drug or Alcohol Abuse
- ☐ 2. Disorders of Vision or Speech
- ☐ 3. Hypertension/High Blood Pressure, Chest Pain, Angina, Coronary Artery Disease
- ☐ 4. Heart Attack, Angioplasty or Heart Surgery
- ☐ 5. Stroke, (CVA), Transient Ischemic Attack (TIA), Carotid Artery Disease or Surgery
- ☐ 6. Congestive Heart Failure (CHF), Atrial Fibrillation, Pacemaker
- ☐ 7. Aneurysm, Peripheral Vascular Disease (PVD)
- ☐ 8. Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Asthma, Chronic Bronchitis
- ☐ 9. Fainting Spells or Blacking Out, Seizures, Epilepsy
- ☐ 10. Tremor, Myasthenia Gravis
- ☐ 11. Paralysis (partial or full), Post Polio Syndrome
- ☐ 12. Cancer, Leukemia, Melanoma, Hodgkin's Disease or other Lymphoma, Multiple Myeloma
- ☐ 13. Depression, Schizophrenia, or other forms of Psychosis or Mental Illness, Mental Retardation
- ☐ 14. Diabetes, Disease of the Pancreas or other glands
- ☐ 15. Fibromyalgia, Chronic Fatigue, Lupus, Scleroderma, or other connective Tissue Disease
- ☐ 16. Injury due to Falls or Imbalance, Fractures, Amputation or Joint Replacement
- ☐ 17. Rheumatoid Arthritis, Osteoarthritis, Osteoporosis, Paget's Disease of the bone
- ☐ 18. Hepatitis C, Cirrhosis of the Liver, Auto Immune Disorder, Ulcerative Colitis, Crohn's Disease
- ☐ 19. Kidney/Renal Failure or Insufficiency, Kidney Dialysis or Incontinence
- ☐ 20. Organ Transplant

☐ **NONE OF THE ABOVE**

Please give details below to all boxes checked in Question #1 of this section. If you need more space, please attach an additional sheet of paper.

Number	Dates From/To	Physician's Name/Address/Phone	Describe

2. In the *past 3 years*, have you had any symptoms or knowledge of any other health condition that is not disclosed above? ☐ yes ☐ no
   If "Yes", please describe. _____

3. In the *past 3 years,* have you:
   a. taken any prescription medications (if "Yes", please list)? ☐ yes ☐ no

Medication	Dosage	Reason

   b. been confined in or advised to enter a hospital or rehabilitation facility? ☐ yes ☐ no
   If "Yes", please explain and include dates and reasons.

c. consulted with or been treated for any reason by a healthcare professional OTHER THAN your Primary Care Doctor, podiatrist, dentist or allergist? ☐ yes ☐ no
If "Yes", please provide the Healthcare Professional's name, location, specialty, reason consulted and dates.

Name	City & State	Specialty	Reason(s)	Dates

d. been advised by a healthcare professional to have a special evaluation testing or a surgery that has not been performed? ☐ yes ☐ no
If "Yes", please explain type, reason and scheduled date of the evaluation, testing or surgery.

e. required assistance with shopping, using transportation, housekeeping, cooking or taking medications? ☐ yes ☐ no
If "Yes", please explain and include dates and reasons.

SECTION F: Applicant Profile

1. Please provide your height _____(ft. & in.) and weight _____(lbs.)

2. In the *past 3 years*, have you used any form of tobacco or nicotine product? ☐ yes ☐ no

Date last used	List types of tobacco or nicotine products used

3. Do you work 20 or more hours a week outside your home? ☐ yes ☐ no
   If "Yes", please list your occupation: _____

4. Do you drive an automobile? ☐ yes ☐ no
   If "Yes", please provide approximate annual mileage: _____ miles

5. With whom do you live? ☐ alone ☐ spouse ☐ family ☐ other

6. Do you live in some form of a residential retirement community? ☐ yes ☐ no
   If "Yes", please list the specific services that you are receiving (e.g., housekeeping, laundry, meals).

   _____

   _____

7. In the *past 3 years*, have you had any nursing home or long term care insurance application denied? ☐ yes ☐ no
   If "Yes", by which company?

   _____

   _____

SECTION G: Coverage Selections

Please select your coverage options.

Benefit Bank: Enter a dollar amount between $75,000 and $1,000,000 _____

Monthly Benefit Access Limit:

☐ 1% of Benefit Bank ☐ 2% of Benefit Bank ☐ 3% of Benefit Bank*

*3% choice not available for Benefit Bank amounts greater than $500,000

Your initial Monthly Benefit Access Limit dollar amount: $ _____ x ____% = $ _____

Benefit Bank Monthly Benefit

Premium Payment Options:

☐ Lifetime Payment Option

☐ To-Age-65 Premium Payment Option*

☐ 10-Year Premium Payment Option*

* These two limited-payment options are available only if you elected Automatic 3% Compound Inflation Protection or Automatic 5% Compound Inflation Protection as part of your coverage.

Money-Back Promise Option:

☐ Yes. I elect to have the Money-Back Promise Option as part of my coverage.

This optional benefit provides for a refund of a percentage of premiums (less benefits paid) to a beneficiary of your choice if you should die while holding your policy for 5 or more years.

Please enter the name of a primary and a contingent beneficiary who should receive such a refund, if any. Please note: If no beneficiary is named, any applicable refund (if any) will be made to your estate.

Name of Primary Beneficiary	Contingent Beneficiary
Relationship	Relationship
Street Address	Street Address
City State Zip	City State Zip

☐ No. I reject the Money-Back Promise Option as part of my coverage.

Optional Automatic Inflation Protection: I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of the policy with and without automatic inflation protection. I select the following option:

☐ Automatic 3% Compound Inflation Protection

☐ Automatic 5% Compound Inflation Protection

☐ I reject the Automatic Compound Inflation Protection options above; however, I understand that my coverage will include the Guaranteed Future Purchase Offers feature.

Optional Lapse Protection Benefit:

☐ Yes. I elect to have the Lapse Protection Benefit as part of my coverage.

☐ No. I have reviewed the Outline of Coverage and compared the benefits and premiums of the policy with and without Lapse Protection benefits and I reject the Lapse Protection Benefit.

SECTION H: Replacement Inquiry

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? ☐ yes ☐ no

   If "Yes", provide details:

   Company Name: _____

   Individual or Group Policy Number: _____

   Type of Coverage: _____

2. Did you have another long term care, nursing home, or home health care insurance policy or certificate in force during the past 12 months? ☐ yes ☐ no

   If "Yes", with which company? _____

   If that policy lapsed, when did it lapse? _____

3. Did you intend to replace the above or any other long term care, medical or health insurance with this coverage? ☐ yes ☐ no

   If "Yes", which company's coverage will you be replacing:

   _____

4. Are you covered by Medicaid? (not a reference to Medicare) ☐ yes ☐ no

SECTION I: Protection Against Unintended Lapse or Termination

I understand that I have the right to designate at least one authorized person, other than myself, to receive notice of lapse or termination of this long term care coverage due to nonpayment of premium. I understand that notice will not be given to this person until 30 days after a premium is due and unpaid.

Please check one of the following:

- ☐ I elect NOT to designate another person to receive this notice.
- ☐ I elect to designate another person to receive this notice.

Complete the information below ONLY if you elect to name an authorized person.

Name of Authorized Person (First) (MI) (Last)

Street Address Apt. #

City **State** **Zip Code**

Phone Number

You may change the named designee at any time by notifying us in writing at the following address:
LifeSecure Administrative Office, P.O. Box 12834, Pensacola, FL 32591

SECTION J: Premium Payment Authorization

Complete this section to authorize your preferred premium payment method.

☐ DIRECT-BILLING (MAIL).

select one billing frequency:

☐ annually ☐ semi-annually ☐ quarterly ☐ monthly*

(* $2.00 monthly fee applicable)

OR

☐ MONTHLY ELECTRONIC FUNDS TRANSFER.

How Monthly Electronic Funds Transfer Works: Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. LifeSecure Insurance Company will collect the long term care insurance premiums from your bank account electronically. You do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Monthly Electronic Funds Transfer Agreement:
I authorize LifeSecure to electronically withdraw money from my account for the payment of premiums for this insurance policy. I authorize LifeSecure to continue to make these withdrawals if there is a renewal, or other change in the policy. I will compensate LifeSecure for any loss, claim, or liability caused by these withdrawals and will not hold LifeSecure responsible for any such loss, claim, or liability. This authorization will not affect the terms of the policy. Authorizing this automatic payment plan does not put the insurance policy into effect. This authorization may be retracted by me or LifeSecure at any time for any reason by giving written notice. LifeSecure may retract the authorization immediately, without giving me written notice, if any debt is not paid by the bank stated below, for any reason.

name of bank: _____

bank address: _____

telephone #: _____

account type: ☐ checking ☐ savings

account #: _____

routing #: _____

OR

☐ AUTOMATIC CREDIT CARD PAYMENT.

select card type: ☐ Visa ☐ MasterCard

credit card #: _____

name as it appears on card: _____

expiration date: _____

OR

☐ AUTOMATIC PAYROLL DEDUCTION (applicable only for participating employers).

By electing this payment method, I authorize my employer to deduct my long term care insurance premiums automatically from my payroll.

SECTION K: Other Notices to Applicant

Medical Information Bureau
LifeSecure or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:
Medical Information Bureau
P.O. Box 105, Essex Station
Boston, Massachusetts 02111
866.692.6901 (TTY 866.346.3642)

LifeSecure, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Insurance Information Practices
To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding.

Upon your written request, LifeSecure will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write or e-mail us at:
LifeSecure Insurance Company
10559 Citation Drive, Suite 300
Brighton, MI 48116
info@YourLifeSecure.com

Telephone Interview Information
To help process your application as soon as possible, LifeSecure may have one of its representatives call you by telephone, at your convenience, in order to obtain additional underwriting information.

Fraud Notice
Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

SECTION L: Long Term Care Insurance Personal Worksheet

People buy long term care insurance for many reasons. Some don't want to use their own assets to pay for long term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this coverage.

Premium Information

Policy Form Series: **LS-0002**

The premium for the coverage you are considering will be $ _____ per month, or $ _____ per year.

Type of Policy: **Guaranteed Renewable – Individual Long Term Care Insurance**

The Company's Right to Increase Premiums

LifeSecure Insurance Company has the right to increase premiums on this policy form in the future, provided it raises premiums for all policies in the same class in this state.

Rate Increase History

LifeSecure Insurance Company has sold long term care insurance since 2006 and has sold this policy since 2007. LifeSecure Insurance Company has never raised its rates for any long term care policy it has sold in this state or any other state.

Questions Related to Your Income

How will you pay each year's premium?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Have you considered whether you could afford to keep this coverage if the premiums went up, for example, by 20%?

What is your annual income? (Check one)

☐ Under $10,000 ☐ $10,000 – $20,000 ☐ $20,000 – $30,000

☐ $30,000 – $50,000 ☐ Over $50,000

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

☐ No change ☐ Increase ☐ Decrease

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

Will you buy inflation protection? (Check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your monthly benefit amount?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of nursing home care in 2006 was $70,912, but this figure varies across the country. In ten years the national average annual cost would be about $115,508 if costs increase 5% annually.

What elimination period (also referred to as Benefit Wait Period) are you considering?
Number of days: _____ Approximate cost $ _____ for that period of care.

How are you planning to pay for your care during the elimination period?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all your assets (your savings and investments) worth? (Check one)

☐ Under $20,000 ☐ $20,000 – $30,000 ☐ $30,000 – $50,000 ☐ Over $50,000

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

☐ Stay about the same ☐ Increase ☐ Decrease

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

Disclosure Statement (Check one)

☐ The answers to the questions above describe my financial situation.

☐ I choose not to complete the questions related to my financial situation. I acknowledge that I should read the National Association of Insurance Commissioners' (NAIC) *A Shopper's Guide to Long Term Care Insurance*. I also understand that the policy has a 30-day Free Look provision which allows me to return my policy for a full refund of premium for any reason within that period of time. Finally, I understand that this policy may not be suitable for me; however, after careful consideration, I am requesting the Company to consider my application and issue my long term care insurance policy if I meet their underwriting guidelines.

I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**

Signed: _____ _____

(Applicant) (Date)

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

Signed: _____ _____

(Agent) (Date)

Agent's Printed Name:_____

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

Signed: _____ _____

(Applicant) (Date)

LifeSecure Insurance Company may contact you to verify your answers.

SECTION M: Agent's Report, Certification & Signature

Number of years you have known applicant: _____

1. Did you personally see the applicant on the date of this application, ask each question, and accurately record the answers yourself? ☐ yes ☐ no
   If "No", please provide details in the "Remarks" section below.

2. Are you aware of any information that would adversely affect the applicant's eligibility, acceptability, or insurability? ☐ yes ☐ no
   If "Yes", please provide details in the "Remarks" section below.

3. Did you observe any physical or mental impairments with regard to walking, talking, or any form of tremor? ☐ yes ☐ no
   If "Yes", please provide details in the "Remarks" section below.

4. Please list other health insurance policies sold by you to the applicant:

   _____

5. Please list other health insurance policies sold by you to the applicant in the last five years that are no longer in force.

   _____

Remarks

_____

_____

6. If this application is approved, the Policy Welcome Kit should be sent to the:

   ☐ Policyholder ☐ Sales Agent (Select Agent Name in Case Split Information section below.)

   If sent to the policyholder, please select an address:

   ☐ Policyholder Home Address (listed in Section B)

   ☐ New Shipping Address:

   Name (First) (MI) (Last)

   Street Address Apt. #

   City **State** **Zip Code**

   Phone

☐ I have truthfully and accurately recorded the information supplied to me by the applicant for completion of this application.

☐ I have provided the applicant copies, either printed or electronic, of 10 Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Potential Rate Increase Disclosure Form, and the Shopper's Guide to Long Term Care Insurance.

☐ I have provided the applicant a copy of the Personal Worksheet and have expained the importance of completing the information on their Personal Worksheet.

CHECK THE BOX BELOW ONLY IF THE APPLICANT SPECIFIED IN SECTION H OF THIS APPLICATION THAT HE/SHE PLANS TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

☐ I acknowledge that I have provided the applicant with the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance.

My signature below represents my acknowledgement and certification for all statements checked above.

_____ _____

Soliciting Agent's Signature **Date**

_____ ____ _____

Soliciting Agent's Name (First) (MI) (Last)

_____

LifeSecure ID #

Case Split Information (if applicable)

☐ Agent Name _____ % Split _____

LifeSecure ID # _____ Contract # _____

☐ Agent Name _____ % Split _____

LifeSecure ID # _____ Contract # _____

☐ Agent Name _____ % Split _____

LifeSecure ID # _____ Contract # _____

100%

SECTION N: Applicant Authorizations and Signature

Your signature, whether electronic or handwritten, represents your acknowledgement, acceptance and authorization of each statement checked below. The first four statements must be accepted before your Application can be processed. The remaining statements must be accepted before your Application can be processed *only* if you elected the optional choices referenced in those statements. Please read each statement carefully before providing your signature authorization.

- ☐ I acknowledge that I have received either printed or electronic copies of 10 Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Personal Worksheet, Potential Rate Increase Disclosure Form, and the Shopper's Guide to Long Term Care Insurance.
- ☐ I acknowledge that I have read the Other Notices to Applicant regarding the Medical Information Bureau, Insurance Information Practices and Telephone Interview Information, and the Fraud Notice which appear in Section K of this Application.
- ☐ I acknowledge that I have reviewed my answers and statements to all sections of this Application. I declare that all information supplied here is true and complete to the best of my knowledge.
- ☐ I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure has the right to deny benefits or rescind my policy. I agree to notify LifeSecure of any change in my medical condition while my application is pending. I understand that LifeSecure will have no liability until a policy is issued to me and the full first premium for the issued policy has been paid. I understand that the policy will not take effect until my application is approved by LifeSecure and there has been no change in my health that would change the answer to any questions in my application.

CHECK ONLY THE FOLLOWING BOXES THAT APPLY TO OPTIONAL CHOICES MADE BY YOU IN OTHER SECTIONS OF THIS APPLICATION, AS SPECIFIED.

- ☐ I acknowledge my rejection of the Automatic Compound Inflation Protection options, as chosen in Section G of this Application.
- ☐ I acknowledge my rejection of the Lapse Protection Benefit option, as chosen in Section G of this Application.
- ☐ I acknowledge my decision to NOT designate another person to receive a notice of lapse or termination, as chosen in Section I of this Application.
- ☐ I acknowledge that LifeSecure is authorized to accept my premium payment withdrawals from my bank account or credit card, as chosen in Section J of this Application.
- ☐ I acknowledge that LifeSecure is authorized to accept my premium payments via automatic payroll deduction, as chosen in Section J of this Application.

CHECK THE BOX BELOW ONLY IF YOU SPECIFIED IN SECTION H OF THIS APPLICATION THAT YOU PLAN TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

- ☐ I acknowledge that I have read the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance. That particular notice was delivered to me on: _____.

My signature below represents my acknowledgement, acceptance and authorization for all statements checked above.

Applicant's Name: _____ ***Date of Birth:*** _____

Applicant's Signature: _____ ***Last 4 Digits of SSN:*** _____

Signed at: _____ ***on Date:*** _____

City, State

SECTION O: Applicant Authorization to Obtain and Disclose Information

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (HIPAA).

By signing this authorization form, I agree to the following:

I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, pharmacy or pharmacy benefit management (PBM) company, insurance company, consumer reporting agency, such as the Medical Information Bureau (MIB), or insurance support organization or other person or organization that has such information, to disclose the following categories of health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as HIV, AIDS or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to LifeSecure Insurance Company (LifeSecure) and any representatives performing services for LifeSecure, including its insurance support organizations, third-party administrators, affiliates, any reinsurers, and any consumer reporting agency such as the MIB.

Such disclosures may be made upon presentation of this form, or a copy of it. I recognize that such health information shall be used in connection with my Application for Long Term Care Insurance from LifeSecure - specifically, for purposes of underwriting, servicing and claims.

I agree that this authorization will be valid for 24 months from the date signed. This authorization may be revoked upon submission of a written request to LifeSecure's administrative office: LifeSecure Administrative Office, 3050 Universal Blvd., Suite 150, Weston, FL 33331. Any action taken by LifeSecure (or one of its representatives) before receipt of the written notice of revocation will still be valid.

Although my signature on this form is voluntary, I understand that it is required to determine my insurability and qualification to be issued a long term care insurance policy from LifeSecure. Without my signature, I understand that my Application for Long Term Care Insurance cannot be processed. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws.

I understand that a copy of this signed authorization form will be provided to me.

My signature below represents my acknowledgement, acceptance and authorization for all statements above.

Applicant's Name: _____ ***Date of Birth:*** _____

Applicant's Signature: _____ ***Last 4 Digits of SSN:*** _____

Date: _____