

**SAMPLE LONG TERM CARE INSURANCE SUITABILITY LETTER**

Dear [Applicant]:

Your recent application for long term care insurance included a "Personal Worksheet", which asked questions about your finances and your reasons for buying long term care insurance. For your protection, State law requires us to consider this information when we review your application. This prevents issuing a policy to those who may not need coverage.

Your answers on the worksheet indicate that long term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Taking Care of Tomorrow - A Consumer's Guide to Long Term Care Insurance" and the page titled "Things You Should Know Before Buying Long Term Care Insurance". Your State Insurance Department also has information about long term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.

Your state requires that we confirm your request to proceed before we can continue to underwrite your application. We need to hear from you within the next 60 days to complete the underwriting of your application. If we do not hear from you within the next 60 days, we cannot issue you a policy and your file will be closed.

You should understand that you will not have any coverage until you respond to this letter, we approve your application and issue you a policy.

*Please check one box and return in the enclosed envelope.*

- Yes, I wish to purchase this coverage. Please continue the review of my application.
- No. I have decided not to purchase long term care coverage at this time.

**SIGN HERE**

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE

**Please return to:**  
*Berkshire Life Insurance Company of America  
Long Term Care Administrative Office  
P.O. Box 4243  
Woodland Hills, CA 91365-4243 by [Date]*



**Berkshire Life Insurance Company of America**

Home Office: Pittsfield, Massachusetts  
Long Term Care Administrative Office  
Post Office Box 4243  
Woodland Hills, CA 91365-4243  
888-505-8743

**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 policy.

**Premium Information**

Policy Form Numbers: BG-01A(06/04) -CA

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

Type of Policy: Guaranteed Renewable Annual Amt. Annum

**The Company's Right To Increase Premiums**

The Company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in the state your policy is issued.

**Rate Increase History**

The company has sold long term care insurance since 2004 and has sold this policy since 2006. The company has never raised its rates for any long term care policy it has sold in this state or any other state.

A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies and sample premiums. The rate guide also provides a history of the rate increases, if any, for the policies issued by different insurers in each state in which they do business, since January 1990. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll free number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program's (HICAP) toll-free number (1-800-434-0222), or by accessing the Department of Insurance's Internet web site ([www.insurance.ca.gov](http://www.insurance.ca.gov)).

**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 policy if the premiums went up, for example, by 20%?

Turn the Page



**What Is Your Annual Income?** (check one)

- Under \$10,000
- \$10-20,000
- \$20-30,000
- \$30-50,000
- 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 policy 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 daily benefit amount?

- From my income
- From my Savings/Investments
- My family will pay

*The national average annual cost of care in 2001<sup>1</sup> was: \$56,000 in a nursing home; \$22,476 in a residential care facility and \$14,000 for home health care, but these figures vary across the country. In ten years the national average annual cost would be about \$91,280 in a nursing home; \$36,636 in a residential care facility and \$22,820 for home health care, if costs increase 5% annually.*

**What Elimination 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? (check one)

- 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 of your assets (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 policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long term care.*

**Comparison To Current Coverage**

If you have existing long term care coverage and you intend to add to or replace your current coverage, please indicate your reason for doing so (check one):

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

Premium for your current long term care coverage: \$ \_\_\_\_\_ per \_\_\_\_\_

<sup>1</sup> 2003 NAIC Shopper's Guide

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N/A



**Disclosure Statement**

(Check One)  The answers to the questions above describe my financial situation. **Or**  I choose not to complete this information. However, I still want the Company to consider my application (complete Authorization to Process Application below).

I acknowledge that the agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increase in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future. (This box must be checked in order to consider your application for Long Term Care.)**

Signed:  \_\_\_\_\_ (Applicant) SIGN HERE  
 \_\_\_\_\_ (Joint Applicant) SIGN HERE / / 2009 (Date)

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

Signed: \_\_\_\_\_ (Agent) \_\_\_\_\_ (Date)  
 Geoff Phillips (Agent's Printed Name)

In order for us to process your application, please return this signed statement to Berkshire Life Insurance Company of America, along with your application.

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

Signed:  \_\_\_\_\_ (Applicant) SIGN HERE  
 \_\_\_\_\_ (Joint Applicant) SIGN HERE (Date)

*The Company may contact you to verify your answers.*

This confidential information will be used only to determine your suitability for long term care insurance and may not be used for any other purpose or disseminated outside of the Company or agency.

**Authorization to Process Application**

My agent has explained to me that my personal financial circumstances are an important consideration in determining whether or not long term care insurance is an appropriate purchase for me.

My agent has also given me a copy of "Things You Should Know Before You Buy Long Term Care Insurance" and has explained the importance of completing the Long Term Care Insurance Personal Worksheet.

I hereby confirm that I have chosen not to complete the Long Term Care Insurance Personal Worksheet. Nevertheless, I request that you continue to process my application for long term care insurance.

Signed:  \_\_\_\_\_ (Applicant) SIGN HERE  
 \_\_\_\_\_ (Joint Applicant) SIGN HERE (Date)



**PREMIUM**

**Long Term Care Insurance Policy**

> Elimination Period:  0 Days  30 Days  90 Days  180 Days

> Daily Benefit (\$50 - \$300): \$ \_\_\_\_\_

> Benefit Period:  Lifetime  1,825 Days (5 Years)  1,460 Days (4 Years)  1,095 Days (3 Years)

The following are the Annual Premiums for the coverage you have applied for:

Comprehensive coverage is Nursing Facility and Residential Care Facility plus Home Care

**Premium**

**Select only one of the following coverage combinations:**

- >  Comprehensive \$ \_\_\_\_\_
- Comprehensive with Indemnity Benefit Rider \$ \_\_\_\_\_
- Comprehensive with Indemnity and Personal Caregiver Rider (*Available only with Preferred Plus Rate Class and Lifetime Premium Payment Option*) \$ \_\_\_\_\_
- Comprehensive with Monthly Benefit Rider  
(*One of the Compound Inflation Protection Riders must also be selected*) \$ \_\_\_\_\_

**Inflation Protection Riders (select only one):**

- >  Compound 5% \$ \_\_\_\_\_
- Compound 3% \$ \_\_\_\_\_

**Nonforfeiture Benefit Rider:**

- Shortened Benefit Period Nonforfeiture \$ \_\_\_\_\_

**Additional Riders:**

- >  Return of Premium \$ \_\_\_\_\_
- Waiver of Premium \$ \_\_\_\_\_
- Restoration of Benefits (*Not available with Lifetime Benefit Period*) \$ \_\_\_\_\_
- Paid-Up Survivor (*Available only with joint coverage and Lifetime Premium Payment Option*) \$ \_\_\_\_\_

**Premium Payment Options:**  Lifetime

- 10-Year Premium \$ \_\_\_\_\_
  - Paid-Up At Age 65 Premium (**Available to age 55**) \$ \_\_\_\_\_
- TOTAL ANNUAL PREMIUM: \$ \_\_\_\_\_

**ADDITIONAL FEATURES**

**Medical Underwriting**

Your insurability for the policy will be determined by the answers given in your application and any other authorized medical information we obtain regarding your current state of health.

**10-Year and Paid-up at 65 Premium Payment Options**

These options provide that at the end of the premium payment period if each required premium has been paid, the policy will automatically be renewed for the rest of your life with no further premium payments required. During the premium payment period, premiums will be subject to change as described under "TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED" on the first page of this outline of coverage.

**Modes of Premium Payment**

Premiums may be paid on an annual, semi-annual or quarterly basis, or by monthly automatic premium plan. We will change the mode of premium payment if we receive a proper written request at our Long Term Care Administrative Office before the premium due date. The amount of each modal premium is calculated by multiplying the annual policy premium by the applicable modal factors. Modal Factors are: Semi-Annually (0.52), Quarterly (0.27) and Monthly (0.088). The modal premiums will be shown on the Policy Schedule page of the policy.



**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 plan may be adjusted. The benefit levels of the basic policy will not increase over time. For an additional premium payment, you may purchase one of the optional Inflation Protection Riders described below.

**GRACE PERIOD**

Except for the first premium, you will have 31 days after each due date to pay the premium due. The policy remains in force during the Grace Period.

**Unintentional Lapse**

If your premium is not paid by the 30th day of the Grace Period, we will provide written notice to you and any individuals designated by you to receive notice of nonpayment of premium. Notice will be sent at least 30 days before cancellation of your coverage. If your premium is not paid within 35 days after notice is sent, the policy will lapse for nonpayment of premium.

**ALZHEIMER'S DISEASE, ORGANIC DISORDERS AND RELATED MENTAL DISEASES**

Subject to Eligibility for Payment of Benefits, Payment of Benefits, any Limitations and Exclusions described above, the policy provides coverage if you are clinically diagnosed as having Alzheimer's disease, organic disorders or related degenerative and dementing illnesses.

**PREMIUM**

**Nursing Facility and Residential Care Facility Only Insurance Policy**

Elimination Period:  0 Days  30 Days  90 Days  180 Days

Daily Benefit (\$50 - \$300): \$ \_\_\_\_\_

Benefit Period:  Lifetime  1,825 Days (5 Years)  1,460 Days (4 Years)  1,095 Days (3 Years)

The following are the Annual Premiums for the coverage you have applied for:

**Premium**

**Select only one of the following coverage combinations:**

- Nursing Facility and Residential Care Facility Only Policy \$ \_\_\_\_\_
- Nursing Facility and Residential Care Facility Only Policy with Indemnity Benefit Rider \$ \_\_\_\_\_

**Inflation Protection Riders (select only one):**

- Compound 5% \$ \_\_\_\_\_
- Compound 3% \$ \_\_\_\_\_

**Nonforfeiture Benefit Rider:**

- Shortened Benefit Period Nonforfeiture \$ \_\_\_\_\_

**Additional Riders:**

- Return of Premium \$ \_\_\_\_\_
- Restoration of Benefits *(Not available with Lifetime Benefit Period)* \$ \_\_\_\_\_
- Paid-Up Survivor *(Available only with joint coverage and Lifetime Premium Payment Option)* \$ \_\_\_\_\_

**Premium Payment Options:**  Lifetime

- 10-Year Premium \$ \_\_\_\_\_
- Paid-Up At Age 65 Premium **(Available to age 55)** \$ \_\_\_\_\_

**TOTAL ANNUAL PREMIUM:** \$ \_\_\_\_\_

**ADDITIONAL FEATURES**

**Medical Underwriting**

Your insurability for the policy will be determined by the answers given in your application and any other authorized medical information we obtain regarding your current state of health.



**Berkshire Life Insurance Company of America**  
 Home Office: Pittsfield, Massachusetts  
 Long Term Care Administrative Office  
 Post Office Box 4243  
 Woodland Hills, CA 91365-4243  
 888-505-8743

**APPLICATION FOR NURSING  
 FACILITY AND RESIDENTIAL CARE  
 FACILITY ONLY OR COMPREHENSIVE  
 LONG TERM CARE INSURANCE  
 (PLEASE PRINT)**

BG01A(06/04)-CA

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

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

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<b>Applicant Information</b>	Applicant (First Name, Middle Initial, Last Name)			Sex <input type="radio"/> M <input type="radio"/> F	Birthplace (City, State)
	Social Security Number	Height	Weight	Birthdate	Age as of Nearest Birthday
	Residence Address (Street, City, State, Zip)				Phone Work: ( ) Home: ( ) Other: ( )
	Billing Address — If different (Name, Street, City, State, Zip)				Acceptable times to call: <input type="radio"/> Day <input type="radio"/> Evening <input type="radio"/> Sat/Sun

<b>Health Questions</b>	<b>1. During the past 10 years, have you been medically diagnosed with or treated for:</b>					
	Yes	No		Yes	No	
	<input type="radio"/>	<input type="radio"/>	a) AIDS	<input type="radio"/>	<input type="radio"/>	h) Myasthenia Gravis
	<input type="radio"/>	<input type="radio"/>	b) Alzheimer's Disease	<input type="radio"/>	<input type="radio"/>	i) Organic Brain Syndrome
<input type="radio"/>	<input type="radio"/>	c) Amyotrophic Lateral Sclerosis	<input type="radio"/>	<input type="radio"/>	j) Parkinson's Disease	
<input type="radio"/>	<input type="radio"/>	d) Dementia	<input type="radio"/>	<input type="radio"/>	k) Parkinsonism	
<input type="radio"/>	<input type="radio"/>	e) Hepatitis C	<input type="radio"/>	<input type="radio"/>	l) Lupus Erythematosus or Scleroderma	
<input type="radio"/>	<input type="radio"/>	f) Multiple Sclerosis	<input type="radio"/>	<input type="radio"/>	m) Lymphoma	
<input type="radio"/>	<input type="radio"/>	g) Muscular Dystrophy				
	2. Are you covered by Medicaid? (This does not mean Medicare) <input type="radio"/> Yes <input type="radio"/> No					
<b>IF YOU ANSWERED "YES" TO QUESTION 1 OR 2 ABOVE, YOU ARE NOT ELIGIBLE FOR THIS PROGRAM - DO NOT COMPLETE OR SUBMIT THIS APPLICATION.</b>						
	3. During the past 24 months, have you:					
	a. needed assistance or supervision for any of the following everyday activities?					
	Yes	No	Yes	No	Yes	No
	<input type="radio"/>	<input type="radio"/>	dress	<input type="radio"/>	<input type="radio"/>	bathing
	<input type="radio"/>	<input type="radio"/>	toilet	<input type="radio"/>	<input type="radio"/>	walking
	b. used any of the following items or devices?					
	Yes	No	Yes	No	Yes	No
	<input type="radio"/>	<input type="radio"/>	wheelchair	<input type="radio"/>	<input type="radio"/>	oxygen equipment
	<input type="radio"/>	<input type="radio"/>	cane	<input type="radio"/>	<input type="radio"/>	dialysis
	4. During the past 10 years, have you been medically advised or treated for:					
	Yes	No		Yes	No	
	<input type="radio"/>	<input type="radio"/>	a) abnormal blood pressure	<input type="radio"/>	<input type="radio"/>	m) amnesia
	<input type="radio"/>	<input type="radio"/>	b) heart attack	<input type="radio"/>	<input type="radio"/>	n) paralysis
	<input type="radio"/>	<input type="radio"/>	c) arterial fibrillation	<input type="radio"/>	<input type="radio"/>	o) cirrhosis of the liver
	<input type="radio"/>	<input type="radio"/>	d) coronary artery disease	<input type="radio"/>	<input type="radio"/>	p) alcohol dependency or abuse
	<input type="radio"/>	<input type="radio"/>	e) peripheral vascular disease	<input type="radio"/>	<input type="radio"/>	q) drug dependency or abuse
	<input type="radio"/>	<input type="radio"/>	f) diabetes	<input type="radio"/>	<input type="radio"/>	r) arthritis
	<input type="radio"/>	<input type="radio"/>	g) asthma	<input type="radio"/>	<input type="radio"/>	s) osteoporosis
	<input type="radio"/>	<input type="radio"/>	h) emphysema	<input type="radio"/>	<input type="radio"/>	t) depression
	<input type="radio"/>	<input type="radio"/>	i) cancer; internal	<input type="radio"/>	<input type="radio"/>	u) seizures
	<input type="radio"/>	<input type="radio"/>	j) cancer; melanoma	<input type="radio"/>	<input type="radio"/>	v) renal failure
	<input type="radio"/>	<input type="radio"/>	k) stroke	<input type="radio"/>	<input type="radio"/>	w) glaucoma
	<input type="radio"/>	<input type="radio"/>	l) TIA (transient ischemic attack)	<input type="radio"/>	<input type="radio"/>	x) macular degeneration

*Berkshire Life Insurance Company of America, Pittsfield, MA is a wholly owned stock subsidiary of The Guardian Life Insurance Company of America, New York, NY.*



Health Questions (continued)

5. During the past 12 months have you:

Yes No

- a) been advised to have any surgery that has not yet been performed?
- b) smoked cigarettes?
- c) been declined by another company for a policy providing nursing home or home health care coverage?
- d) received disability benefits?
- e) been confined to a nursing facility or received Home Care services?

6. During the past 2 years have you taken prescription medications?

Yes  No

List all medications and the name, address and telephone number of the prescribing MD. Additional information may be provided on page 4:

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Additional Questions

Yes No

- 7. Due to any mental or physical disability that you now have or have had in the past, is any person or institution authorized to act on your behalf?
- 8. Are you actively at work? If "Yes", hours per week: \_\_\_\_\_
- 9. Occupation: \_\_\_\_\_ If retired, date of retirement: \_\_\_\_\_
- 10. With whom do you currently live?  Spouse  Family  Alone  Other: \_\_\_\_\_
- 11. Type of residence?  House or Condo  Apartment  Retirement Community  Other



Information About Your Insurance Coverage

Yes No

- 12. Do you have a policy, certificate or application with this or any other company providing long term care insurance?
- 13. Did you have another long term care insurance policy or certificate in force during the last twelve (12) months (including a health care service contract or health maintenance organization contract)?  
If that policy lapsed, when did it lapse? \_\_\_\_\_
- 14. Do you intend to replace any of your long term care, medical or health insurance coverage (other than CalPERS (California Public Employees Retirement System) coverage) with this policy?

If you answered "Yes" to any of Questions 12-14, provide full details below and complete required replacement forms. Additional details may be provided on page 4:

Ques. No.	Company	Issue Date	Type	Daily Benefit	Paid-to-Date



Complete if Joint

**COMPLETE THIS PAGE FOR JOINT COVERAGE APPLICANT ONLY**

Applicant Information

Applicant (First Name, Middle Initial, Last Name)			Sex <input type="radio"/> M <input type="radio"/> F	Birthplace (City, State)
Social Security Number	Height	Weight	Birthdate	Age as of Nearest Birthday
Phone Work: ( ) Home: ( ) Other: ( ) Acceptable times to call: <input type="radio"/> Day <input type="radio"/> Evening <input type="radio"/> Sat/Sun			Relationship to Primary Applicant	

Health Questions

- 1. During the past 10 years, have you been medically diagnosed with or treated for:**
- |   |                                  |   |                                       |
|---|----------------------------------|---|---------------------------------------|
| <b>Yes</b>                                  | <b>No</b>                        | <b>Yes</b>                                  | <b>No</b>                             |
| <input type="radio"/> <input type="radio"/> | a) AIDS                          | <input type="radio"/> <input type="radio"/> | h) Myasthenia Gravis                  |
| <input type="radio"/> <input type="radio"/> | b) Alzheimer's Disease           | <input type="radio"/> <input type="radio"/> | i) Organic Brain Syndrome             |
| <input type="radio"/> <input type="radio"/> | c) Amyotrophic Lateral Sclerosis | <input type="radio"/> <input type="radio"/> | j) Parkinson's Disease                |
| <input type="radio"/> <input type="radio"/> | d) Dementia                      | <input type="radio"/> <input type="radio"/> | k) Parkinsonism                       |
| <input type="radio"/> <input type="radio"/> | e) Hepatitis C?                  | <input type="radio"/> <input type="radio"/> | l) Lupus Erythematosus or Scleroderma |
| <input type="radio"/> <input type="radio"/> | f) Multiple Sclerosis            | <input type="radio"/> <input type="radio"/> | m) Lymphoma                           |
| <input type="radio"/> <input type="radio"/> | g) Muscular Dystrophy            |   |                                       |
- 2. Are you covered by Medicaid? (This does not mean Medicare)  Yes  No**
- IF YOU ANSWERED "YES" TO QUESTION 1 OR 2 ABOVE, YOU ARE NOT ELIGIBLE FOR THIS PROGRAM - DO NOT COMPLETE OR SUBMIT THIS APPLICATION.**
- 3. During the past 24 months, have you:**
- a. needed assistance or supervision for any of the following everyday activities?
- |   |           |   |              |   |           |
|---|-----------|---|--------------|---|-----------|
| <b>Yes</b>                                  | <b>No</b> | <b>Yes</b>                                  | <b>No</b>    | <b>Yes</b>                                  | <b>No</b> |
| <input type="radio"/> <input type="radio"/> | dressing  | <input type="radio"/> <input type="radio"/> | eating       | <input type="radio"/> <input type="radio"/> | bathing   |
| <input type="radio"/> <input type="radio"/> | toileting | <input type="radio"/> <input type="radio"/> | transferring | <input type="radio"/> <input type="radio"/> | walking   |
- b. used any of the following items or devices?
- |   |            |   |           |   |                  |
|---|------------|---|-----------|---|------------------|
| <b>Yes</b>                                  | <b>No</b>  | <b>Yes</b>                                  | <b>No</b> | <b>Yes</b>                                  | <b>No</b>        |
| <input type="radio"/> <input type="radio"/> | wheelchair | <input type="radio"/> <input type="radio"/> | walker    | <input type="radio"/> <input type="radio"/> | oxygen equipment |
| <input type="radio"/> <input type="radio"/> | cane       | <input type="radio"/> <input type="radio"/> | braces    | <input type="radio"/> <input type="radio"/> | dialysis         |
- 4. During the past 10 years, have you been medically advised or treated for:**
- |   |                                    |   |                                |
|---|------------------------------------|---|--------------------------------|
| <b>Yes</b>                                  | <b>No</b>                          | <b>Yes</b>                                  | <b>No</b>                      |
| <input type="radio"/> <input type="radio"/> | a) abnormal blood pressure         | <input type="radio"/> <input type="radio"/> | m) amnesia                     |
| <input type="radio"/> <input type="radio"/> | b) heart attack                    | <input type="radio"/> <input type="radio"/> | n) paralysis                   |
| <input type="radio"/> <input type="radio"/> | c) arterial fibrillation           | <input type="radio"/> <input type="radio"/> | o) cirrhosis of the liver      |
| <input type="radio"/> <input type="radio"/> | d) coronary artery disease         | <input type="radio"/> <input type="radio"/> | p) alcohol dependency or abuse |
| <input type="radio"/> <input type="radio"/> | e) peripheral vascular disease     | <input type="radio"/> <input type="radio"/> | q) drug dependency or abuse    |
| <input type="radio"/> <input type="radio"/> | f) diabetes                        | <input type="radio"/> <input type="radio"/> | r) arthritis                   |
| <input type="radio"/> <input type="radio"/> | g) asthma                          | <input type="radio"/> <input type="radio"/> | s) osteoporosis                |
| <input type="radio"/> <input type="radio"/> | h) emphysema                       | <input type="radio"/> <input type="radio"/> | t) depression                  |
| <input type="radio"/> <input type="radio"/> | i) cancer; internal                | <input type="radio"/> <input type="radio"/> | u) seizures                    |
| <input type="radio"/> <input type="radio"/> | j) cancer; melanoma                | <input type="radio"/> <input type="radio"/> | v) renal failure               |
| <input type="radio"/> <input type="radio"/> | k) stroke                          | <input type="radio"/> <input type="radio"/> | w) glaucoma                    |
| <input type="radio"/> <input type="radio"/> | l) TIA (transient ischemic attack) | <input type="radio"/> <input type="radio"/> | x) macular degeneration        |



Complete if Joint

**COMPLETE THIS PAGE FOR JOINT COVERAGE APPLICANT ONLY**

Health Questions (continued)

**5. During the past 12 months have you:**

Yes No

- a) been advised to have any surgery that has not yet been performed?
- b) smoked cigarettes?
- c) been declined by another company for a policy providing nursing home or home health care coverage?
- d) received disability benefits?
- e) been confined to a nursing facility or received Home Care services?

**6. During the past 2 years have you taken prescription medications?**

Yes  No

List all medications and the name, address and telephone number of the prescribing MD. Additional information may be provided on page 4:

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Additional Questions

Yes No

- 7. Due to any mental or physical disability that you now have or have had in the past, is any person or institution authorized to act on your behalf?
- 8. Are you actively at work? If "Yes", hours per week: \_\_\_\_\_
- 9. Occupation: \_\_\_\_\_ If retired, date of retirement: \_\_\_\_\_
- 10. With whom do you currently live?  Spouse  Family  Alone  Other: \_\_\_\_\_
- 11. Type of residence?  House or Condo  Apartment  Retirement Community  Other

Information About Your Insurance Coverage

Yes No

- 12. Do you have a policy, certificate or application with this or any other company providing long term care insurance?
- 13. Did you have another long term care insurance policy or certificate in force during the last twelve (12) months (including a health care service contract or health maintenance organization contract)?  
If that policy lapsed, when did it lapse? \_\_\_\_\_
- 14. Do you intend to replace any of your long term care, medical or health insurance coverage (other than CalPERS (California Public Employees Retirement System) coverage) with this policy?

If you answered "Yes" to any of Questions 12-14, provide full details below and complete required replacement forms. Additional details may be provided on page 4:

Ques. No.	Company	Issue Date	Type	Daily Benefit	Paid-to-Date



**Coverage Applied For**

**Comprehensive coverage is Nursing Facility and Residential Care Facility Services plus Home Care**  
**Select only one of the following coverage combinations:**

- Nursing Facility and Residential Care Facility Only
- Nursing Facility and Residential Care Facility Only with Indemnity Benefit Rider
- Comprehensive
- Comprehensive with Indemnity Benefit Rider
- Comprehensive with Indemnity and Personal Caregiver Rider (Available only with Preferred Plus Rate Class and Lifetime Premium Payment Option)
- Comprehensive with Monthly Benefit Rider (One of the Compound Inflation Protection Riders must also be selected)

**Inflation Protection Riders (select only one):**

- Compound 5%
- Compound 3%

**Nonforfeiture Rider:**

- Shortened Benefit Period Nonforfeiture

**Additional Riders:**

- Return of Premium
- Waiver of Premium (Not available with Nursing Facility and Residential Care Facility Only coverage)
- Restoration of Benefits (Not available with Lifetime Benefit Period)
- Paid-Up Survivor (Available only with joint coverage and Lifetime Premium Payment Option)

**Daily Benefit Applied For (\$50-\$300): \$** \_\_\_\_\_

**Elimination Period:**

- 0 Days
- 30 Days
- 90 Days
- 180 Days

**Benefit Period:**

- Lifetime
- 1,825 Days (5 Years)
- 1,460 Days (4 Years)
- 1,095 Days (3 Years)

**Required Benefit Rejection**

**COMPOUND 5% INFLATION PROTECTION RIDER** - I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of this policy with and without Inflation Protection. Specifically, I have reviewed the plan, and I reject 5% annual Compound Inflation Protection.

Applicant's Signature	Joint Applicant's Signature	Date	Signatures required if applicable
-----------------------	-----------------------------	------	-----------------------------------

**COMPOUND 3% INFLATION PROTECTION RIDER** - I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of this policy with and without the Compound 3% Inflation Protection Rider and I have chosen to  accept  reject coverage under the Compound 3% Inflation Protection Rider.

**NONFORFEITURE RIDERS** - I have reviewed the Outline of Coverage and the nonforfeiture benefits as described therein. Specifically, I have reviewed the Shortened Benefit Period Nonforfeiture Rider and I have chosen to  accept  reject coverage under the nonforfeiture rider.

Applicant's Signature	Joint Applicant's Signature	Date
-----------------------	-----------------------------	------

**Premium Information**

**Primary Applicant Rate Class:**

- Preferred Plus
- Preferred
- Standard

**Joint Applicant Rate Class:**

- Preferred Plus
- Preferred
- Standard

**Payment Mode and Amount (select only one):**

- Annual
- Semi-Annual
- Quarterly
- Monthly Automatic Payment Plan
- List Billing (select mode as shown below):
  - Annual
  - Semi-Annual
  - Quarterly
  - Monthly

**Approved Employer or Association Group?**

- Yes
- No

If "Yes", Group Identification Code or Name: \_\_\_\_\_

**Premium Payment Options (select only one):**

- Lifetime Premium
- 10-Year Premium
- Paid-Up At Age 65 Premium (Available to age 55)

<b>Paid with Application</b> \$	<b>Beneficiary Name and Relationship</b> Spouse or ...
------------------------------------	---

**Special Request / Requested Effective Date**





**CAUTION: If your answers on this application are misstated or untrue, Berkshire Life Insurance Company of America may have the right to deny benefits or rescind your policy.**

Those parties who sign below agree and acknowledge that:

Representations of the Applicant(s)

1. This application and any other supplements to the application will form the basis for, and become part of and attached to, any policy issued.
2. All of the statements that are part of the application and any other supplements to the application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them.
3. No agent, broker or medical examiner has any right to accept risks, make or change contracts, or to waive or modify any of Berkshire Life Insurance Company of America's rights or requirements.
4. The Effective Date of the Policy is the date from which premiums are calculated and become due. No insurance shall take effect unless and until this application is approved by Berkshire Life Insurance Company of America, a policy is issued during the lifetime of the applicant(s), the initial premium payment has been made and, as of the Effective Date of the Policy, the health status of the applicant(s) remains insurable under Berkshire Life Insurance Company of America's underwriting standards.
5. By paying premiums on a basis more frequently than annually, the total premium payable during one year's time will be greater than if the premium were paid annually. That is, the cost of paying annualized periodic premiums will be more than the cost of paying one annual premium.

Signatures

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
City and State Day Month Year

**x** \_\_\_\_\_  
**Signature of Applicant**

**x** \_\_\_\_\_  
**Signature of Joint Applicant**



Applicant Checklist

ACKNOWLEDGMENT - I acknowledge delivery / receipt of:

- Outline of Coverage (including HICAP notice)
- Shopper's Guide – Taking Care of Tomorrow
- The Long Term Care Insurance Personal Worksheet
- Disclosure Statement (which includes the Notice of Insurance Practices and Notice of Privacy Practices)
- (If applicable) The "Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance"

**x** \_\_\_\_\_  
**APPLICANT'S SIGNATURE**

**x** \_\_\_\_\_  
**Licensed Agent's Signature**

\_\_\_\_\_  
**Date**

**x** \_\_\_\_\_  
**JOINT APPLICANT'S SIGNATURE**



**THIS AGENT'S CERTIFICATION IS TO BE USED WITH THE APPLICATION ON:**

Print Applicant's Name

Print Joint Applicant's Name

Yes No

1. How well do you know the Applicant(s)?

- Known well for \_\_\_\_ years
- Met very recently
- Known slightly for \_\_\_\_ years
- Relative? \_\_\_\_\_

2a. To the best of your knowledge, is the insurance applied for intended to replace any long term care, medical or health insurance in force with this or any other company?

2b. List any other health insurance policies that you have sold to the applicant(s):

(a) Which of the policies listed above are still in force, if any?

(b) Which of the policies listed above sold in the past five (5) years are no longer in force, if any?

3. Did you ask the applicant(s) all the questions face to face and witness their signature(s)?

If "No", provide details: \_\_\_\_\_

4. Did you deliver to the applicant(s) the Outline of Coverage, the required Disclosures, including the Notice of Insurance Information Practices, the Shopper's Guide and the Notice of Privacy Practices?

Agent's Certification

Licensed Agent's Name	Agent's Code	Split Percentage	Manager/GA Code
_____	2W946	_____ %	_____ - _____
_____	_____	_____ %	_____ - _____
_____	_____	_____ %	_____ - _____

I represent that to the best of my knowledge and belief the information provided in the application is complete, accurate and correctly recorded; and there is nothing adversely affecting the insurability of the applicant(s) other than as indicated in the application. I have reviewed the current health insurance coverage of the applicant(s) and find that the coverage of the type and amount applied for is appropriate for the needs of the applicant(s). Further, if this is a replacement, I have reviewed the current health insurance coverage of the applicant(s) and find that this replacement is appropriate for the needs of the applicant(s). I represent that I am duly licensed in the state in which the application was signed.

Geoff Phillips

Type or Print Agent's Name

2W946

Soliciting Agent's Code

x

Signature of Soliciting Agent

066-56-7451

Soliciting Agent's Social Security Number

Date



Kaiser Foundation Health Plan, Inc.  
Kaiser Foundation Hospitals  
The Permanente Medical Group, Inc.

If Applicable  
15



**AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION**

IMPRINT AREA

I understand that Kaiser Permanente will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

**I hereby authorize:**

**To disclose to:**

**X**  
Name of Disclosing Party

**X**  
Address

**X**  
City State ZIP

**X** COPY SVC  
EMSI PO BOX 2505 WACO, TX 76702-2505

**X**  
INS CO

**If requesting your own records for yourself, specify facilities:** \_\_\_\_\_

**Records and information pertaining to:**

**X**  
Name of Member/Patient (List Other Names Used)

**X**  
Medical Record Number

**X**  
Date of Birth

**X**  
Address

**X**  
Telephone Number

**DURATION:** This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here \_\_\_\_\_ (Date).

**REVOCAION:** This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

**REDIS-CLOSURE:** I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

**SPECIFY RECORDS:** Check the box, initial and/or sign to specify which type of information is to be disclosed.

<input checked="" type="checkbox"/> <b>MEDICAL INFORMATION</b>	<b>X</b> _____ (Initial)	<b>X</b> _____
<input checked="" type="checkbox"/> <b>PSYCHIATRIC INFORMATION</b>	<b>X</b> _____	<b>X</b> _____
<input checked="" type="checkbox"/> <b>DRUG/ALCOHOL INFORMATION</b>	<b>X</b> _____	<b>X</b> _____
<input checked="" type="checkbox"/> <b>RESULTS OF AN HIV TEST</b>	<b>X</b> _____	<b>X</b> _____
<input checked="" type="checkbox"/> <b>GENETIC RECORDS</b>	<b>X</b> _____	<b>X</b> _____
	Signature	Date
	Signature	Date
	Signature	Date
	Signature	Date

Specify the records to be disclosed: **X** \_\_\_\_\_

The recipient may use the health information authorized on this form for the following purposes:  
**PROCESSING INSURANCE**

A copy of this authorization is as valid as the original.

Member/Patient has a right to a copy of this authorization.

**X** \_\_\_\_\_ **X** \_\_\_\_\_ **X** \_\_\_\_\_  
Date Signature If Signed by Other than Member/Patient, Indicate Relationship



## Berkshire Life Insurance Company of America

Home Office: Pittsfield, Massachusetts  
 Long Term Care Administrative Office  
 Post Office Box 4243  
 Woodland Hills, CA 91365-4243  
 888-505-8743

### AUTHORIZATION FOR DISCLOSURE, RECEIPT AND USE OF PERSONAL HEALTH INFORMATION

This Authorization complies with the HIPAA Privacy Rule

**"I", "me", "my" means each Applicant signing this Authorization.**

#### AUTHORIZATION FOR DISCLOSURE

I authorize any licensed physician or licensed health care practitioner, hospital, clinic, medical facility, health care provider, insurance company or health plan that has provided treatment, payment or health care services to me or any other insurance company to which I have applied for insurance coverage ("My Providers"), to disclose my entire medical record and any knowledge of my past or present health or medical condition to Berkshire Life Insurance Company of America, its reinsurers and any third party administrator designated by Berkshire Life Insurance Company of America ("the Company"). This includes any information relating to HIV, AIDS and any sexually transmitted diseases, mental illness, the use of drugs, alcohol and tobacco, but excludes psychotherapy notes. Psychotherapy notes mean notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes exclude the following information that is subject to disclosure under this Authorization: medication prescription and monitoring; counseling session start and stop times; the modalities and frequencies of treatment furnished; results of clinical tests; and any summary of the following items: diagnosis; functional status; the treatment plan; symptoms; prognosis; and progress to date.

By my signature below, I terminate any agreements I have made with My Providers to restrict information in my medical records or any knowledge of my past or present health or medical condition and I instruct My Providers to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

#### AUTHORIZATION FOR RECEIPT AND USE

I authorize the employees and business associates of the Company, its reinsurers and any third party administrator designated by the Company who are responsible for the processing of my application for long term care insurance to receive and use any information I have provided on my application form or provided by me during the course of a personal interview with me and to receive and use any information provided by other parties under the above Authorization For Disclosure for the purpose of determining my eligibility to obtain coverage under the long term care insurance policy for which I have applied, and to determine the rates and terms which apply to any policy issued.

**I understand that the information which will be provided under this Authorization is necessary for the Company to determine my eligibility for coverage under the long term care insurance policy I have applied for and that the Company will condition the review of my application for long term care insurance on my providing this Authorization. I also understand that my application may be denied if I refuse to provide this Authorization.**

#### REDISCLASURE OF INFORMATION

I understand that if the person or entity that receives information provided pursuant to this Authorization is not subject to federal privacy regulations, the information may be redisclosed and will no longer be protected by the federal privacy regulations. In the case of this Authorization, however, the information described above will be received by an insurance company which is covered by the federal privacy regulations, and will not be used or redisclosed except as described above or required by law, and the information will continue to be protected under the federal privacy regulations.

#### REVOCAION OF AUTHORIZATION

I understand that I may revoke this Authorization in writing at any time by sending a written revocation to: *Berkshire Life Insurance Company of America, ATTN: Privacy Administrator, P.O. Box 4243, Woodland Hills, CA 91365-4243*. I also understand that any such revocation will not be effective to the extent that action has been taken by the Company in reliance on this Authorization or the extent that the Company has a legal right to contest a claim under the policy which I have applied for or to contest the policy itself.

#### EXPIRATION OF AUTHORIZATION

This Authorization will be valid for 24 months from the date of my signature below. A copy of this Authorization is as valid as the original.

Applicant's Name (Please Print) \_\_\_\_\_

Date of Birth \_\_\_\_\_

SIGN HERE

Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_

Joint Applicant's Name (Please Print) \_\_\_\_\_

Date of Birth \_\_\_\_\_

SIGN HERE

Joint Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_

*Berkshire Life Insurance Company of America, Pittsfield, MA is a wholly owned stock subsidiary of  
 The Guardian Life Insurance Company of America, New York, NY.*



**Berkshire Life Insurance Company of America**

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**NOTICE OF INSURANCE INFORMATION PRACTICES AND CONDITIONS OF COVERAGE**

**DISCLOSURE STATEMENT**

**NOTICE OF INSURANCE INFORMATION PRACTICES** — To evaluate your application, we will need some personal information about you. It may be necessary to obtain some of that information from sources other than yourself. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information. The information we obtain about you will be used by Berkshire Life Insurance Company of America to determine eligibility for insurance and/or benefits under an existing policy and for other business purposes in connection with the insurance relationship. A detailed description of our information practices is contained in the Notice of Privacy Practices furnished to you with your application.

**CONDITIONS OF COVERAGE**

I/We \_\_\_\_\_ the applicant(s) have applied for a comprehensive long term care insurance policy or a nursing facility and residential care facility only insurance policy from Berkshire Life Insurance Company of America (the Company) and have submitted \$ \_\_\_\_\_ to the Company. The amount of premium which may accompany an application is a monthly premium amount. It is understood and agreed that no liability is created or assumed by the Company, except for the refund of any premium amount submitted, unless and until a long term care insurance policy becomes effective. If approved, the effective date will be stated in the policy issued to the applicant(s).

The insurance applied for will become effective and in force only if:

1. This application is approved by the Company; and
2. A policy is issued during the lifetime of the applicant(s); and
3. The initial premium payment has been paid; and
4. Until the effective date of the policy as set by the Company, the health status of the applicant(s) remains insurable under the Company's underwriting standards.

Requests for a specific effective date are honored at the Company's discretion in accordance with its published guidelines on policy dating upon the conclusion of the underwriting review.

Should the applicant(s) be determined uninsurable based on the Company's underwriting standards, or if the Company is unable to obtain required underwriting information within 90 days, the amount submitted will be returned to the applicant(s). Should the amount submitted not be honored by the applicant's bank, the Company will discontinue consideration of the application.

No agent or broker has the authority to waive or alter any of the terms or conditions of the application for insurance or these Conditions of Coverage.

**ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA. DO NOT MAKE CHECK PAYABLE TO THE AGENT, AGENCY, OR LEAVE PAYEE BLANK.**

I/We have read and understand the Conditions of Coverage.

Signed at \_\_\_\_\_  
City, State \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature  Joint Applicant's Signature 

\_\_\_\_\_  
Licensed Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_



**Berkshire Life Insurance Company of America**

Home Office: Pittsfield, Massachusetts  
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Post Office Box 4243  
Woodland Hills, CA 91365-4243  
888-505-8743

**SUPPLEMENTAL APPLICATION FOR  
POLICY OWNERSHIP  
(PLEASE PRINT)**

BG01AO(06/04)

Applicant (First Name, Initial, Last Name)		Birthdate	Social Security Number
Joint Applicant (First Name, Initial, Last Name)		Birthdate	Social Security Number
Policy Owner and Relationship to Applicant(s)			Social Security or Tax I.D. Number
Residence Address (Street, City, State, Zip)			
Bill to: <input type="radio"/> Owner <input type="radio"/> Insured	Policy Owner's Billing Address - If Different (Name, Street, City, State, Zip)		
Policy Owner is: <input type="radio"/> Individual <input type="radio"/> Partnership <input type="radio"/> Corporation <input type="radio"/> Trustee			
Contingent Policy Owner and Relationship to Applicant(s)			Social Security or Tax I.D. Number
Residence Address (Street, City, State, Zip)			
Contingent Policy Owner's Billing Address - If Different (Name, Street, City, State, Zip)			
Contingent Policy Owner is: <input type="radio"/> Individual <input type="radio"/> Partnership <input type="radio"/> Corporation <input type="radio"/> Trustee			

Signed at \_\_\_\_\_ City, State \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature Policy Owner's Signature

\_\_\_\_\_  
Joint Applicant's Signature Agent's Signature

**Berkshire Life Insurance Company of America**

Home Office: Pittsfield, Massachusetts  
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 Post Office Box 4243  
 Woodland Hills, CA 91365-4243  
 888-505-8743

**Automatic Payment Authorization**

I (We) hereby authorize **Berkshire Life Insurance Company of America**, hereinafter called COMPANY, to debit my (our) financial institution named below, hereinafter called BANK, and to initiate an electronic funds transfer from my (our)  checking  savings account indicated below on or about the 15th of each month to pay premiums that become due for my (our) insurance policy issued by COMPANY.

Bank Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Routing Number \_\_\_\_\_

Account No. \_\_\_\_\_

This authority is to remain in effect until I (we) notify COMPANY or BANK to terminate it and COMPANY or BANK has reasonable time to act on its termination; or until COMPANY or BANK has sent me (or either of us) ten (10) days written notice of termination of this arrangement.

---

 DEPOSITOR NAME(S) AS SHOWN ON BANK RECORDS
 

---

Date \_\_\_\_\_ Signed \_\_\_\_\_

Date \_\_\_\_\_ Signed \_\_\_\_\_

**IMPORTANT: Please attach two (2) months' premium and a voided check for the above account, except for the following:**

**California - Please attach one (1) month's premium and a voided check.**

**Berkshire Life Insurance Company of America**


John P. Cifu  
Secretary

**TO BANK:** As provided above, your depositor has authorized us to initiate debits to, and you to debit, the above account as specified. So that you may comply with this authorization, we agree that these arrangements shall be subject to the Automated Clearing House rules, as they may be in effect from time to time, and we recognize your status as a participating bank.