



Employer Name:

Northrop Grumman

**Long Form Application**

Use this form if you are an employee or employee's spouse or domestic partner who cannot use the Short Form Application, or an eligible family member, or a retiree or retiree's spouse.

Policy Number: 10341-IS

**Tips and general information for completing the application**

As part of our underwriting process, we may call you after we receive your application. The purpose of this short interview is to make sure we fully understand the facts about your health as noted on the application and to answer any questions you may have about the application process. We greatly appreciate your cooperation during this process.

If during the past 7 years you have been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), Alzheimer's Disease, Parkinson's Disease, Chronic Organic Brain Syndrome, Multiple Sclerosis, or Internal Lupus Erythematosus **you are not eligible for this coverage. In addition to the conditions listed above, there are other conditions which may make you ineligible for coverage.**

**SECTION 1 – APPLICANT INFORMATION**

Applicant's Name: First, Middle Initial, Last			Social Security Number	
Date of Birth	Sex (M or F)	Daytime Phone Number	Evening Phone Number	
Applicant's Address: Number and Street			City	State Zip Code

**SECTION 2 – BENEFIT SELECTION (See Brochure Page 5 for Detailed Explanation)**

Select A Daily Maximum Benefit:  \$100  \$125  \$150  \$175  \$200  \$225  \$250  \$275  \$300

Select An Inflation Option:  Plan A - Guaranteed Benefit Increase Option (GBI)\*  Plan B - Automatic Benefit Increase Option (ABI)

**VERY IMPORTANT – Please sign below if you have selected Inflation Option Plan A.**

**Inflation Protection Rejection:** I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this insurance with and without inflation protection, and I reject the Automatic Benefit Increase Option.

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

**SECTION 3 – ELIGIBILITY**

- I certify that I am:  A full-time actively-at-work employee.  An employee's spouse or domestic partner.  
 An employee's parent or parent-in-law.  An employee's grandparent or grandparent-in-law.  
 An employee's sibling  A retiree.  A retiree's spouse or domestic partner.

Employee's Name	Employee Number	Date of Hire	Employee's Social Security Number
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**SECTION 4 – PREMIUM PAYMENT METHOD**

- Annual Billing  Semi-Annual Billing  Quarterly Billing  Monthly – Automatic Bank Draft Only. (Please attach voided check from the bank account you wish to use.)

By checking the box above, I authorize and request GLTC Insurance Administrators, Inc. (GLTC), Plan Administrator for the Future Guard Long-Term Care Group Insurance Plan, to initiate monthly withdrawals to my checking or savings account on the fifth calendar day of each month to pay my premiums. This authorization will remain in effect until I notify GLTC and my bank in writing to cancel it. I understand that if insufficient funds are in the account on the specified payment dates, GLTC reserves the right to cancel the automatic payment plan and change my account to a quarterly billing to my last known address. GLTC shall incur no liability by reason of the dishonor of any payment by my bank for any reason, even through such dishonor results in the forfeiture of insurance.

THE POLICY IS NOT APPROVED FOR MEDICAID ASSET PROTECTION UNDER THE ILLINOIS LONG TERM CARE PARTNERSHIP PROGRAM. HOWEVER, THE POLICY IS AN APPROVED TRADITIONAL LONG TERM CARE POLICY UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES APPROVED UNDER THE ILLINOIS LONG TERM CARE PARTNERSHIP PROGRAM, CALL THE SENIOR HELPLINE AT THE DEPARTMENT ON AGING AT 1-800-252-8966.

**Instructions for Section 5**

Under Section 5 - "Statement of Insurability," question 1 asks about Medicaid eligibility. This is not Medicare. Medicare is a medical program for individuals over 65 and certain disabled individuals. Medicaid is a medical program for individuals who have met their state's definition of poverty. Individuals eligible for Medicaid do not need long term care insurance.

Under the medical conditions listed in Question 2, be sure to check "Yes" or "No" to every question. We cannot process your application if there are any blanks.

Question 9 asks about any prescription drugs that you are taking even if the condition is not shown previously. The information on name and dosage can be found on the label of the medication container.

**SECTION 5 – STATEMENT OF INSURABILITY**

Height \_\_\_\_\_ ft. \_\_\_\_\_ in.      Weight \_\_\_\_\_

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. At any time in the last five years have you applied for or received Social Security <u>Disability</u> benefits or Medicaid?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. During the last seven years have you been diagnosed, received medical advice, or treated by a member of the medical profession for any of the following:  |                          |                          |
| a. Auto or Acquired Immune Disorder.   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Acquired immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC).   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Internal Lupus Erythematosus or any other connective tissue disease or disorder.  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Alzheimer's Disease, Dementia, or change in cognitive functioning.  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Parkinson's Disease, Multiple Sclerosis, Huntington's Disease, or Amyotrophic Lateral Sclerosis.  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Seizures, Epilepsy, or any other Neurologic Disease or Disorder.  | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Emphysema, Asthma, or Chronic Bronchitis.   | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Diabetes Mellitus, Glucose intolerance, or Hyperglycemia.   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Internal cancer or Melanoma.  | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Disorder, Disease, or Surgery of the Heart or Circulatory System.   | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Cerebral Vascular Accident, Stroke, or Transient Ischemic Attack.   | <input type="checkbox"/> | <input type="checkbox"/> |
| l. High Blood Pressure.  | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Osteoporosis.   | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Arthritis, or any other Bone, Spine, Joint or Muscular Disease, Disorder or Surgery.  | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Reproductive, Kidney, or Urinary System Disease, Disorder, or Surgery.  | <input type="checkbox"/> | <input type="checkbox"/> |
| p. Liver, Digestive, Colon, or Rectal Disease Disorder or Surgery.   | <input type="checkbox"/> | <input type="checkbox"/> |
| q. Alcoholism or Substance Abuse.  | <input type="checkbox"/> | <input type="checkbox"/> |
| r. Any Mental, Emotional or Nervous Disease or Disorder, Depression or Chemical Imbalance.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. During the past 12 months have you consulted a physician, been diagnosed or treated for any of the following? <b><i>If yes, check those which apply.</i></b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> dementia <input type="checkbox"/> dizziness <input type="checkbox"/> loss of appetite<br><input type="checkbox"/> unstable gait <input type="checkbox"/> falling <input type="checkbox"/> deterioration of vision<br><input type="checkbox"/> disorientation <input type="checkbox"/> fainting <input type="checkbox"/> bladder control |                          |                          |
| 4. At any time during the past 12 months have you needed assistance or supervision or were you limited in any way physically or cognitively from performing any of the following daily activities? <b><i>If yes, check those which apply.</i></b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> bathing <input type="checkbox"/> dressing <input type="checkbox"/> toileting <input type="checkbox"/> continence<br><input type="checkbox"/> eating <input type="checkbox"/> managing medications <input type="checkbox"/> housekeeping <input type="checkbox"/> preparing meals<br><input type="checkbox"/> mobility                   |                          |                          |

5. At any time during the past 12 months have you used any of the following medical devices? Yes  No   
***If yes, check those which apply:***  
 cane     walker     wheelchair     oxygen equipment     catheter
6. Have you been confined in a long term care facility or received home health care or adult day care services during the past 12 months? Yes  No
7. Have you used any tobacco products at any time during the last three years? Yes  No
8. During the past five years, have you received any medical advice, treatment or diagnosis for any condition other than those stated in questions 2 through 7? Yes  No
9. Are you taking any prescription drugs? **If yes, please provide the name and daily dosage below.** Yes  No

Drug Name	Daily Dosage	Taken for (diagnosis or condition)	Prescribing Doctor

10. **If you answered "Yes" to any part of questions 2 through 9 provide details below.**  
 For more details attach a separate signed and dated sheet.

Question Number	Diagnosis	Date Treatment Began	Ongoing or Date of Recovery/Control	Name of Doctor or Facility

11. Please list all physicians which you have consulted or been treated by in the past five years.  
 For more details attach a separate signed and dated sheet.

Name of Doctor	Specialty	Phone Number	Address

12. Does someone else hold your power of attorney? Yes  No

**If yes, explain why, what type of power of attorney, and if that power of attorney is being actively used at this time. To provide more details attach a separate sheet of paper which is signed and dated.**

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13. Do you currently have long term care insurance in force or have you recently applied for such insurance?

Yes No

If **yes**, please list all such coverages in the space provided below. Indicate if you intend to replace any medical or health insurance coverage including health care service contract or health maintenance organization with the insurance applied for with this application.

Company Name	Policy Number	Is coverage to be replaced?		When?
		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
		Yes <input type="checkbox"/>	No <input type="checkbox"/>	

**SECTION 6 – ALTERNATE BILLING DESIGNEE**

I understand I have the right to designate at least one person other than myself to receive notice before my coverage terminates for nonpayment of premium. I designate:

<b>First Designee Name:</b> First, Middle Initial, Last	<b>Phone Number</b>		
<b>Home Address:</b> Number and Street	<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Second Designee Name:</b> First, Middle Initial, Last	<b>Phone Number</b>		
<b>Home Address:</b> Number and Street	<b>City</b>	<b>State</b>	<b>Zip Code</b>

**OR**

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

**Applicant's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**PLEASE CONTINUE TO SECTION 7 ON NEXT PAGE**

**SECTION 7 – AUTHORIZATION**

**NOTICE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**

I understand and agree that the statements in this application are complete and true to the best of my knowledge and belief and that they will form a part of the contract of insurance. I also understand and agree that the insurance for which I am applying, if issued, shall be based on these statements.

**Authorization to Obtain Information**

“Information Provider” as used herein may include any physician, medical practitioner, hospital, clinic, other medical or medically related facility, clearinghouse, insurance or reinsuring company, agent, broker, service provider, Medical Information Bureau, Inc. (MIB), credit bureau or other consumer reporting agency, employer or the Veterans Administration.

“Information” received from an Information Provider may include advice, diagnosis, prognosis, treatment or care of any physical or mental condition concerning me, including information about HIV or AIDS, drug or alcohol abuse or mental illness (except psychotherapy notes) and/or financial, consumer report, or any other non-medical information concerning me.

I AUTHORIZE any Information Provider to give Continental Casualty Company (the Company) any and all Information regardless of any previous restriction or limitation on disclosure of such Information. In order to expedite my request, I further authorize an Information Provider (except MIB) to release Information to the Company’s agents, brokers, service providers, its reinsurers, or any other third party retained by the Company to collect and transmit such Information.

I UNDERSTAND that the Information obtained by use of this Authorization is at my request and will be collected by the Company to determine eligibility for insurance. I understand that this Authorization to Obtain Information shall remain valid for two years from the date shown below. I understand that if I do not sign this Authorization, the Company may not accept my application for insurance.

I UNDERSTAND that the Company may maintain or have access to personal information acquired separately through any previous insurance applications with the Company or its affiliates for insurance even in instances where insurance was not placed with me. I authorize the Company to use or disclose such information for consideration of my current application for insurance.

I UNDERSTAND that I may revoke this Authorization at any time by providing written notice to the Company, except: (i) to the extent that an individual has taken action in reliance upon such authorization prior to notice of the revocation, or (ii) to the extent that this authorization was provided as a condition of obtaining insurance coverage and other law provides the Company with the right to contest a claim for coverage under the policy or the insurance coverage under the policy itself.

I UNDERSTAND that Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer the responsibility of the Information Provider or protected by the privacy rule under the Health Insurance Portability and Accountability Act.

I UNDERSTAND that I may request to receive a copy of this Authorization and I agree that a photographic copy shall be as valid as the original.

I CERTIFY that I have read, or had read to me, the completed application. All statements in this application are representations and not warranties. If this application is accepted, the insurance will take effect on the effective date shown on the schedule page attached to the certificate of coverage.

**Caution Notice: If your answers on this application are incorrect or untrue, the Continental Casualty Company may have the right to deny benefits or rescind your coverage, subject to the Incontestability provision in the policy.**

**Applicant’s Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Coverage is not guaranteed and is based on the information provided.**

## Long Term Care Insurance Personal Worksheet

People buy long-term care insurance for a variety of 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 Number 10341-IS

The premium for the coverage you are considering is shown in the premium exhibit.

**Type of Policy:** Guaranteed Renewable.

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 this state.

### Rate Increase History

The company has sold long-term care insurance since 1988 and has sold this policy since 2002. The company has never raised its rates for any group 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 Savings/Investments  From Family members

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 gross income.*

Please consider whether you could afford to keep this policy if the premiums were raised, for example, by 20%?

**OVER, PLEASE**

**Waiting Period.** Most group long-term care plans are sold with a waiting period before benefits become payable. Please consider how you would pay for your care during this waiting period.

- From my Income     From Savings/Investments     From Family members

**Questions Related to Your Savings and Investments**

Not counting your home, what is the approximate value of all of your assets (savings and investments)? (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.*

**Disclosure Statement**

The answers to the questions above describe my financial situation.

**OR**

I choose not to complete this information.

I acknowledge that I have reviewed this form 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.** (This box must be checked).

**Signed:** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Applicant)

In order for us to process your application, please return this signed statement to GLTC Insurance Administrators, Inc., along with your application.

The company may contact you to verify your answers.