

Continental Casualty Company

CNA Future Guard Long Term Care Plan



Employer Name:

Short Form Application

Northrop Grumman

Use this form if you are a full-time actively-at-work employee, or the spouse or domestic partner of a full-time actively-at-work employee.

Policy Number: 10341-IS

For Illinois Residents: THIS CERTIFICATE IS NOT APPROVED FOR MEDICAID ASSET PROTECTION UNDER THE ILLINOIS LONG TERM CARE PARTNERSHIP PROGRAM. HOWEVER, THIS CERTIFICATE IS AN APPROVED TRADITIONAL LONG TERM CARE CERTIFICATE 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.

SECTION I – 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 SELECTIONS

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 – EMPLOYEE INFORMATION

I certify that I am an employee The spouse or domestic partner of an employee.

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.

PLEASE CONTINUE TO NEXT PAGE

NOTE: If you answer "Yes" to any of the following questions, please use the Long Form Application instead.

SECTION 5 – STATEMENT OF INSURABILITY

- | | | |
|--|--------------------------|--------------------------|
| 1) Height _____ Weight _____ | | |
| 2) During the last seven (7) years have you been diagnosed, received medical advice or treatment by a member of the medical profession for any of the following: | YES | NO |
| a. Acquired Immune Deficiency Syndrome (AIDS)) or any other immune system disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Alzheimer's Disease, dementia, or change in cognitive functioning | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Multiple Sclerosis, Huntington's Disease, Parkinson's Disease, or Amyotrophic Lateral Sclerosis | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Emphysema, Chronic Bronchitis, or Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Internal Lupus Erythematosus or any other connective tissue disease or disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Cancer which has spread or metastasized | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Heart Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Diabetes Mellitus, Glucose Intolerance, or Hyperglycemia | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Cerebral Vascular Accident, Stroke, or Transient Ischemic Attack | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Alcoholism or Substance Abuse | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Bone or joint disease or disorder requiring prescription medications or surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Mental, Emotional, Nervous disease or disorder, Depression, or Chemical Imbalance | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Have you used any tobacco products more than once a month at any time during the last three years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) At any time during the last two years have you needed assistance or supervision or were you limited in any way physically or cognitively in performing any of the daily activities of bathing, dressing, toileting, mobility, eating, or managing medications? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) At any time in the last seven years have you applied for or received Social Security <u>Disability</u> Benefits or <u>Medicaid</u> ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Do you currently have or have you had in the past 12 months any long term care insurance in force other than Group Long Term Care from Continental Casualty Company or have you applied for such insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Do you intend to replace any medical or health insurance coverage including a health care service contract or health maintenance organization with insurance applied for with this application other than Group Long Term Care from Continental Casualty Company? | <input type="checkbox"/> | <input type="checkbox"/> |

PLEASE CONTINUE TO NEXT PAGE

SECTION 6 – 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 of my 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 I may request to receive a copy of this Authorization and I agree that a photographic copy of this Authorization 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.