MEDAmerica INSURANCE COMPANY
An Excellus Company
Home Office: Pittsburgh, PA

DO NOT USE - MICROFILM USE ONLY

Mailing Address: MedAmerica Insurance Company
c/o MedAmerica Administrators
165 Court Street
Rochester, NY 14647
1-800-544-0327

Enrollment Form

CARE DIRECTIONS PREMIER

BlueCross BlueShield of Arizona, Inc.

Group 635 – Voluntary

Long-Term Care Insurance Certificate # GRP11-342-MA-AZ-200

A Separate Enrollment Form Must be Completed for Each Enrollee.

GENERAL INFORMATION

ELIGIBLE EMPLOYEE/RETIREE NAME: (Last) (First) (M.I.)		**Social Security Number**
Address		
City **County** **State** **Zip**		
Home Phone: ( )	**Work Phone:** ( )	**Best Time to be Reached:** ❑ AM ❑ PM

ENROLLEE - Required Information Please Verify: (Must be age 18 through age 85)

For Increase in Coverage OR after Open Enrollment – ALL enrollees must complete a Standard Issue Health Statement.

Employees: Choose Active Employee if you work 30 or more hours per week on a regular basis

Modified Guaranteed Issue - Open Enrollment Only

❑ New Employee Date of Hire: ____________________

Standard Issue – (Standard Issue Health Statement required)

Note: After Open Enrollment **-** Standard Issue Health Statement is required for ALL enrollees

❑ Active Employee (After Open Enrollment)	❑ Parent
❑ Retired Employee	❑ Parent-in-law
❑ Spouse of Active Employee	❑ Grandparent
❑ Spouse of Retired Employee	❑ Grandparent-in-law

ENROLLEE INFORMATION

Name (First) (Middle Initial) (Last)					**Social Security Number:**
Address					
City **County** **State** **Zip**					
Home Phone: ( )		**Work Phone:** ( )		**Best Time to be Reached:** ❑ AM ❑ PM	
Date of Birth Month/Day/Year ____/____/____	**Age**	**Marital Status** ❑ Married ❑ Single ❑ Widowed	**Sex** ❑ Male ❑ Female	**Height**	**Weight**

Check ONE, **if applicable** ❑ Spouse is enrolling at this time.
(Please submit enrollment forms together.)
❑ Spouse is a current certificateholder

Spouse's Social Security Number
(Required if spouse is applying or a certificateholder)

BENEFIT SELECTIONS (Please Complete Sections 1 & 2)

1) Benefit Period:	2) Daily Benefit Amount: Nursing Facility, Assisted Living Facility, Hospice Program, Home Care, Adult Day Care	3) Lifetime Elimination Period:
❑ 1095 days (3 Years)	❑ $100	90 Days
❑ 1825 days (5 Years)	❑ $120	
❑ Unlimited (Lifetime)		

OPTIONAL BENEFITS APPLIED FOR (Please Complete Sections 1 & 2)

1) Inflation Protection Option (Choose ONE)	2) Spousal Benefit Transfer Rider (not available for Unlimited Benefit Period)
❑ Compound Inflation (5% for Life)	❑ Yes ❑ No
❑ Simple Inflation (5% for 20 Years)	

PAYMENT TERMS (Choose ONE)

❑ **Lifetime** ❑ **10 Years Paid in Full** ❑ **20 Years Paid in Full**

PAYMENT METHOD (Choose ONE of the following three options)

1) ❑ Direct Bill

Payment Frequency

Annual

2) ❑ Bank Account Draft OR ❑ Credit Card

❑ VISA ❑ Mastercard

Payment Frequency (Choose **ONE**)

❑ Monthly ❑ Annual

Account Type ❑ Checking ❑ Credit Card

(Account withdrawal is the 5th of the month.)

______________________ ______________________

Bank Name Bank Account #

Attach Voided Check

______________________ ______________________

Credit Card # Expiration Date

I authorize my financial institution or credit card company to automatically make payments to MedAmerica Insurance Company for my insurance. This authorization shall remain in force until I give notification of termination to my financial institution or credit card company and MedAmerica Insurance Company in writing.

X______________________________

Signature of Account Holder

X______________________________

Signature of Joint Account Holder

3) ❑ Payroll/Retirement Deduction

(Must be pre-approved by your employer.)

I authorize my employer/retirement system to deduct the applicable premium from my salary/retirement.

I authorize MedAmerica Insurance Company to adjust these deductions based on rate changes or changes in coverage as provided by the Group Policy.

I may revoke this authorization at any time by written notice to my employer/retirement system and to MedAmerica Insurance Company.

X______________________________

Employee/Retiree Signature

INSURANCE INFORMATION

1. Are you covered by a state assistance program (Medicaid)? ❑ Yes ❑ No

2. **List all** accident, sickness, disability, **nursing home, home health care and long-term care insurance policies**, including any health care service contracts and health maintenance organization contracts **that are currently in force.** (Include any MedAmerica Insurance Company policies.)

Company Name (Use extra paper if necessary)	**Address** (Street, City, State, Zip)	**Policy Type**	**Policy Number**	**Intend to Replace**
				❑ **Yes** ❑ **No**
				❑ **Yes** ❑ **No**
				❑ **Yes** ❑ **No**

3. **Did you have another** nursing home, home health care or long-term care insurance policy or certificate **in force during the last twelve (12) months?** ❑ **Yes** ❑ **No**

If Yes, Name of Company ______________________________

If Policy Lapsed, **Date of Lapse** ______________________________

4. Have you ever been turned down for nursing home, home health care, long-term care or disability insurance? ❑ **Yes** ❑ **No**

If Yes, please explain:______________________________

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HEALTH STATEMENT

Please answer "Yes" or "No" by checking the box.

Yes	**No**		
❑	❑	1.	Do you need assistance or supervision in performing activities of daily living, such as walking, dressing, eating, taking medication, getting in and out of bed, bathing, toileting, bowel and bladder control or are you currently receiving, or have you received in the past 12 months: nursing home care, home care, or adult day care services?

In most cases, answering "Yes" to this question will disqualify you from acceptance into the program at this time. If you feel you have fully recovered or are no longer requiring the services described above, please attach an explanation including conditions, services used, and time frames.

PHYSICIAN INFORMATION

Physician(s) Name	**Physician(s) Street Address City, State, Zip**	**Phone #**	**Date Last Seen**
1. **Primary Care Physician**			
2. Other Physicians (Indicate Specialty)			
3. Other Physicians (Indicate Specialty)			

OPTIONS AND SIGNATURE

1. **PROTECTION AGAINST UNINTENDED LAPSE:** 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 insurance policy for nonpayment of premium. I understand that notice will not be given until **31 days after** a premium is due and unpaid. I understand, also, that I have the right not to appoint a lapse designee. Therefore, **I select *one* of the following options:**

   ❑ **I elect NOT to designate** any person to receive such notice.

   ❑ **I designate** the person listed below to be notified by MedAmerica Insurance Company if my premium is not paid:

   ____ (   ) ____________

   Name Address City State Zip Telephone

Declaration and Enrollment Form Conditions

To the best of my knowledge and belief, I have answered all questions completely and truthfully. I understand this enrollment form and my health statement, if applicable, is for consideration and the company will use this enrollment form and my health statement, if applicable, or require, at their expense, that I see a health care professional to determine if I am accepted. My coverage will begin on the effective date noted on the schedule page issued to me provided that payment of the first premium has been made. To receive benefits under this certificate, I will satisfy the elimination period and the benefit eligibility requirements as set forth in the certificate.

Authorization to Obtain and Disclose Information

I agree to permit company representatives to contact me to discuss my enrollment.

I understand that only information contained on this enrollment form and my health statement, if applicable, may be used to rescind my Certificate.

I authorize any physician, medical practitioner, hospital, clinic, other health care provider or health-related facility, insurance or reinsuring company or employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to furnish MedAmerica Insurance Company and/or insurance support organizations representing MedAmerica Insurance Company any information needed to determine eligibility for insurance or benefits. THIS AUTHORIZATION EXPRESSLY INCLUDES INFORMATION ABOUT DRUGS, ALCOHOLISM, MENTAL ILLNESS AND COMMUNICABLE DISEASES.

I agree that a photocopy of this release and authorization shall be as valid as this original.

I agree that this authorization will be valid for 24 months from the date this enrollment form is signed.

I understand that I, or my authorized representative, have the right to obtain a copy of this authorization by notifying MedAmerica Insurance Company at 1-800-544-0327.

I acknowledge receipt of "A Shopper's Guide to Long-Term Care Insurance," published by the National Association of Insurance Commissioners, and the Outline of Coverage.

Dated at: ____________________ / ______________ **on** ______________ / __________ / __________

City **State** **Month** **Day** **Year**

Enrollee's Signature X____

CAUTION: If your answers on this enrollment form or your health statement, if applicable, are incorrect or untrue, MedAmerica Insurance Company has the right to deny benefits or rescind your policy.

FRAUD NOTICE: Any person who knowingly presents false or fraudulent claim for payment of a benefit or knowingly presents false, incomplete or misleading information in an application for insurance may be prosecuted for fraud and may be subject to fines and confinement in prison.

COMPANY USE

Ap Rec____________________Ap Status______________Effective Date____________UW/Date______________

Mailing Address:
MedAmerica Insurance Company
c/o MedAmerica Administrators
165 Court Street
Rochester, NY 14647
1-800-544-0327

Long-Form Health Statement

Name:______________________ **Phone #:**____________ **Social Security #:**___________

MEDICAL PROFILE PART I **Please answer "Yes" or "No" by checking the box.**

Yes No

❑ ❑ 1. Do you need assistance or supervision in performing activities of daily living, such as walking, dressing, eating, taking medication, getting in and out of bed, bathing, toileting, bowel and bladder control?

❑ ❑ 2 Do you currently need and use a wheelchair, walker, quad cane, catheter, dialysis machine, hospital bed or oxygen?

❑ ❑ 3. Do you have Diabetes **AND** have you **EVER** had one of the following conditions:

Skin Ulcers, Renal Failure, Progressive Neuropathy or Retinopathy, Vascular or Circulatory Disease?

❑ ❑ 4. In the past **5 YEARS** have you received Medical Advice, Consultation, or Treatment for:

- AIDS*
- Liver Cirrhosis
- Parkinson's Disease
- Multiple Sclerosis
- Lou Gehrig's Disease (ALS)
- Muscular Dystrophy
- Multiple Strokes
- Organic Brain Syndrome
- Senile Dementia
- Chronic Memory Loss
- Alzheimer's Disease
- Amputation-Due to Disease
- Internal Lupus (SLE)
- Neurogenic Bladder
- Renal Failure
- Double Heart Valve Replacement
- Spinal Cord or Brain Tumor
- Myasthenia Gravis
- Shunts

*** You need not answer "yes" if you have only been diagnosed as a carrier of AIDS. In addition, you need not answer "yes" if you do not have, or have never been tested for AIDS. You are obliged to answer "yes" if you have actually been diagnosed as having AIDS.**

❑ ❑ 5. In the past **3 YEARS** have you received Medical Advice, Consultation, or Treatment for Internal Cancer, except for Breast, Prostate, Colon or Uterine Cancer?

6. In the past **2 YEARS** have you:

❑ ❑ A. Been confined to or medically advised to be confined to a Nursing Home, Adult Day Care, Mental Institution, or Alcohol Rehabilitation, or received services of a Home Care Agency?

❑ ❑ B. Received Medical Advice, Consultation, or Treatment for Drug Addiction or for Compression Fractures?

7. In the past **YEAR** have you:

❑ ❑ A. Received Medical Advice, Consultation, or Treatment for Stroke or Transient Ischemic Attacks (TIA)?

❑ ❑ B. Received Medical Advice, Consultation, or Treatment for Breast, Prostate, Colon or Uterine Cancer?

❑ ❑ 8. In the past **6 MONTHS** have you had or been medically advised to have: Angioplasty, a Coronary Bypass Graft, Vascular Surgery, or a Pacemaker, or have you had a Heart Attack?

❑ ❑ 9. In the past **3 MONTHS** have you had or been medically advised to have Back, Knee, or Hip Surgery?

In most cases, checking any box above will disqualify you from acceptance into the program at this time. If you feel you have fully recovered or are no longer requiring the services described above, please attach an explanation including conditions, services used, and time frames.

(Long Form Health Statement Continued on Reverse Side)

PART II If any question in Part II is answered **Yes**, give full details in **Part IV.**

Yes	No		
❑	❑	1.	During the past **2 YEARS** have you been hospitalized for any medical condition or special tests?
❑	❑	2.	During the past **2 YEARS** have you had or been medically advised to have any surgery?
❑	❑	3.	Are you **CURRENTLY** receiving Physical Therapy, Occupational Therapy, or Rehabilitation Services?
❑	❑	4.	Are you **CURRENTLY** receiving disability income, worker's compensation, or Social Security **Disability** benefits?

PART III If any question in Part III is answered **Yes**, give full details in **Part IV**.

Yes	No		During the past **5 Years** have you received Medical Advice, Consultation, or Treatment for any of the following:
❑	❑	1.	Heart problem or heart failure, heart or vascular surgery, circulatory or blood disease, stroke, TIA, angina, or high blood pressure?
❑	❑	2.	Arthritis, osteoporosis, bone or joint problem, or any condition causing limitations or use of medical equipment?
❑	❑	3.	Any respiratory problem, asthma, Chronic Obstructive Pulmonary Disease (COPD), or emphysema?
❑	❑	4.	Any diabetes, cancer, loss of vision, neurological or muscular disorder?
❑	❑	5.	Any bowel, bladder, digestive, kidney or liver problem?
❑	❑	6.	Any memory loss, mental or emotional disorder or alcohol/drug problem?

PART IV List **ALL** Medications **AND** Detail **ALL CONDITIONS** noted in Part II and Part III.

Part/ Question #	Description of Accident or Sickness	Date of Onset	Type of Treatment/Medication	Length of time on Medication

Use this space for additional information

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SIGNATURE:

I certify that the forgoing statements and answers are true and complete to the best of my knowledge and belief. I certify that no material information has been **withheld** or **omitted** concerning the past and present state of my health.

I agree to advise you if, prior to the date my insurance takes effect, there is a change to the answers to these questions.

I understand that this health statement will be made a part of the certificate applied for and that false and/or incomplete responses or statements may result in rescission of coverage and/or non payment of claims under the certificate during the two-year incontestability period.

X ____ ____________

Enrollee's Signature **Date**