Increasing Coverage is Easy for Employees

Instructions for the application form for employees who wish to increase their coverage.

Please complete the Short Form Application, picking the new benefit level you would like. Please fill in each section of the form carefully, answering each question completely. If any parts are left blank, we cannot process your application. Be sure to select the one daily maximum benefit, and one lifetime maximum benefit you would like. Indicate if you want the benefit account non-forfeiture option and/or the automatic benefit increase option. Premiums for your coverage choice will be deducted from the employee's paycheck. You will be mailed a certificate of coverage that reflects the coverage you have selected.

For a change to existing coverage you do not need to have the grey area on the first page of the form completed by your benefits office. That is only needed by applicants applying for coverage for the very first time.

Mail the completed enrollment form to:
CNA Group Long Term Care, PO Box 64908, St. Paul, MN 55164.

Questions?
Just call a CNA customer service representative:
1-888-653-9600

Continental Casualty Company

CNA

STATE OF MINNESOTA PLAN

Policy Number: 9938 TQ

Long Term Care Insurance

Short Form Application for employees' spouses and late-enrolling employees

M-Pel

SECTION 1 – APPLICANT INFORMATION

Full name (first, middle, last)	Date of birth	❑ Male ❑ Female
Address	Social Security Number	
City	State:	Zip
Daytime phone	Evening phone	

SECTION 2 – BENEFIT SELECTIONS

Select ONE daily benefit:

❑ Option 1: $100 daily benefit

❑ Option 2: $150 daily benefit

❑ Option 3: $200 daily benefit

Select ONE lifetime maximum:

❑ Choice A: 730 days x daily benefit (2 years)

❑ Choice B: 1250 days x daily benefit (3.4 years)

❑ Choice C: 1825 days x daily benefit (5 years)

Select OPTIONAL benefits:

For an additional cost, you may select one or both of the following optional features:

❑ Non-forfeiture benefit account

❑ Automatic benefit increase option *(Selecting this option qualifies coverage for the MN Long Term Care Partnership)*

SECTION 3 – EMPLOYEE INFORMATION

I certify that I am ☐ an employee ☐ the spouse of an employee

Employee's full name	
Employee's ID number	Employee's Social Security Number

To be completed by benefits personnel,
For employees and spouses enrolling after the May 2010 enrollment period

Date of hire	Date of benefit eligibility	Payroll location (Check ONE) ❑State of Minnesota Central Payroll ❑IBU _____

OVER, PLEASE

SECTION 4 – PAYMENT METHOD

I authorize my employer to make payroll deductions for the above-specified coverage and release other necessary information to the administrators of this program.

Employee's signature _____ **Date** ____/____/____

SECTION 5 – STATEMENT OF INSURABILITY

1.	Height _____ ft. _____ in. Weight _____ lbs.	
2.	During the last seven years have you been diagnosed, received medical advice or been treated 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.	❑ ❑
b.	Alzheimer's Disease, dementia or change in cognitive functioning.	❑ ❑
c.	Multiple Sclerosis, Huntington's Disease, Parkinson's Disease or Amyotrophic Lateral Sclerosis.	❑ ❑
d.	Emphysema, chronic bronchitis or asthma.	❑ ❑
e.	Internal lupus erythematosus or any other connective tissue disease or disorder.	❑ ❑
f.	Cancer which has spread or metastasized.	❑ ❑
g.	Heart disorder.	❑ ❑
h.	Diabetes mellitus, glucose intolerance or hyperglycemia.	❑ ❑
i.	Cerebral vascular accident, stroke or transient ischemic attack.	❑ ❑
j.	Alcoholism or substance abuse.	❑ ❑
k.	Bone or joint disease or disorder requiring prescription medication or surgery.	❑ ❑
l.	Mental, emotional or nervous disease or disorder, depression, or chemical imbalance.	❑ ❑
3.	Have you used any tobacco products more than once a month at any time during the last three years?	❑ ❑
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 from performing any of the daily activities of bathing, dressing, toileting, mobility, eating or managing medications?	❑ ❑
5.	At any time in the last seven years have you applied for or received Social Security Disability benefits or Medicaid?	❑ ❑
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 Insurance from Continental Casualty Company or have you applied for such insurance?	❑ ❑
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 with M-Pel long term care insurance from Continental Casualty Company?	❑ ❑

NEXT PAGE, PLEASE

SECTION 6 – AUTHORIZATION

NOTICE: Any person who, with intent to defraud or knowing that he or she 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 provisions in the policy.

Applicant's Signature _____ **Date** ____/____/____

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