APPLICATION For Insurance

Genworth Life Insurance Company
Administrative Office: 3100 Albert Lankford Dr., Lynchburg, VA 24501

THE GROUP POLICY/CERTIFICATE DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE IOWA LONG TERM CARE ASSET PRESERVATION PROGRAM. HOWEVER, THE GROUP POLICY/CERTIFICATE IS AN APPROVED LONG TERM CARE INSURANCE POLICY/CERTIFICATE UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE IOWA LONG TERM CARE ASSET PRESERVATION PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE DIVISION OF INSURANCE AT 1-515-281-5705.

A. INSURABILITY PROFILE

Applicant A YES	Applicant A NO	Question	Applicant B YES	Applicant B NO
☐	☐	**1.** Are you covered by Medicaid (not the same as Medicare)?	☐	☐
☐	☐	**2**A. Do you use a Walker, Wheelchair or Quad Cane; Hospital Bed; Oxygen, Respirator or Kidney Dialysis; or need assistance or supervision by another person in performing any of the following: Moving in/out of bed or chair, Bathing, Dressing, Eating, Toileting, Bowel/Bladder control, or Walking?	☐	☐
☐	☐	B. Have you been advised to: receive home care, use an adult day care facility, enter a nursing home, enter an assisted care facility, or enter any other long term care facility?	☐	☐
☐	☐	**3.** Have you had, do you currently have, or have you ever been medically diagnosed as having any of the following: (see list below)	☐	☐
☐	☐	**4.** In the past 4 years have you had Cancer of the: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas, or Stomach?	☐	☐
☐	☐	**5.** Have you ever been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) caused by the Human Immunodeficiency Virus (HIV) infection, or other sickness or condition derived from such infection, or tested positive for HIV or exposure to the HIV infection?	☐	☐

Question 3 list:

- ALS (Lou Gehrig's disease)
- Alzheimer's Disease
- Congestive Heart Failure (CHF) *in combination* with any of the following: Heart Attack or Angina; Emphysema/ Chronic Obstructive Pulmonary Disease (COPD); Angioplasty or Heart Surgery; Asthma or Chronic Bronchitis
- Cirrhosis of the Liver
- Cystic Fibrosis
- Dementia
- Diabetes under treatment with Insulin or with a history of TIA, Heart Disease, or Circulatory/Vascular Disease
- Frequent or persistent forgetfulness or memory loss
- Huntington's Chorea
- Metastatic Cancer (spread from original site/location)
- Multiple Sclerosis (MS)
- Muscular Dystrophy
- Organic Brain Syndrome
- Parkinson's Disease
- Senility
- Stroke
- Transient Ischemic Attack (TIA) within the past 5 years
- TIA *in combination* with Diabetes or Heart Surgery
- TIA two or more times

PLEASE NOTE BEFORE YOU CONTINUE WITH THIS APPLICATION: If you answered YES to any of the questions in Part A, we suggest that you do not submit this application. If you answered NO to every question, please continue.

B. PERSONAL PROFILE

Print clearly - Use black ink

APPLICANT A

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other Title:

Name ____________________
(As it should appear on your Coverage documents)

☐ Married/Legal Couple ☐ Single ☐ Widowed

Social Security Number ____________________

Employee Number ____________________

Employer/Group Name ____________________

Birthdate __________ Age ______ Birthplace (state) ________

☐ Male ☐ Female Height: ft. ____in. ______ Weight: lbs. ______

Daytime Phone ( ) ____________________

Evening Phone ( ) ____________________

Best time to call ____________________ ☐a.m. ☐p.m

E-mail address ____________________

I am eligible as: ☐ Actively at work Employee ☐ Spouse/Partner ☐ Other ____________

APPLICANT B

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other Title:

Name ____________________
(As it should appear on your Coverage documents)

☐ Married/Legal Couple ☐ Single ☐ Widowed

Social Security Number ____________________

Employee Number ____________________

Employer/Group Name ____________________

Birthdate __________ Age ______ Birthplace (state) ________

☐ Male ☐ Female Height: ft. ____in. ______ Weight: lbs. ______

Daytime Phone ( ) ____________________

Evening Phone ( ) ____________________

Best time to call ____________________ ☐a.m. ☐p.m

E-mail address ____________________

I am eligible as: ☐ Actively at work Employee ☐ Spouse/Partner ☐ Other ____________

Resident Address ____________________ (Street Address Only, No P.O. Boxes -- Your Coverage will be issued based on this address.)

City ____________________ State __________ Zip __________

Mailing Address (if different) ____________________

City ____________________ State __________ Zip __________

LONG TERM CARE INSURANCE APPLICATION INSTRUCTIONS

The information included below is intended to assist you in completing the application and other documents required to apply for LTCI coverage with Genworth Life Insurance Company. If an agent is not involved in the preparation of this application and other forms please disregard any reference to agent sections or agent signatures. Employee Advantage and their spouses are direct bill unless otherwise noted.

Step 1 – Ensure basic underwriting eligibility.

a) Check height and weight to see if you meet the Basic Eligibility Requirements in the table below.

b) Complete the Insurability Profile section on page A-1.

Step 2 – Complete the *entire* application to avoid returned applications and processing delays.

BASIC ELIGIBILITY REQUIREMENTS

If over or under limits below, we recommend that you do not submit an application. If the applicant has diabetes or osteoporosis, please see the underwriting guide.

HEIGHT	WEIGHT MIN.	MAX. *Female*	MAX. *Male*
4′ 6″	71	149	157
4′ 7″	73	155	163
4′ 8″	76	160	169
4′ 9″	79	166	175
4′ 10″	82	172	182
4′ 11″	84	178	188
5′ 0″	87	184	194
5′ 1″	90	190	201
5′ 2″	93	197	208
5′ 3″	96	203	214
5′ 4″	99	210	221
5′ 5″	102	216	228
5′ 6″	106	223	235

HEIGHT	WEIGHT MIN.	MAX. *Female*	MAX. *Male*
5′ 7″	109	230	243
5′ 8″	112	237	250
5′ 9″	115	244	257
5′ 10″	119	251	265
5′ 11″	122	258	272
6′ 0″	126	265	280
6′ 1″	129	273	288
6′ 2″	133	280	296
6′ 3″	136	288	304
6′ 4″	140	296	312
6′ 5″	144	304	321
6′ 6″	147	312	329

DISCOUNTS

With Long Term Care Business Solutions, a Couples Discount is available in one of two situations if the applicant meets the Insurability Profile criteria in his or her application:

(1) Both persons submit valid applications at the same time; or

(2) One person submits a valid application within 12 months of the effective date of his or her partner's insurance.

If coverage for one applicant is under a different group policy, a Couples Discount is available only when similar underwriting criteria apply. If coverage is issued to both applicants, a 40% discount will apply. If coverage is issued to one applicant, a 25% will apply.

	COUPLES DISCOUNT	PREFERRED HEALTH DISCOUNT (if available)		TOTAL DISCOUNT APPLICANT	
		1	2	1	2
1 Applicant with Preferred Health	n/a	20%	–	20%	–
2 Applicants/ 1 Issued with Preferred	25%	10%	–	35%	–
2 Applicants/ Both Issued / Both Preferred	40%	10%	10%	50%	50%

COUPLES

In addition to married couples, applicants who are not married but meet certain criteria may be eligible to receive a Couples Discount. Please refer to the "Requirements to Access Couples Discount" form for an explanation of the criteria and instructions on how to access the discount.

AGENT'S REPORT

Used for processing only, this does not become part of the issued Certificate.

FAMILY HISTORY PROFILE

Information obtained in Section E "Family History Profile" will not be used to decline an application or deny a Preferred Health Discount.

OUTLINE OF COVERAGE

Applicant(s) should retain the outline of coverage.

PHONE AND IN-PERSON HEALTH INTERVIEW REQUESTS

When needed, phone and in-person health interviews will be ordered by the Home Office.

The interviews include questions about daily activities and a brief cognitive exercise. The in-person health interview takes approximately 1 hour, and the phone health interview takes about 20 minutes.

CHECKLIST

Use this checklist to help ensure that you send in all necessary information. If you have any questions regarding any of these materials please call the phone number below.

- ◯ Application *(fully completed)*
- ◯ EFT/Credit Card Authorization *(if paying by either method)*
- ◯ A check for Full Modal Premium *(if applicable)*
- ◯ Health Information Authorization
- ◯ Replacement Notice *(when coverage is being replaced)*
- ◯ Personal Worksheet (if applicable)
- ◯ State required forms
- ◯ Requirements to Access Couples Discount form *(when required)*

Please complete the above forms, provide agent, if applicable, and applicant signatures, date all forms, and mail *(with any required premium payment made payable to)*:

Genworth Life Insurance Company, Administrative Office
3100 Albert Lankford Drive, Lynchburg, VA 24501-4948

PART 3 INSURABILITY QUESTIONS

SIMPLIFIED UNDERWRITING PROGRAM – If you are part of the Simplified Underwriting Program please complete Section A and skip to Part 4. If you are part of the full underwriting program please complete all Parts of the application.

Section A

- **Please check "yes" or "no" to each question. If "yes", circle all diagnoses or conditions that apply.**
- **If you answer "yes" to any question 1-6, then we suggest you do not submit an application. We will be unable to offer you coverage.**

	Applicant A		Applicant B	
1 Do you have or have you ever been diagnosed for: • Alzheimer's Disease • ALS (Lou Gehrig's Disease) • Cirrhosis • Chronic Kidney Failure • Dementia • Diabetes –treated with greater than 49 units of insulin or with amputation or ongoing complications affecting the kidney • Memory Loss • Mental Retardation • Metastatic Cancer • Multiple Sclerosis • Muscular Dystrophy • Neurological Conditions affecting the Brain or Spinal Cord • Organic Brain Syndrome • Parkinson's Disease • Paralysis • Post Polio Paralytic Syndrome • Schizophrenia • Scleroderma • Systemic Lupus Erythematosus • Stroke/CVA • TIA's 2 or more	❑ Yes	❑ No	❑ Yes	❑ No
2 Do you currently require human assistance or supervision in any of the following activities: eating; dressing; toileting; transferring from bed to chair; walking; maintaining continence; or bathing?	❑ Yes	❑ No	❑ Yes	❑ No
3 Do currently reside in, have you been advised to enter, or are you planning to enter a nursing home, assisted living facility or other custodial facility, or are you currently receiving home health care services or attending adult day care?	❑ Yes	❑ No	❑ Yes	❑ No
4 Do you currently use one of the following medical devices: wheelchair; walker; hospital bed; quad cane; oxygen; stairlift; or dialysis?	❑ Yes	❑ No	❑ Yes	❑ No
5 Have you been diagnosed or treated by a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex?	❑ Yes	❑ No	❑ Yes	❑ No
6 Are you currently receiving Social Security Disability, Worker's Compensation or Long Term Disability Benefits?	❑ Yes	❑ No	❑ Yes	❑ No

SAMPLE

Section B

If you are part of the Simplified Underwriting Program please skip to Part 4.

MEDICAL HISTORY	Applicant A		Applicant B	
1 Have you consulted with your Primary Care Physician within the last 18 months?	❑ Yes	❑ No	❑Yes	❑ No

Applicant A: Primary Care Physician Name:	**Applicant B:** Primary Care Physician Name:
______________________________	______________________________
Address:______________________	Address:______________________
City, State, Zip Code:______________	City, State, Zip Code:______________
Tel. #: ______________________	Tel. #: ______________________
Date Last Seen: ________________	Date Last Seen: ________________

Simplicity[ii]

Long Term Care Insurance
TAX QUALIFIED COVERAGE

Administrative Offices:
165 Court Street
Rochester, NY 14647
1-800-544-0327

SIMPLIFIED

SPL2-336-XX

HEALTH QUESTIONS: Please read the Instructions Carefully.

Applicant Name	Applicant Social Security Number

INSTRUCTIONS: You must answer each question by **checking YES or NO.**

1. **Have you ever received Medical Advice, Consultation, or Treatment for any of the following conditions:** ☐ YES ☐ NO
   - Diabetes Treated with Insulin
   - Any Diabetes with Skin Ulcers
   - Multiple Joint Replacements OR Any Joint Deformities
   - Kidney Disease
   - Liver Cirrhosis
   - Hepatitis B, C, D, or E
   - Stroke or Transient Ischemic Attack (TIA)
   - Memory Loss, Alzheimer's Disease, or Dementia
   - Bipolar Disorder, Schizophrenia, Psychosis, Mental Retardation
   - Amyotrophic Lateral Sclerosis (ALS), Myasthenia Gravis
   - Multiple Sclerosis
   - Parkinson's Disease/Parkinsonism
   - Muscular or Neurological Conditions causing Limits
   - Post-Polio Syndrome
   - Lupus (SLE)
   - Scleroderma
   - Amputation-Due to Disease
   - Organ or Bone Marrow Transplants
   - Brain or Spinal Tumors-benign or malignant
   - Metastatic Cancer, Multiple Myeloma
   - Pulmonary Embolism
   - Carotid Artery Disease
   - Peripheral Vascular Disease
   - AIDS- You need not answer "yes" if you have only tested positive for Human Immunodeficiency Virus (HIV). In addition, you need not answer "yes" if you do not have, or have never been tested for HIV or AIDS. You are obligated to answer "yes" if you have actually been diagnosed as having AIDS.

2. ***In the PAST YEAR*: Have you needed assistance or supervision in taking medication, performing activities of daily living* OR used any Medical Equipment**?** ☐ YES ☐ NO
   *Activities of Daily Living Include Bathing, Dressing, Eating, Toileting, Getting In and Out of Bed, Bowel OR Bladder Control
   **Medical Equipment Includes Wheelchair, Walker, Motorized Scooter, Quad Cane, Canadian Crutches, Catheters, Ventilators, Oxygen, Stair lift, or Home Intravenous Medications.

3. ***In the PAST YEAR*: Have you been admitted to a nursing home, assisted living facility, psychiatric hospital, OR alcohol/drug rehabilitation?** ☐ YES ☐ NO

STOP! If questions 1,2 OR 3 are checked "Yes," we cannot offer coverage at this time. **Do not Submit the Application.**

4. ***In the PAST YEAR*: Have you been hospitalized overnight (except for uncomplicated childbirth) OR been advised to have surgery, OR been diagnosed with cancer AND received OR been advised to receive Radiation or Intravenous Chemotherapy?** ☐ YES ☐ NO

5. ***In the PAST YEAR*: Have you been referred to or received medical advice, consultation or treatment from any physician specializing in any of the following: Neurology (Nerves), Nephrology (Kidney/Renal), Pulmonary (Respiratory), OR Hematology (Blood)?** ☐ YES ☐ NO

6. ***In the PAST YEAR*: Have you been declined, postponed, or had your benefits modified for a long term care application?** ☐ YES ☐ NO

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties.
CAUTION: If your answers on this application are incorrect or untrue, or you fail to include all material medical information requested, MedAmerica Insurance Company has the right to deny benefits or rescind your policy.

To the best of my knowledge and belief, I have answered all questions completely and truthfully.

Dated at:

City	State	Month	Day	Year

APPLICANT'S SIGNATURE:

SAMPLE

S2-346B-XX SIMP 1

MetLife®

PART B — INSURABILITY QUESTIONS

SIMPLIFIED UNDERWRITING – Answer questions in Parts B and C, skip Part D (not applicable to Simplified Underwriting) and continue to Part E.
MODIFIED UNDERWRITING – Answer questions in all sections.

	APPLICANT 1	APPLICANT 2
1. Have you been medically advised as having or have you been medically treated for: **Circle all that apply** • Stroke (CVA) • Multiple Transient Ischemic Attacks (TIA's) • TIA within 5 years • Alzheimer's Disease • Dementia • Mental Retardation • Schizophrenia • Amyotrophic Lateral Sclerosis (Lou Gehrig's disease) • Muscular Dystrophy • Multiple Sclerosis • Parkinson's Disease • Diabetes with amputation or complications affecting the kidney • Cancer that has spread to another area of your body including nodes; or cancer diagnosed or treated in the past 2 years (except basal cell cancer, squamous cell cancer of the skin or early stage breast or prostate cancer). • Organ Transplant	☐Yes ☐No	☐Yes ☐No
2. Have you ever been treated for or medically diagnosed as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), any AIDS related condition(s) or tested positive for antibodies to the AIDS virus?	☐Yes ☐No	☐Yes ☐No
3. Do you currently reside in, or have you been advised to enter, or are you planning to enter a nursing home, assisted living facility or residential care facility or are you currently receiving home health care services or attending Adult Day Care?	☐Yes ☐No	☐Yes ☐No
4. Do you require human help or supervision for any of the following?: • bathing • dressing • eating • walking • toileting • transferring from bed or chair • controlling bowel or bladder	☐Yes ☐No	☐Yes ☐No
5. Do you currently use any of the following?: • dialysis • oxygen • wheelchair • walker • quad cane • crutches	☐Yes ☐No	☐Yes ☐No

SPOUSE OR DOMESTIC PARTNER OF EMPLOYEES ONLY

Complete this section if: You are part of a Simplified Underwriting group, and your Spouse's or Domestic Partner's employer is paying the premium.

Do you currently need or receive help with any of the following activities because you are unable to perform them yourself? ☐ **Yes** ☐ **No**

• taking medications • shopping • meal preparation • managing finances

IF "YES" please explain:

____

This information will be reviewed to determine if the coverage you selected can be approved. We may need to contact you for additional information.

MAIL THIS PAGE TO METLIFE

Section D — Complete for MODIFIED GUARANTEED, SIMPLIFIED or FULL UNDERWRITING

- **If you answer "Yes" to questions in this section, do not continue. We will be unable to offer you Long-Term Care coverage.**
- **If you answer "No" to questions in this section and are in the Modified Guaranteed Underwriting program, SKIP to Section G.**

	Question	Applicant A Yes	Applicant A No	Applicant B Yes	Applicant B No
1	Do you currently use any of the following: • wheelchair • walker • nebulizer • electric scooter • quad cane • oxygen	☐	☐	☐	☐
2	Do you require the assistance or supervision of another person or a device of any kind for any of the following: • bathing • toileting • dressing • eating • medication management • getting in and out of a chair or bed • your inability to control your bowel or bladder	☐	☐	☐	☐
3	Are you currently eligible for benefits under, or covered by, Medicaid (not Medicare), disability income, workers' compensation, Social Security disability or any federal or state disability plan?	☐	☐	☐	☐

Section E — Complete for SIMPLIFIED or FULL UNDERWRITING

- **If you answer "Yes" to questions in this section, do not continue. We will be unable to offer you Long-Term Care coverage.**
- **If you answer "No" to questions in this section and are in the Simplified Underwriting program, SKIP to Section G.**

	Question	Applicant A Yes	Applicant A No	Applicant B Yes	Applicant B No
1	Within the past 6 months have you been confined to, or been advised to have, any of the following: • residential care, assisted living or adult day care facility services • nursing home or home health care services • physical, occupational or speech therapy	☐	☐	☐	☐
2	Have you ever had, been diagnosed as having, or received medical advice or medical care from a physician or health care provider for any of the following: • Alzheimer's Disease • Dementia • Memory Loss • Mental Retardation • Schizophrenia • Psychosis • Organ Transplant • Amyotrophic Lateral Sclerosis (ALS) • Huntington's Chorea • Kidney Failure or received Dialysis • Parkinson's Disease • Multiple Sclerosis • Muscular Dystrophy • Chronic Hepatitis • Cirrhosis • Myasthenia Gravis • Paralysis • Scleroderma • Systemic Lupus • Ministroke or Transient Ischemic Attack (TIA) in the past year, single episode stroke in the past 2 years, two or more strokes or TIAs, or you have not fully recovered or continue to have weakness, decreased sensation or loss of function from a stroke or TIA • Diabetes and currently taking more than 50 units of insulin daily, or with peripheral neuropathy, numbness, tingling or decreased sensation in your feet, retinopathy or history of a stroke, ministroke or a TIA • Cancer (except basal or squamous cell skin cancers, or stage I/A bladder, thyroid, breast or prostate cancers) in the past 2 years • Chronic Obstructive Pulmonary Disease (COPD), Emphysema or Chronic Bronchitis and have used tobacco in the past year	☐	☐	☐	☐
3	Have you been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic)?	☐	☐	☐	☐

☐ Yes ☐ No 1 Do you use a: ☐ Walker ☐ Oxygen ☐ Respirator ☐ Kidney Dialysis ☐ Wheelchair?

☐ Yes ☐ No 2 Within **the past 12 months** have you: ☐ Used Adult Day Care ☐ Needed Home Health Care

☐ Yes ☐ No Been medically advised to enter or been confined to:
☐ A Nursing Home ☐ An Assisted Living Facility ☐ Other Long Term Care Facility

☐ Yes ☐ No 3 Do you currently need assistance or supervision by another person in performing any of the following activities:
☐ Bathing ☐ Eating ☐ Toileting ☐ Bowel or Bladder Control
☐ Moving In and Out of Bed or Chair ☐ Dressing ☐ Taking your Medication

4 Have you had, do you currently have, or have you ever been diagnosed as having any of the following medical conditions:

☐ Yes ☐ No a Organic Brain Syndrome, Dementia, Senility, Confusion, Memory Loss, Alzheimer's Disease, or Schizophrenia?

☐ Yes ☐ No b Metastatic Cancer (cancer that has spread from the original site or location)?

☐ Yes ☐ No c Multiple Sclerosis (MS) Muscular Dystrophy, Multiple Transient Ischemic Attacks (TIA), Parkinson's Disease, Amyotrophic Lateral Sclerosis (ALS), Stroke Cerebrovascular Accident (CVA), or Huntington's Disease?

☐ Yes ☐ No d Diabetes with heart, circulatory, or kidney complications?

☐ Yes ☐ No 5 Have you had, do you currently have, or have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), or a Human Immunodeficiency Virus (HIV) Infection?

Y or N Within the past 12 months have you been hospitalized or within the past 24 months have you applied for or received any form of Disability or Workman's Compensation or been declined for Long Term Care Insurance?

Prudential

Transamerica

MODIFIED GUARANTEE ISSUE – Answer Questions in SECTION A only.
SIMPLIFIED ISSUE- Answer Questions in SECTIONS A & B.
FULL UNDERWRITING - Answer Questions in SECTIONS A, B & C.

A

1. During the last 6 MONTHS, have you been continuously and actively at work for your current employer for a minimum of 30 hours per week (away from home), except for vacation? ☐ Yes ☐ No
2. During the last 6 MONTHS, have you missed more than five consecutive days of work due to accidents, injury, sickness or any physical or cognitive impairment? ☐ Yes ☐ No
3. During the last 12 MONTHS, have you ever required assistance or supervision of any kind to perform any everyday activity, such as mobility (including the use of pronged canes), taking medications, dressing, eating, walking, bathing, transferring, or toileting? ☐ Yes ☐ No

If any question 4 – 8 is answered Yes, You are not eligible for coverage.

B

4. Have you EVER had, or been diagnosed, treated or consulted a physician for any of the following conditions? ☐ Yes ☐ No

   If Yes, please check the applicable condition(s):

   - ☐ AIDS (Acquired Immune Deficiency Syndrome) or tested positive for HIV
   - ☐ Alzheimer's disease
   - ☐ Amputation due to disease
   - ☐ Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)
   - ☐ Arthritis with narcotic pain medication
   - ☐ Cerebrovascular Accident* (Stroke, CVA, TIA)
   - ☐ Dementia or Senility
   - ☐ Mobility Deficit
   - ☐ Multiple Sclerosis
   - ☐ Muscular Dystrophy
   - ☐ Myasthenia Gravis
   - ☐ Organic Brain Syndrome
   - ☐ Huntington's Chorea
   - ☐ Osteoporosis with fractures
   - ☐ Paraplegia or Quadriplegia
   - ☐ Parkinson's disease
   - ☐ Polymyositis
   - ☐ Scleroderma
   - ☐ Memory loss requiring medical consultation

   *If applicant has had a single Cerebrovascular Accident more than 2 years ago, complete Section C.

5. During the last 3 YEARS, have you used over 60 units of insulin per day to treat Diabetes, or have you been diagnosed or treated for Diabetes WITH COMPLICATIONS (Neuropathy, Retinopathy, Heart Disease, Stroke), Chronic Hepatitis or Cirrhosis, alcohol abuse, drug or prescription drug addiction, or Transient Global Amnesia? ☐ Yes ☐ No
6. During the last 12 MONTHS, have you used a catheter, dialysis, oxygen equipment, a quad or three-pronged cane, respirator, walker, wheelchair, crutches, motorized scooter or chair lift? ☐ Yes ☐ No
7. During the last 12 MONTHS, have you been confined to a nursing home, assisted living facility, attended an adult day care facility, or required home health care? ☐ Yes ☐ No
8. Do you have a direct family history (parents or siblings) of Huntington's Chorea or Polycystic Kidney Disease? ☐ Yes ☐ No
9. Are you currently taking or been prescribed any prescription drugs or medications? ☐ Yes ☐ No

   If Yes, please list **all**: ______________________________

PRIMARY PHYSICIAN'S NAME	TELEPHONE NUMBER	HMO/PPO ID# (if known)

ADDRESS	DATE LAST CONSULTED

REASON LAST SEEN

If any question 10 – 13 is answered Yes, You are not eligible for coverage. For questions 14-16, if Yes, circle any applicable diagnosis or condition(s) and give details in question # 17.

C

10. Have you EVER had, been diagnosed with, treated for, or consulted a physician for:

a) COPD (Emphysema) with oxygen use, or steroid medications? .... ☐ Yes ☐ No

b) Multiple Strokes (CVA's), or Metastatic or Multi-site Cancer? .... ☐ Yes ☐ No

11. In the last 24 MONTHS, have you had a Single Stroke (CVA or TIA)? .... ☐ Yes ☐ No

12. In the last 12 MONTHS, have you had Cardiomyopathy? .... ☐ Yes ☐ No

13. Within the last 3 MONTHS, have you had a Heart Attack (MI) or Chest Pain; uncontrolled Blood Pressure; Hip or Back Surgery; or Cancer? .... ☐ Yes ☐ No

14. In the last 5 YEARS, have you been diagnosed with, received treatment for, or consulted a physician for:

a) Chronic Lymphocytic Leukemia, Diabetes, Cancer or Macular Degeneration? .... ☐ Yes ☐ No

b) Arthritis, Osteoporosis, Rheumatoid Arthritis, Fibromyalgia, Fractures, Joint Replacement or used a straight cane? .... ☐ Yes ☐ No

c) Heart Attack, Chest Pain, Heart Disease, Congestive Heart Failure (CHF), High Blood Pressure, Heart Murmur, Cardiomyopathy or Peripheral Vascular Disease? .... ☐ Yes ☐ No

d) Stroke, Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), Aneurysm, irregular heartbeat, Carotid Artery Stenosis, or Heart Surgery? .... ☐ Yes ☐ No

e) Mental or cognitive disorder including memory loss, confusion, disorientation, mental retardation, depression; or Epilepsy? .... ☐ Yes ☐ No

f) Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Emphysema? .... ☐ Yes ☐ No

g) Dizziness, fainting, blurred vision, convulsions, paralysis, falls, loss of balance or strength? .... ☐ Yes ☐ No

h) Any condition requiring treatment, surgery, home care or hospitalization, but not mentioned above (NOT including routine Colds, Flu, etc.) or unplanned weight loss of 15 lbs or more? .... ☐ Yes ☐ No

15. In the last 12 MONTHS, has any medical treatment, follow-up, diagnostic testing, or surgery been recommended, but not yet completed? If Yes, give details: ☐ Yes ☐ No

____

____

____

16. Do you have a handicap sticker, handicap placard, or handicap license plate? .... ☐ Yes ☐ No

17. Give details for all Yes answers. FOR EVERY MEDICATION THERE SHOULD BE A CONDITION AND FOR MOST CONDITIONS THERE SHOULD BE A MEDICATION OR TREATMENT.

Question #	Nature of Condition/Medication	Date Last Treated/ Medication Taken	Name of Physician Seen/ Physician's Address

If more space is needed, attach a signed and dated additional sheet and check this box: ☐