PARTNERSHIP REQUIREMENTS:

- For ages 18-60, provide 5% compound annual inflation protection
- For ages 61-75, provide some level of inflation protection (does not include Guaranteed Purchase Option)
- For ages 76+, no purchase of inflation protection is required

FlexibleBenefitLTC®

LONG TERM CARE INSURANCE

Fully Underwritten APPLICATION

for Brokerage, Associations, and Employer Groups

☐ **BROKERAGE – NON-FRANCHISE**

☐ **NON-PARTNERSHIP** ☐ **PARTNERSHIP**

Complete this section only for pre-approved Association or Employer Group accounts.

Name of Association or Employer Group (PRINT) ______________________

Service Group Number ______________________

☐ **ASSOCIATION–FRANCHISE**

Application is for:

☐ **Member**

☐ **Member's Spouse**

☐ **Family Member.** Relationship to Member: ______________________

☐ **Employee of Member**

☐ **Employee's Spouse**

☐ **EMPLOYER GROUP– FRANCHISE**

Type of Application:

☐ Voluntary

☐ Executive Carve-Out/Employer Pay-All

Application is for:

☐ **Employee**

☐ **Employee's Spouse**

If a **Telephonic Signature** (ages 18-64) is being requested, check this box: ☐

☐ **Family Member.** Relationship to Employee: ______________________

☐ **Retiree**

☐ **Retiree's Spouse**

Pre-Screen Comments:____

____

____

OHIO

AIMS GA FBF APP OH 108 (REV309)

INSTRUCTIONS

- Grayed out areas of the application are no longer available.
- Always include a **rate disk proposal** with the application.
- Electronic Funds Transfer (bank draft) applications require two month's premium. Exception: If the Effective Date Request on the application is "Date of Approval," only **one** month's premium is required. If one bank account is going to be used to pay for more than one policy, the bank draft form on each application must be signed by the person whose name is on the account being drafted.
- Always leave the following with each applicant:
  - Product brochure
  - Completed Client Information booklet
  - "A Shopper's Guide to LTC Insurance"
  - If eligible for Medicare, "A Guide to Health Insurance for People with Medicare."
- **Please refer to the Underwriting Guide for the Height/Weight Chart and Medical Conditions.**

RATE CLASS SELECTION

If applicant qualifies for Select 1, Select 2, or Select 3, hand write the rate class in the white box at the end of Section 3.

1. **Preferred** .... Applicant has not been a tobacco user in the last 24 months; the Height/Weight is within the **Preferred** Height/Weight guidelines; and Question 6g* is answered NO. *Medical Records will be ordered on all applicants applying for Preferred Rates.*
2. **Standard** .... Applicant has not been a tobacco user in the last 24 months; the Height/Weight is within the **Standard** Height/Weight guidelines; and Question 6g* is answered NO.
3. **Select 1** .... Applicant has not been a tobacco user in the last 24 months; the Height/Weight is within the **Select 1** Height/Weight guidelines and/or Question 6g* is answered YES.
4. **Select 2** .... Applicant has not been a tobacco user in the last 24 months; the Height/Weight is within the **Select 2** Height/Weight guidelines.
5. **Smoker** .... Applicant has been a tobacco user in the last 24 months. *As reflected on the rate disk, Smoker premiums and Select 2 premiums are the same.*
6. **Select 3** .... Applicant's Height/Weight is within the **Select 3** Height/Weight guidelines. ***Select 3 is not available for tobacco users.***

**Question 6g in most states.*

Application for Long Term Care Insurance to Great American® Life Insurance Company
Home Office: Cincinnati, Ohio. LTC Administrative Office: P. O. Box 559002, Austin, Texas 78755-9002

Producer's Name ______________________ Producer's Writing Number ______________________

Application is for: ☐ New Coverage ☐ Reinstatement ☐ Upgrade/Conversion to Policy Number ______________

SECTION 1: PERSONAL INFORMATION

Applicant's Name *(Please Print)* First	MI	Last	Sex	Date of Birth Month	Day	Year	Age	Height	Weight

Street Address ______________________

City ______________________ State ________ Zip ________

Social Security Number ______________________

Daytime Phone ______________________ Evening Phone ______________________

Best Time to Call (Provide a 2+ Hour Time Period): From ________ ☐ AM ☐ PM to ________ ☐ AM ☐ PM

	YES	NO
Are you covered by Medicaid? *(Not Medicare)*	☐	☐
Employment Status: Do you work outside your home a minimum of 30 hours per week?	☐	☐

If YES, list occupation ______________________

SECTION 2: MARITAL STATUS *(Select one of the following)*

☐ **Couples Discount**............. You are married and your Spouse is: ☐ Applying for coverage at the same time, or ☐ Already has a Great American Life Insurance Company long term care policy.

Spouse's First Name ____________ Spouse's Last Name ____________ Spouse's Social Security Number ____________

If applying for the Joint Coverage rider, this application is for the: ☐ First Applicant (Policyowner) ☐ Second Applicant.

☐ **One Spouse Discount**........ You are married, but your Spouse is not applying for coverage.

☐ **Individual**.......................... You are not married.

SECTION 3: RATE CLASS *(Select one of the following)*

☐ **Preferred**.......................... You have not been a tobacco user in the last 24 MONTHS; your Height/Weight is within the Preferred Rate Class guidelines; and you answer NO to Question 6g.

☐ **Standard**........................... You have not been a tobacco user in the last 24 MONTHS.

☐ **Smoker**............................. You have been a tobacco user in the last 24 MONTHS.

SECTION 4: BENEFIT SELECTION

4a. **DAILY BENEFIT** *(Complete all of the following)*

Nursing Home (NH) .... $ ____________

Assisted Living Facility..(*Select one*): ☐ 50% ☐ 75% ☐ 100% ☐ 125%

Home Health Care and Adult Day Care (HHC) ....(*Select one*): ☐ 50% ☐ 75% ☐ 100% ☐ 125% ☐ 150%

Monthly Cash Benefit Alternative ....(*Select one*): ☑ 10X HHC Daily ☐ 15X HHC Daily

4b. **BENEFIT PERIOD:** ☐ 365 Days ☐ 550 Days ☐ 730 Days ☐ 915 Days ☐ 1095 Days ☐ 1280 Days ☐ 1460 Days ☐ 1645 Days ☐ 1825 Days ☐ 2190 Days ☐ 2555 Days ☐ 2920 Days ☐ Unlimited

4c. **MAXIMUM BENEFIT (BLOCK OF DOLLARS):** $ ____________ **OR** ☐ Unlimited

4d. **ELIMINATION PERIOD:** ☐ 0 Day ☐ 30 Days ☐ 60 Days ☐ 100 Days ☐ 180 Days ☐ 365 Days

---

4e. **BENEFIT INCREASE OPTION**

☐ 5% Compound

☐ 5% Compound 3X Max.

☐ 5% Compound 2X Max.

☐ 5% Compound Daily and 3% Compound Maximum Benefit

☐ 5% Compound Delayed to Age 65

☐ 5% Simple

☐ Guaranteed Purchase Option

☐ None

If this 5% Compound Option is not selected, the Rejection box in 4f. must be checked.

4f. ☐ **REJECTION OF COMPOUND BENEFIT INCREASE OPTION.** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this insurance with and without inflation protection. Specifically, I have reviewed the features of the Compound Benefit Increase Option and I reject the Option.

4g. **NONFORFEITURE BENEFIT – SHORTENED BENEFIT PERIOD RIDER**

Applicant must accept or reject

☐ I **accept** the Nonforfeiture Benefit Rider.

☐ I **reject** the Nonforfeiture Benefit Rider. I have reviewed the Outline of Coverage and the nonforfeiture benefit described therein. Specifically, I have reviewed this optional benefit available to me and I reject the nonforfeiture benefit.

4h. **OPTIONAL BENEFITS**

☐ Premium Rate Guarantee Period.

Total Number of Years: ____________ (4 to 20 Years).
Policy has a standard 3 Year rate guarantee.

☐ Waiver of Elimination Period for Home Health Care, Adult Day Care, and Monthly Cash Benefit Alternative

☐ Prescription Drug Benefit in a Nursing Home (*Select one*):
☐ 1X NH Daily ☐ 2X NH Daily ☐ 3X NH Daily

☐ Full Restoration of Benefits

☐ Limited Premium Payment Period (*Select one*):
☐ Single Pay ☐ 10 Years ☐ 20 Years
☐ 5 Years ☐ 15 Years ☐ Paid Up at Age 65

☐ Enhanced Nursing Home Care

☐ Monthly Home Care

☐ Enhanced Home Health Care

☐ Return of Premium (*Select one*):
☐ Full ☐ Less Claims ☐ Graded

☐ Accelerated Payment of Premium (*Select one*):
☐ 5 Years ☐ 10 Years

☐ 80/20 Coinsurance Rider, with a Benefit Copayment Limit of:

$ ____________

4i. **OPTIONAL BENEFITS FOR COUPLES**

☐ Survivorship Paid Up Benefit (*Select one*):
☐ Full option ☐ 10/10 option

☐ Dual Waiver of Premium

☐ Joint Coverage

SECTION 5: EFFECTIVE DATE REQUEST

Select one of the following:

☐ Date of Application

☐ Date of Approval

☐ List Bill *(The Effective Date will be determined by Great American Life Insurance Company)*

☐ Other Requested Date: ______________________ *(No more than 90 days from date of Application)*

SECTION 6: UNDERWRITING

PART A

If any question in PART A is answered YES, you are not eligible for coverage.

	Question	YES	NO
6a.	Do you need assistance or supervision in performing any of the following activities: Bathing, Continence, Dressing, Eating, Toileting, Transferring?	☐	☐
6b.	Are you dependent on the use of a walker, wheelchair, quad or 4 prong cane, or motorized scooter; or are you confined to a bed, your home, a hospital, or nursing home; or do you use medical equipment such as oxygen, a respirator, or a dialysis machine?	☐	☐
6c.	Have you been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Diabetes using over 50 units of insulin per day, or Diabetes with amputation or kidney problems?	☐	☐
6d.	Due to any mental or physical disability, either current or past, is any person or institution currently authorized to act on your behalf?	☐	☐
6e.	During the last 12 MONTHS have you been diagnosed or treated for a Transient Ischemic Attack (TIA), Stroke, or Heart Attack; or have you used Nursing Home, Assisted Living Facility, Adult Day Care, or Home Care services?	☐	☐
6f.	During the last 5 YEARS have you been diagnosed or treated for any of the following conditions?	☐	☐

- ALS (Lou Gehrig's Disease)
- Alzheimer's Disease
- Aneurysm (Cerebral)
- Central Nervous System Shunt
- Cerebral Vascular Disease
- Chronic Lymphocytic Leukemia
- Cirrhosis of the Liver
- Dementia
- Huntington's Chorea
- Kidney Failure
- Memory Loss (recurring)
- Metastatic Cancer (cancer that has spread from the original site)
- Multiple Sclerosis (MS)
- Multiple Strokes
- Multiple Transient Ischemic Attacks (TIAs)
- Parkinson's Disease
- Schizophrenia or Psychosis
- Systemic Lupus Erythematosus (SLE)

PART B

If any question in PART B is answered YES, provide details in the Comments section.

	Question	YES	NO
6g.	During the last 3 YEARS, have you been diagnosed, treated, or consulted with a member of the medical profession for any of the following conditions?	☐	☐

If YES to any condition in this Question 6g., the Preferred Rate Class is not available.

☐ Alcoholism or Drug Abuse
☐ Balance Disorders
☐ Cancer (excluding Basal & Squamous Cell Skin Cancer)
☐ Carotid Artery Disease
☐ Chronic Bronchitis
☐ Chronic Depression with Medication
☐ Chronic Obstructive Pulmonary Disease
☐ Coronary Artery Disease
☐ Congestive Heart Failure
☐ Degenerative Joint/Disc Disease
☐ Diabetes
☐ Dizziness
☐ Emphysema
☐ Fibromyalgia
☐ Irregular Heart Beat/Atrial Fibrillation
☐ Macular Degeneration
☐ Mental Disorder
☐ Osteoporosis
☐ Osteoarthritis with Drug Treatment
☐ Peripheral Vascular Disease
☐ Rheumatoid Arthritis
☐ Stroke
☐ Transient Ischemic Attack (TIA)
☐ Vertigo

	YES	NO
6h. During the last 5 YEARS have you been diagnosed or treated for any of the following conditions?	☐	☐

- ☐ Amputation
- ☐ Anemia
- ☐ Aneurysm (abdominal)
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Bypass Surgery or Angioplasty
- ☐ Colitis (ulcerative or Crohn's)
- ☐ Fractures (weight bearing joints)
- ☐ Heart Attack
- ☐ Hypertension/High Blood Pressure
- ☐ Joint Disorder or Replacement
- ☐ Paralysis
- ☐ Phlebitis
- ☐ Post Polio Syndrome
- ☐ Seizure Disorders/Epilepsy/Convulsions
- ☐ Skin Ulcers
- ☐ Sleep Apnea
- ☐ Spine or Back Disorder
- ☐ Tremor
- ☐ Other condition causing crippling or limited motion, or requiring adaptive devices

	YES	NO
6i. During the last 12 MONTHS have you sought medical advice or treatment for any of the following?	☐	☐

- ☐ Confusion/Disorientation
- ☐ Vision Loss Due to Disease
- ☐ Fainting
- ☐ Falling
- ☐ Numbness
- ☐ Tremors
- ☐ Unstable Gait

	YES	NO
6j. During the last 12 MONTHS have you used physical or rehabilitative services; braces for spine or lower extremities; or have you been medically advised that you will need surgery which has NOT been performed?	☐	☐

6k. Complete the following information regarding your prescription medications.

Medication	Dosage	Frequency	Condition	Date From/To

6l. Complete the following information regarding your primary care physician.

First Name ______________________ Last Name ______________________

Phone ______________________ Street Address ______________________

City ______________________ State __________ Zip __________

Date Last Seen ______________________ Reason ______________________

SECTION 7: COMMENTS

Include question number, condition, treatment, dates, etc.

SECTION 8: OTHER INSURANCE INFORMATION

Do you now have or are you applying for any other type of long term care insurance (including a health care service contract, and/or a health maintenance organization contract); or have you had any other long term care insurance in force during the last 12 MONTHS? *(If YES, provide details below)*........ YES ☐ NO ☐

Name of Company	In Force	Applied For	Lapsed	Type and amount of benefits for nursing home, assisted living, or home care	To be replaced by this coverage?
	☐	☐	☐		☐ Yes ☐ No
	☐	☐	☐		☐ Yes ☐ No

SECTION 9: PREMIUM PAYMENT METHOD

Select one of the following:

☐ **DIRECT BILL**
Premium Mode: ☐ Quarterly ☐ Semi-Annual ☐ Annual

☐ **ELECTRONIC FUNDS TRANSFER (BANK DRAFT).** *Complete the Electronic Funds Transfer authorization form.*
Premium Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

☐ **LIST BILL**
Premium Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

SECTION 10: ADDITIONAL PREMIUM INFORMATION

Modal Premium $ ____________ Payment with Application $ ____________

SECTION 11: PREMIUM PAYOR, IF OTHER THAN APPLICANT

If paying by List Bill, skip this Section.

First Name ____________ Last Name ____________

Company Name (if applicable) ____________

Phone ____________ Billing Address ____________

City ____________ State ____________ Zip ____________

SECTION 12: BENEFICIARY, IF OTHER THAN POLICYOWNER'S ESTATE

First Name ____________ Last Name ____________

Phone ____________ Address ____________

City ____________ State ____________ Zip ____________

Relationship to Applicant ____________

SECTION 13: THIRD PARTY NOTIFICATION

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 Policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

☐ I designate the following person to receive notice prior to cancellation of the Policy for nonpayment of premium:

Full Name ______________________ Phone ______________

Address, City, State, Zip ______________________________

☐ I elect not to designate any person to receive such notice.

SECTION 14: ACKNOWLEDGEMENT AND AGREEMENT

I understand and agree that: (1) the answers contained herein are true and complete to the best of my knowledge and belief; (2) this application will be part of the Policy for which I am applying; (3) no producer has the authority to waive any questions or determine insurability; and (4) no insurance will take effect under the Policy for which I am applying: (a) until this application is approved by Great American Life Insurance Company; (b) unless the first premium is paid; and (c) prior to the Policy effective date which is assigned by Great American Life Insurance Company.

I have received the following items: (1) Outline of Coverage; (2) Description of Information Practices; (3) Things You Should Know Before You Buy Long Term Care Insurance; (4) Potential Rate Increase Disclosure Form; (5) the applicable Shopper's Guide; and (6) if I submitted premium with the application, the Conditional Premium Receipt. For applications requesting Joint Coverage: if I am the Second Applicant, I acknowledge that my Spouse, the First Applicant, will be the Policyowner and have all the rights associated with ownership of the Policy.

I understand that any intent to defraud or knowingly facilitate a fraud against Great American Life Insurance Company by submitting an application or filing a claim containing a false or deceptive statement is insurance fraud.

CAUTION: If your answers on this application are incorrect or untrue, Great American Life Insurance Company may have the right to deny benefits or rescind your Policy.

By my signature, I affirm all the elections and answers in the above application.

SIGN

Applicant's Signature	**Date**	**State Where Application Was Signed**

SECTION 15: PRODUCER'S STATEMENT

15a. Did you review the current health insurance coverage of the Applicant and find that additional coverage of the type and amount applied for is **appropriate** for the Applicant's needs? .... ☐ Yes ☐ No

15b. To the best of your knowledge, is the insurance applied for intended to **replace** any other health insurance coverage in force with this or any other company? .... ☐ Yes ☐ No

15c. List any other health insurance policies you have sold to the Applicant:

Company	Type of Policy	In Force?	Lapse Date
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

I certify I have accurately recorded the information supplied by the Applicant.

Producer's Signature	**Date**	**If Splitting: Share %**

Other Producer's Name (Print)	Other Producer's Writing Number	Share %

LIFE INSURANCE COMPANY

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

Proposed Insured's Name | Policy Number (if Available)

Financial Institution Name and Telephone Number

Financial Institution Address

9 Digit Routing Number | Account Number

Requested Withdrawal Date (1st thru 28th): ______________

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Type of Account:

☐ Personal Checking Account

☐ Personal Savings Account

☐ Corporate/Business Checking Account

Name of Employer Group ______________

Purpose for Submitting this Authorization – Check appropriate box(es):

☐ New authorization

☐ Change in checking/savings account

☐ Change in financial institution

☐ Change in existing coverage

Please tape a VOIDED Check (checking account) or Deposit Slip (savings account) in this box.

TAPE VOIDED CHECK HERE

1111

VOID

Pay to the order of ______________ $

DOLLARS

The Routing number is 9 digits between the ⑆ ⑆ symbols

The Account number is usually to the left of ⑈. If check number is left of account number, ignore check number

The Check number should match the number in the upper-right corner

⑆111222333⑆ 111222333⑈ 1111

APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Great American Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT INFORMATION FOR GREAT AMERICAN LIFE INSURANCE COMPANY: It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract, and no other notice of premiums due will be given. No premium shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium payment has been received by Great American Life. The cancelled draft will constitute receipt of premium payment. The privilege of paying premiums under this Plan may be revoked by Great American Life if any draft is not paid upon presentation. The payment of premiums under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Great American Life upon 30 days written notice.

X

Print Name of Depositor (as it appears on account) | Signature of Depositor | Date

AUTHORIZATION FORM FOR DISCLOSURES OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me and my family as described below.

1. I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, the U.S. Veterans Administration and Selective Service System, insurance company, the Medical Information Bureau, or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to Great American Life Insurance Company's (Great American Life's) underwriting, new business, claims, sales agents and premium accounting representatives any such records or information.
2. The protected health information described above will be disclosed to Great American Life to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
3. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Great American Life in reliance on this authorization, by sending a written revocation to Great American Life's Privacy Officer at P.O. Box 26580, Austin, Texas 78755-0580.
4. I understand that the information which will be provided under this authorization is necessary for Great American Life to determine my eligibility for coverage under the policy and that Great American Life will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
5. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
6. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
7. If you are the representative of an applicant, describe the scope of your authority to act on the applicant's behalf:

____

____
Applicant's Name (Print)

____
Applicant's Social Security Number

X ____________________________
Applicant's Signature Date

____
Agent's Signature Date

____
Name of Applicant's personal representative, if applicable

____
Relationship of personal representative to the applicant

____
Signature of personal representative Date

A signed copy of this form will be provided with the policy if issued and any other time upon request.

Long Term Care Administrative Office: P. O. Box 559002, Austin, Texas 78755-9002

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

People buy long-term care insurance for many 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: ☐ Franchise Policy 4LTCIP0001-OH or ☐ Non-Franchise Policy 4LTCIP0002-OH

The premium for the coverage you are considering will be $ _________ per month, or $ _________ per quarter, or $ _________ semi-annually or $ _________ per year, or $ _________ per year for 5 years, or $ _________ per year for 10 years, or $ _________ per year for 15 years, or $ _________ per year for 20 years, or $ _________ per year to age 65, or a one-time single premium of $ _________.

Type of Policy
This policy is guaranteed renewable.

The Company's Right to Increase Premiums
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 1998 and has sold this policy since 2006. The company has never raised its rates for any 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 my Savings/Investments ☐ My Family will Pay

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

What is your annual income? ☐ 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? ☐ 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 income.

Will You Buy Inflation Protection? ☐ Yes ☐ No
If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?
☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of care in 1999 was $47,000, but this figure varies across the country. In ten years the national average annual cost would be about $76,610 if costs increase 5% annually.

What Elimination Period are You Considering?

______ Number of days   Approximate cost $ __________ for that period of care.

How are You Planning to Pay for Your Care During the Elimination Period?

☐ From my Income   ☐ From my Savings/Investments   ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth?

☐ Under $20,000   ☐ $20-30,000   ☐ $30-50,000   ☐ Over $50,000

How do you expect your assets to change over the next ten years?

☐ 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
(Check one)

☐ **The answers to the questions above describe my financial situation.**
or
☐ **I choose not to complete this information. (Not available with EGP)**

(This must be checked.) ☐ I acknowledge that the carrier and/or its agent (below) has reviewed this form with me 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.**

Applicant's Signature X ______________________ **Date** ____________

I explained to the applicant the importance of completing this information.

Agent's Signature ______________________ Date ____________

Agent's Printed Name ______________________

My agent has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.

Applicant's Signature ______________________ Date ____________

The company may contact you to verify your answers.

Long Term Care Administrative Office: P. O. Box 559002, Austin, Texas 78755-9002

LONG-TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM

1. **Premium Rate:** The premium rate that is applicable to you and that will be in effect until a request is made and approved for an increase is on the application.
2. **The premium for this policy will be shown on the schedule page of your policy.**
3. **Rate Schedule Adjustments:** Any premium rate adjustments will be effective on the next premium due date.
4. **Potential Rate Revisions:**

   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards).
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

*** Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture Cumulative Premium Increase over Initial Premium That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge receipt of the Long Term Care Potential Rate Increase Disclosure Form.

Applicant's Signature X ______________________ **Date** ____________

Agent's Signature ______________________ Date ____________

Long Term Care Administrative Office: P. O. Box 559002, Austin, Texas 78755-9002

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to lapse or otherwise terminate an existing accident and sickness or long term care insurance policy or certificate and replace it with an individual long term care insurance policy to be issued by Great American Life® Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. The policy has no exclusion for pre-existing conditions. This means that health conditions which you may presently have are fully and immediately covered under the new coverage.
2. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

____
Signature of Agent or Broker

____
Type or Print Name and Address of Agent or Broker

The above “Notice to Applicant” was delivered to me on:

____
Date

X ______________________________
Applicant’s Signature

American Insurance
Marketing Services, Inc.

Serving The LTCi
Market For Over 20 Years