

# Applying is easy!

**Just follow these simple instructions. *Send no money now.***

Complete the **Short-Form Application** if you are an **employee** who is enrolling after the initial enrollment period or the **spouse or same sex domestic partner** of an employee who is enrolling at any time.

## **TIPS**

1. Fill in each section of the application carefully, answering each question completely. If any part is left blank, we cannot process your application.
2. If both the employee and spouse / same sex domestic partner are applying for coverage, each should complete their own application.
3. Select **Only One** Plan and Daily Benefit option. The premium rates for each option are in enclosed.
4. If you are an employee, complete sections 1 through 4. Then read and sign sections 5 and 6.
5. If you are a spouse or same sex domestic partner, complete sections 1 through 4. Be sure to include the employee's name and Social Security Number in section 3. Then read and sign section 6. The employee must read and sign section 5.
6. Return the completed application to:  

CNA GLTC  
P O Box 946760  
Maitland, FL 32794-9776
7. We will inform you by mail whether you have been accepted. If accepted, we will send your certificate via First Class Mail.
8. Premiums will be deducted from the employee's paycheck and are based on applicant's age on the effective date of coverage.

## **Questions?**

**Just call a CNA customer service representative at**





## Short-Form Application

### SECTION 1 - APPLICANT INFORMATION

|   |                             |                                |              |
|---|-----------------------------|--------------------------------|--------------|
| Applicant's Name: First, Middle Initial, Last |                             | Date of Birth<br>/ /           | Sex (M or F) |
| Applicant's Address: Number and Street        |                             | Social Security Number:<br>— — |              |
| City  | State                       | Zip Code                       |              |
| Daytime Phone Number<br>( )                   | Evening Phone Number<br>( ) |                                |              |

### SECTION 2 – BENEFIT SELECTIONS

Select ONE Plan Option:

**Fixed**

- Low Plan
- Medium Plan
- High Plan

**Inflating**

- Low Plan
- Medium Plan
- High Plan

### SECTION 3 – EMPLOYEE INFORMATION

I certify that I am:  An employee  The spouse or same sex domestic partner of an employee

|                                    |                        |              |
|------------------------------------|------------------------|--------------|
| Employee Name: First, Middle, Last | Social Security Number | Date of Hire |
|------------------------------------|------------------------|--------------|

**OVER, PLEASE**

## SECTION 4 – 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:   | <b>YES</b>               | <b>NO</b>                |
| 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 medication or surgery.  | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Mental, Emotional or 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 anytime during the last three years?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. At anytime 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. At anytime in the last seven years have you applied for or received Social Security disability benefits or Medicaid?   | <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 Insurance from CNA 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 with Group Long Term Care from CNA?                  | <input type="checkbox"/> | <input type="checkbox"/> |

**OVER, PLEASE**

## SECTION 5 – 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 6 – AUTHORIZATION

**NOTICE: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.**

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.

I authorize any insurance company, reinsuring company, insurance reporting agency, employer, the Veterans Administration, licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility having medical records or knowledge of me, or my health, to give to the Continental Casualty Company any such information, in order to evaluate my application for long term care insurance. A photostatic copy of this authorization is as valid as the original.

This authorization shall remain in effect for two years and six months from the date shown below. I have read this authorization and understand I can receive a copy.

I certify that I have read, or have had read to me, the completed application. All statements in this application are true and complete to the best of my knowledge and belief. 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. However, this insurance will not take effect unless the employee is actively-at-work as determined by the employer.

**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.