

# Eligibility

## WHO CAN ENROLL FOR THIS COVERAGE?

### WHO IS ELIGIBLE

Persons eligible under this Contract include the following:

- 1) Employees: An actively-at-work full-time or part-time regular Employee on U.S. payroll working at least 80 hours per month (except Local 77, Local 2898 and SPOG member) for the Contract Holder.
- 2) Retired Employees: A person who has retired by the terms of the Contract Holder's retirement plan.
- 3) Family Members:
  - a) Spouse: The legal Spouse or Registered Domestic Partner of an Employee or Retired Employee.
  - b) Surviving Spouse: The legal Spouse of a deceased Employee or Retired Employee.
  - c) Domestic Partner: The Domestic Partner of an Employee or Retired Employee.
  - d) Parent: The parent, parent-in-law, step-parent or step-parent-in-law of an Employee, Retired Employee or Surviving Spouse and the parent or step-parent of a Domestic Partner.
  - e) Grandparent: The grandparent, grandparent-in-law, step-grandparent or step-grandparent-in-law of an Employee, Retired Employee or Surviving Spouse or the grandparent or step-grandparent of a Domestic Partner.
  - f) Adult Child: A person who is at least 18 years old and who is a natural child, adopted child or stepchild of an Employee or Retired Employee, Spouse, Surviving Spouse, Registered Domestic Partner or Domestic Partner.
  - g) Sibling: A person who is the brother or sister or stepbrother or stepsister of an Employee, Retired Employee, Spouse, Surviving Spouse or Registered Domestic Partner.

A Domestic Partner is a person of the same or opposite sex who meets all the criteria listed below:

- 1) He or she is over the age of 18;
- 2) He or she has lived with you for at least 12 consecutive months preceding the date of Application;
- 3) He or she has a serious and committed relationship with you;
- 4) He or she is not legally married nor a Partner to anyone else;
- 5) He or she is financially interdependent with you. Financially interdependent means that you and this person are jointly responsible for the cost of food and housing.

A Registered Domestic Partner is a person participating in a domestic relationship as defined under State law

who has filed a Declaration of Domestic Partnership in their state of residency.

You must be at least age 18 but less than age 85 when your Enrollment Form is completed. All Qualified Family Members, Retirees and Late Entrants are required to provide evidence of insurability as part of the enrollment process. All sections of the Enrollment Form must be completed.



# Privacy Notice

## LONG-TERM CARE NOTICE

Thank you for choosing The Prudential Insurance Company of America (Prudential) for your insurance needs. Before we can issue coverage we must review your application/enrollment form. To do this, we need to collect and evaluate personal information about you. This notice is being provided to inform you of certain information practices Prudential engages in, and your rights, with regard to your personal information. We would like you to know that:

- Personal information may be collected from persons other than yourself or other individuals, if applicable, proposed for coverage;
- This personal information as well as other personal or privileged information subsequently collected by us may in certain circumstances be disclosed to third parties without authorization;
- You have a right of access and correction with respect to personal information we collect about you; and
- Upon request from you, we will provide you with a more detailed notice of our information practices and your rights with respect to such information. Should you wish to receive this notice, please contact:

The Prudential Insurance Company of America  
Long-Term Care Customer Service Center  
Attention: Privacy Contact  
P.O. Box 8526  
Philadelphia, PA 19176-8526

Any information we obtain regarding a person's insurability will be treated as confidential. We may, however, make a brief report of it to the Medical Information Bureau (the Bureau), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. When you apply for life, disability, or health insurance to any company, including Prudential, which is a member of the Bureau, or submit a claim for benefits to such a company, the Bureau will, on request, give the company the information in its files. In addition, upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If the information came from the Bureau and you question the accuracy of the information in the Bureau's files, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: P.O. Box 105, Essex Station, Boston, MA 02112, (612) 426-3660.



# State Notices

## IMPORTANT STATE NOTICES ABOUT PRUDENTIAL LONG TERM CARE SOLID SOLUTIONS<sup>SM</sup>

**Caution: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fine, and denial of insurance benefits.**

**Please note: The coverage you are applying for will not qualify you for Medicaid (or Medi-Cal) Asset Protection under your state's Long-Term Care insurance program. However, the coverage is an approved long-term care insurance contract under state law and insurance regulations.**



# Enrollment Form

**INSTRUCTIONS:** Read and complete all necessary parts of this enrollment form. **Please print using blue or black ink.** Use an "X" to mark boxes where indicated. **Provide your signature in all areas required.** Return completed forms to: Prudential Long Term Care Unit, P.O. Box 8526, Philadelphia, PA 19176. *If you have questions, call 1-800-732-0416.*

## A APPLICANT INFORMATION

### Eligibility Status

(check one)

- Actively-at-work regular full time Employee
- Actively-at-work regular part time Employee
- Spouse
- Surviving spouse
- Registered domestic partner
- Domestic partner
- Parent
- Parent-in-law
- Grandparent
- Grandparent-in-law
- Adult child
- Spouse of adult child
- Adult sibling
- Retiree
- Spouse of retiree

Mr.  Mrs.  Ms.  \_\_\_\_\_ **Marital Status**  Married  Unmarried

**Full name** \_\_\_\_\_

**Address** \_\_\_\_\_

**Apt.** \_\_\_\_\_

**City** \_\_\_\_\_

**State** \_\_\_\_\_

**ZIP** \_\_\_\_\_

**Daytime phone** (       )       -       **Evening phone** (       )       -

Best time to call:  AM  PM

**Date of birth** \_\_\_\_\_

**Date of hire** \_\_\_\_\_

**Social Security Number** \_\_\_\_\_

(Needed for 1099-LTC reporting purposes)

**E-mail address:** \_\_\_\_\_

**If married, is your spouse applying for this insurance?**

Yes  No

If your spouse currently has Prudential Long Term Care

Insurance, please provide policy/certificate number: \_\_\_\_\_

\*Note:-An employee who is on leave of absence/disability is not eligible for insurance. However upon return to work, that employee may become eligible.

**If this application is for someone other than an eligible Employee/Retiree (e.g., a spouse, family member, domestic partner or other relation), please provide information about the eligible Employee/Retiree in this section.**

Employee/Retiree full name \_\_\_\_\_

Date of hire \_\_\_\_\_

Employee/Retiree Social Security \_\_\_\_\_

Daytime phone (       )       -

Evening phone (       )       -

**B BENEFIT OPTIONS SELECTION for Federally Tax Qualified Long Term Care Insurance contract**

**1. For All Applicants**

Coverage Amounts	Total Facility Daily Benefit	Total Home Care Benefit	Total Lifetime Maximum
<input type="checkbox"/> Plan 1	\$100.00	\$75.00	\$109,500.00
<input type="checkbox"/> Plan 2	\$150.00	\$112.50	\$164,250.00
<input type="checkbox"/> Plan 3	\$200.00	\$150.00	\$219,000.00
<input type="checkbox"/> Plan 4	\$250.00	\$187.50	\$273,750.00
<input type="checkbox"/> Plan 5	\$300.00	\$225.00	\$328,500.00
<input type="checkbox"/> Plan 6	\$100.00	\$75.00	\$182,500.00
<input type="checkbox"/> Plan 7	\$150.00	\$112.50	\$273,750.00
<input type="checkbox"/> Plan 8	\$200.00	\$150.00	\$365,000.00
<input type="checkbox"/> Plan 9	\$250.00	\$187.50	\$456,250.00
<input type="checkbox"/> Plan 10	\$300.00	\$225.00	\$547,500.00

**2. Optional Automatic Inflation Increase Rider** - I have reviewed the Outline of Coverage **Yes  No**  and the graphs which compare the benefits and premiums of this Coverage with and without this Rider, and I want this Rider included in my Coverage.

**X** *If you choose "NO" for the Automatic Inflation Increase Rider, please sign:* \_\_\_\_\_

**3. Optional Non-Forfeiture Benefit** - I have reviewed the explanation of the optional **Yes  No**  Non-Forfeiture Benefit in the Outline of Coverage, and I want this Rider included in my Coverage.

**C PAYMENT METHOD**

Choose **ONE** of the following payment plans.

**Electronic Funds Transfer (EFT) - Monthly Payment** If choosing this option, you must complete and return the enclosed EFT Authorization Form.

**Direct Billing**

Bill to:

- |  |   |
|--|---|
| <input type="checkbox"/> Applicant                                       | How Often:  |
| <input type="checkbox"/> Employee/Retiree,<br>if other than<br>applicant | <input type="checkbox"/> Quarterly                      |
|  | <input type="checkbox"/> Semi-annually w/1.67% discount |
|  | <input type="checkbox"/> Annually w/5.00% discount      |

Billing address, if different from Section A:  
\_\_\_\_\_  
\_\_\_\_\_

**D INSURANCE HISTORY**

- 1. Are you covered by Medicaid or Medi-Cal (not Medicare)? Yes  No
- 2. Do you have another long term care insurance policy or certificate in force (including health care service contract or health maintenance organization contract)? Yes  No
- 3. Did you have another long term care insurance policy or certificate in force during the last 12 months? Yes  No
- 4. Do you intend to replace any of your medical or health insurance coverage with this insurance? Yes  No

If you answered "YES" to questions 3 or 4 of this section, please provide the following information.

Name of company _____ Address _____ _____ Policy number _____ <input type="checkbox"/> Check here if you intend to replace this policy.	Name of company _____ Address _____ _____ Policy number _____ <input type="checkbox"/> Check here if this policy lapsed. Give date: _____ <input type="checkbox"/> Check here if you intend to replace this policy. Give date: _____
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**E NOTIFICATION OF UNINTENTIONAL LAPSE**

You can provide Prudential with the name of a friend or relative to notify if your coverage is about to lapse because the premium was not paid when due. This designation does not constitute an acceptance of liability by the person named. Prudential will notify you periodically of your right to designate or change the existing designation for this purpose. **Choose ONE of the following options:**

**Name a Designee**

First name _____	M.I. _____
Last name _____	
Address _____	
_____	
City _____	
State _____	ZIP _____

**Waive this Notice option**

I understand that I have the right to name at least one person other than myself to receive notice of lapse or termination of my long term care insurance coverage for non-payment of premium. I understand that notice will not be given until 30 days after the premium is due and not paid. **By my signature, I elect NOT to name any person to receive such notice.**

**X** Applicant's signature \_\_\_\_\_

Date \_\_\_\_\_

## **F** APPLICANT AGREEMENTS

**Caution: If your answers on this Enrollment Form are misstated or untrue, Prudential may have the right to deny benefits or rescind your coverage.**

To the best of my knowledge and belief, the answers on this Enrollment Form are complete and true. I understand and agree that:

1. Prudential Long Term Care Insurance coverage is underwritten by The Prudential Insurance Company of America (Prudential), whose corporate offices are located in Newark, New Jersey.
2. This Enrollment Form will be the basis for the Long Term Care Insurance coverage for which I am applying to Prudential under a Group Contract.
3. My coverage will NOT take effect unless Prudential has approved this Enrollment Form and the required full modal premium has been paid when due. If issued, my Long Term Care Insurance coverage will take effect on the Effective Date assigned by Prudential.
4. I certify that my eligibility status as indicated on this Enrollment Form is true and correct as of the date this form is completed.
5. Prudential has the right to change premium rates in the future but only on a class basis.
6. I have received the Outline of Coverage and *A Shopper's Guide to Long Term Care Insurance*.
7. I have received the Privacy Notice concerning Prudential's Information Practices.
8. If I am eligible for Medicare, I have received the *Guide to Health Insurance for People with Medicare*.
9. I have read, or had read to me, the completed Enrollment Form and where applicable, the Potential Rate Increase Disclosure Form, and I understand that any false statement or misrepresentation in my Enrollment Form may result in loss of coverage under the Group Contract.
10. I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums with and without Automatic Inflation Protection. Specifically, I have reviewed the inflation options available and I understand that I am rejecting Automatic Inflation Protection if I did not check the box to elect it.

**X** Applicant's signature

Date

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# Medical History & Insurability Form for Long Term Care Insurance

**INSTRUCTIONS:** Read and complete all necessary parts of this Medical History & Insurability Form. **Please print using blue or black ink.** Use an "X" to mark boxes where indicated. **Provide your signature in all areas required.** If you answer "NO" to each question, attach the completed Insurability Profile Form to your Enrollment Form and mail it in the enclosed, postage-paid envelope to: Prudential Long Term Care Unit, P.O. Box 8526, Philadelphia, PA 19176. *If you have questions, call 1-800-732-0416.*

**Caution: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fine, and denial of insurance benefits.**

## A APPLICANT INFORMATION

Full name \_\_\_\_\_ E-mail address: \_\_\_\_\_

Daytime phone ( ) - Evening phone ( ) - Best time to call:  AM  PM

Date on accompanying enrollment form \_\_\_\_\_ Group Contract Holder City of Seattle \_\_\_\_\_

## B TELL US ABOUT YOUR INSURABILITY

**1. Within the past 7 years, have you had, do you currently have, or have you been diagnosed or treated by a Licensed Health Care Practitioner as having any of the following medical conditions:**

Amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophy or Parkinson's disease? Yes  No

Alzheimer's disease, chronic memory loss, frequent or persistent forgetfulness, senility, dementia or organic brain syndrome? Yes  No

Diabetes treated with more than 50 units of insulin per day or liver cirrhosis? Yes  No

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

Stroke or cerebrovascular accident? Yes  No

Transient Ischemic Attack (TIA) within the past 5 years, multiple TIAs or TIA in combination with diabetes or any heart surgery? Yes  No

**2. Within the past 12 months, have you had, do you currently have or have you been diagnosed with congestive heart failure by a licensed medical physician, or treated for symptoms of congestive heart failure by a Licensed Health Care Practitioner?** Yes  No

**3. Do you use any of the following:** walker or quad-cane, wheelchair or motorized cart, oxygen, respirator, or kidney dialysis? Yes  No

**4. Within the past 12 months, have you needed home health care/home care, used adult day care, or received care in a nursing home, assisted living/residential care facility or other long term care facility?** Yes  No

**5. Within the past 12 months, have you been medically advised to enter a nursing home, assisted living/residential care facility, or other long term care facility?** Yes  No

6. Do you currently need assistance or supervision by another person for taking your medication or in performing any of the following Activities of Daily Living (ADLs): bathing, eating, toileting, bowel or bladder control (continence), dressing, or moving in and out of bed or chair? Yes  No

7. This section pertains to Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) and, if permitted, HIV-related (Human Immunodeficiency Virus) diagnosis and treatment. PLEASE COMPLETE THE SECTION BELOW THAT CORRESPONDS TO YOUR STATE OF RESIDENCE.

Within the past 10 years, have you had, do you currently have, or have you been diagnosed or treated by a Licensed Health Care Practitioner, as having any of the following medical conditions:

Acquired Immune Deficiency Syndrome (AIDS)? Yes  No

AIDS Related Complex (ARC)? Yes  No

Any HIV infection (Human Immunodeficiency Virus)? Yes  No

**NOTE: If you answered "YES" to any question in Part B, do not complete the remainder of this form. We regret that we will be unable to offer you long-term care coverage because you do not meet our minimum acceptance criteria. If you answered "NO" to all questions in Part B, please continue.**

**C TELL US ABOUT YOUR MEDICAL HISTORY**

1. Height: \_\_\_\_\_ft \_\_\_\_\_in      Weight: \_\_\_\_\_lbs      Gender:  Male  Female

2. List any activities in which you regularly participate outside your home (e.g., walking or gardening):

3. Have 2 or more years passed since you received any medical examination or treatment by a health care professional? Yes  No

4. Who is your Primary Care Physician with most of your medical records? (Please print neatly)

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Reason for last visit \_\_\_\_\_ Date of last visit \_\_\_\_\_

5. Within the past 3 years, have you been advised by a Licensed Health Care Practitioner to have surgery that has not been performed? Yes  No

Condition \_\_\_\_\_ Date last treated \_\_\_\_\_

6. Check the appropriate boxes for any care received within the past 3 years:

Home health care Yes  No

Adult day care Yes  No

Nursing home, assisted living/residential care facility or other long-term care facility Yes  No

**7. Within the past 5 years (7 years for cancer), have you received any advice or treatment from a Licensed Health Care Practitioner, taken any medications for, or been medically diagnosed for:**

Any heart or circulatory conditions (angina, congestive heart failure, heart attack, heart surgery, irregular heart beat, high blood pressure, cerebrovascular disorder or peripheral vascular disease)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer of any kind, Hodgkin's disease, leukemia or lymphoma?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tumors (non-cancerous) or skin ulcers, amputation or paralysis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any breathing conditions, such as asthma, chronic bronchitis, chronic obstructive pulmonary disease, emphysema, shortness of breath or tuberculosis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cirrhosis, diabetes or hepatitis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Brain disorder, blackouts, convulsions, epilepsy or seizures?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anxiety, depression or other mental, emotional or nervous disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Alcoholism or chemical dependency?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bone or spinal disorders such as osteoarthritis or rheumatoid arthritis, osteoporosis or joint replacement?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Numbness, dizziness or balance problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**In the space below, provide details for any "YES" answers. If additional space is required, attach the details on a separate piece of paper, including your name and Social Security number. You must also sign and date that page.**

Condition/Medications \_\_\_\_\_ Date Prescribed/Date last treated \_\_\_\_\_

Name, address and phone of the Licensed Health Care Practitioner who treated your condition: \_\_\_\_\_

Condition/Medications \_\_\_\_\_ Date Prescribed/Date last treated \_\_\_\_\_

Name, address and phone of the Licensed Health Care Practitioner who treated your condition: \_\_\_\_\_

**8. Within the past 5 years (7 years for cancer), have you received any advice or treatment from a Licensed Health Care Practitioner other than your Primary Care Physician for any reason not stated? Yes  No**

(For residents of Connecticut, Florida, Maine, Maryland, Vermont and Wisconsin, this does not include HIV testing (Human Immunodeficiency Virus).

*If you answered "YES", please provide details below.*

Condition/Medications \_\_\_\_\_ Date Prescribed/Date last treated \_\_\_\_\_

Check here if treated by your Primary Care Physician only.

Name, address and phone of the Licensed Health Care Practitioner who treated your condition: \_\_\_\_\_

Condition/Medications \_\_\_\_\_ Date Prescribed/Date last treated \_\_\_\_\_

Check here if treated by your Primary Care Physician only.

Name, address and phone of the Licensed Health Care Practitioner who treated your condition: \_\_\_\_\_

**9. Are you currently taking any drug or medication not listed above?**

Yes  No

*If you answered "YES", please provide details below.*

Drug or medication \_\_\_\_\_ Dosage \_\_\_\_\_

How long have you been taking this medication?  Check here if treated by your Primary Care Physician only.

If prescribed by another Licensed Health Care Practitioner, give name, address and phone number, and the condition: \_\_\_\_\_

Drug or medication \_\_\_\_\_ Dosage \_\_\_\_\_

How long have you been taking this medication?  Check here if treated by your Primary Care Physician only.

If prescribed by another Licensed Health Care Practitioner, give name, address and phone number, and the condition: \_\_\_\_\_

Drug or medication \_\_\_\_\_ Dosage \_\_\_\_\_

How long have you been taking this medication?  Check here if treated by your Primary Care Physician only.

If prescribed by another Licensed Health Care Practitioner, give name, address and phone number, and the condition: \_\_\_\_\_

Drug or medication \_\_\_\_\_ Dosage \_\_\_\_\_

How long have you been taking this medication?  Check here if treated by your Primary Care Physician only.

If prescribed by another Licensed Health Care Practitioner, give name, address and phone number, and the condition: \_\_\_\_\_

**D READ AND SIGN APPLICANT AGREEMENTS**

**Caution: If your answers on this form are incorrect or untrue, or fail to include all material medical information requested, Prudential may have the right to deny benefits or rescind your insurance coverage.**

To the best of my knowledge and belief, the answers on this Medical History and Insurability Form for Long Term Care Insurance are complete and true. I understand and agree:

- The information on this Insurability Profile for Long Term Care Insurance is the basis for the coverage for which I am applying to The Prudential Insurance Company of America (Prudential).
- My coverage will NOT take effect unless: Prudential has approved this Insurability Profile for Long Term Care Insurance and statements and answers given in applying for this coverage do not change materially until the date this Insurability Profile for Long Term Care Insurance is approved.
- I certify that I have read this Insurability Profile for Long Term Care Insurance or had it read to me, and I realize that any false statement or misrepresentation in this Insurability Profile for Long Term Care Insurance may result in loss of coverage under the Group Contract.

**X** Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_

The Prudential Insurance Company of America, Newark, NJ, Prudential Financial and the Rock logo are registered service marks of The Prudential Insurance Company of America and its affiliates.



# Federal HIPAA Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

"We" refers to The Prudential Insurance Company of America in its capacity as a provider of Group and Individual Long Term Care insurance. "You" or "yours" refers to any individual covered by a Long Term Care insurance policy issued by The Prudential Insurance Company of America.

Federal law—meaning the Health Insurance Portability and Accountability Act and related privacy rules—requires The Prudential Insurance Company of America to keep your health information private. We are not allowed to use or disclose it unless we receive your permission or unless permitted by law. Federal law requires us to give you this Notice of our legal duties and privacy practices. This Notice is to inform you of uses and disclosures of your health information that we may make. It also informs you of your rights and our duties with regard to this health information.

We must follow the terms of this Notice. We do reserve the right to change the terms of this Notice and make the new Notice provisions apply to all the health information we keep. This includes health information we had prior to any change in this Notice. We must promptly change this Notice when there is a material change to our uses or disclosures, your rights, our duties and other related circumstances. We will mail you any such revised Notice, unless you have agreed to receive Notices electronically. To receive such Notices by E-mail, you should tell the contact listed at the end of this Notice.

**Use and Disclosure of Protected Health Information**  
Federal law permits us to use and disclose protected health information for purposes of treatment, payment and health care operations as those terms are defined under federal law. As an insurer, we do not provide treatment, but we may use and disclose protected health information for payment purposes, such as in connection with the payment of an insurance claim. We may also use and disclose protected health information for our health care operations such as when we decide to give you insurance or when we renew or replace your insurance. We will also comply with any state or federal law that is more restrictive as to our uses and disclosures of protected health information.

There are also times when federal law permits or requires us to use or disclose your information without your written permission.

Additionally, where appropriate, we may disclose protected health information to a group health plan or plan sponsor in accordance with federal law.

## Permitted Disclosures

We may not make all of the uses and disclosures listed here, but federal law permits use or disclosure of your information without your permission:

- When we disclose your information to you.
- To third party non-Prudential business associates that perform services for us or on our behalf, such as vendors.
- Where disclosure is required by law.
- To a public health authority authorized by law to collect or receive your information to prevent or control disease, injury or disability or when reviewing reports of child abuse or for the conduct of other authorized public health activities and responsibilities.
- To a governmental authority when we reasonably believe you may be a victim of abuse, neglect or domestic violence where the governmental authority is allowed by law to have such information.
- To a health oversight agency for such activities.
- For judicial and administrative proceedings.
- To a law enforcement official for a law enforcement purpose.
- To a medical examiner for the purpose of identifying a deceased person, determining the cause of death, or other duties authorized by law.
- To organ donor organizations in order to aid in such donations.
- For certain research purposes authorized by and subject to federal law.
- To avert a serious threat to health or safety.
- To government officials regarding military personnel and certain domestic and foreign government officials for certain functions authorized by federal law.
- To comply with workers' compensation and other similar programs.
- To make certain marketing communications and for certain fundraising purposes.

### Required Disclosures

We are required to disclose your information when required by the Secretary of the Department of Health and Human Services to make sure we comply with federal law.

We are also required, with certain exceptions, to provide you with access to inspect and obtain a copy of your information that we keep. See "Your Right To Inspect and Copy Protected Health Information" below.

### **Need for Authorization**

We will not make any uses or disclosures other than those mentioned above without your permission. You may withdraw such permission in writing. Your withdrawal will not be effective (1) if we took action relying on your permission before it was withdrawn, or (2) if we obtained your permission as a condition of issuing you insurance, and the law allows us to contest a claim under the policy or to contest the policy itself. To withdraw your authorization, please write the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

### **Individual Rights with Respect to Your Protected Health Information**

**FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO REQUEST RESTRICTIONS:** You have the right to request that restrictions be placed on certain uses and disclosures of your information. We are not required to agree. If we do agree, we may not use or disclose any of your information except where you need emergency treatment. We may end an agreement to restrict as allowed by federal law. If you wish additional information, you should write to the contact listed at the end of this Notice.

**FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO ALTERNATIVE CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION:** If you choose to have your information sent to you by a means of your choice or to an address of your choice, we will do so if the request is reasonable. You must clearly state that disclosure of all or any part of your information could endanger you if not sent per your choice. Any such request should be sent in writing to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

**FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO INSPECT AND COPY PROTECTED HEALTH INFORMATION:** You have the right to inspect and copy your information, except for any psychotherapy notes, certain information relating to civil, criminal, or administrative proceedings, and certain information prohibited by law from disclosure. We are allowed by law to deny access in some cases, and subject to certain procedures. Any request should be sent in writing to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

**FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO AMEND PROTECTED HEALTH INFORMATION:** You have the right to request that we amend your information kept in our records. We are allowed to deny your request if we did not create the information in the record. We will review your request and respond to you in writing. All requests should be in writing and sent to the contact listed at the end of this Notice. All requests should provide needed details, including your name, address, insurance policy number, and the reason you think your information needs to be changed. If you wish additional information, you should write to the contact listed at the end of this Notice.

**FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO AN ACCOUNTING:** You have the right to receive an accounting from us of disclosures of your information made for up to the six (6) years prior to your request. This right does not apply to: disclosures made to carry out treatment, payment, or health care operations; disclosures made with your permission; disclosures made for police purposes; disclosures allowed by law; or disclosures made before April 14, 2003. Any request should be sent to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

**FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO A PAPER COPY OF THIS NOTICE:** You have the right, even if you have agreed to receive notice by E-mail, to get a paper copy of this Notice. All requests should be in writing and sent to the contact listed at the end of this Notice.

**FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO FILE A COMPLAINT.** If you believe your privacy rights have been violated, you have the right to complain to us by writing to the contact listed at the end of this Notice or to the Secretary of the U.S. Department of Health & Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, Washington, DC 20201. Federal law prohibits retaliation against you for filing such a complaint. The contact listed at the end of this Notice is also available to provide you information regarding questions you have or other information concerning this Notice.

*When you contact us in writing, you should include your name, address, and policy number. The contact to whom you should address your complaint is:*

The Prudential Insurance Company of America  
Privacy Contact  
Long Term Care Customer Service Center  
P.O. Box 8519  
Philadelphia, PA 19176-8526

Telephone number: 1-800-732-0416

The effective date of this notice is March 1, 2005.



LONG TERM CARE CUSTOMER SERVICE CENTER  
 P.O. BOX 8526, PHILADELPHIA, PA 19176  
 1-800-732-0416

**AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION**

**Attn: Underwriting**

**THIS AUTHORIZATION IS INTENDED TO COMPLY WITH THE HIPAA PRIVACY RULE**

First Name	M.I.	Last Name
Name of Applicant (please print)		
Date of Birth	Social Security #	Policy #

I authorize any health plan, doctor, health care professional, hospital, clinic, laboratory, medical facility, pharmacy benefit manager, retail pharmacy, clearinghouse, data warehouse or other organization that maintains pharmacy data, MIB, Inc. formerly known as Medical Information Bureau, or other health care provider that has provided treatment or services to me or on my behalf ("My Providers"), and any other medical or insurance organization, institution or professional, to disclose my entire medical record and any other health information concerning me, without restriction, to The Prudential Insurance Company of America and its agents, employees and representatives ("Prudential"). This includes medical records and information on diagnoses and/or treatment relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted disease, mental illness, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with My Providers to restrict my protected health information and, for purposes of this authorization, I instruct any of the above providers or entities to release and disclose the entire medical record for me without restriction, including without limitation any restrictions on healthcare items or services for which a healthcare provider has been paid out of pocket in full.

This information is to be disclosed under this Authorization so that Prudential may do the following, with respect to long term care insurance I am applying for: underwrite or make rating determinations, evaluate and determine my eligibility for long term care insurance, or conduct other legally permissible activities related to my application or coverage.

This authorization shall remain in force for 24 months following the date of my signature below, unless state law imposes a shorter time. A copy of this authorization is as valid as the original. I understand I have the right to withdraw this authorization in writing, at any time, by sending a written request to: The Prudential Insurance Company of America, Privacy Contact, P.O. Box 70194, Philadelphia, PA 19176-0194. I understand that a withdrawal is not effective if any of My Providers has relied on this authorization or to the extent that Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be re-disclosed, to the extent allowable under federal law and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization, Prudential may not be able to process my application or, if coverage has been issued, may not be able to make any benefit payments. I understand that Prudential will provide me with a copy of this authorization.

**X** \_\_\_\_\_ Date

Signature of Applicant or Personal Representative

**X** \_\_\_\_\_

Description of Personal Representative's Authority or Relationship to Applicant

**PLEASE SIGN AND RETURN THIS COPY**



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**X** \_\_\_\_\_ Date

Signature of Applicant or Personal Representative

**X** \_\_\_\_\_

Description of Personal Representative's Authority or Relationship to Applicant

**KEEP FOR YOUR RECORDS**



## THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG-TERM CARE INSURANCE

### **Long-Term Care Insurance**

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should not buy this insurance policy unless you can afford to pay the premiums every year. Remember that Prudential can increase premiums in the future.
- The Personal Worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

### **Medicare**

- Medicare does not pay for most long-term care.

### **Medicaid**

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

### **Shopper's Guide**

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' *Shopper's Guide to Long-Term Care Insurance*. Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

### **Counseling**

- Free counseling and additional information about long-term care insurance are available your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

**Facilities**

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.



## 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, Prudential must fill out part of the information on this worksheet and ask you to fill out the rest to help you and Prudential decide if you should buy this insurance.

### Premium Information

**Policy Form Number(s)**      Contract Series 83500

The premium for the coverage you are considering will be \$\_\_\_\_\_ per year.

**Type of Policy** (noncancellable/guaranteed renewable): 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

We have sold long-term care insurance since 1986 and have sold this policy since 2008. The company has never raised its rates for any long-term care insurance policy it has sold in this state or any other state.

### Questions Related to Your Income

How will you pay each year's premium? (check one)

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? (Check one)

Under \$10,000       \$10,000-\$20,000       \$20,000-\$30,000  
 \$30,000-\$50,000       Over \$50,000

How do you expect your income to change over the next 10 years? (Check one)

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?** (check one)     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 average annual cost for a private room in a nursing home in 2010 was \$90,155. The average annual cost for a one-bedroom assisted living facility in 2010 was \$35,160. These figures vary across the country.*

*In ten years, the average annual cost for a private room in a nursing home would be about \$146,853 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?** (check one)

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? (Check one)

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

How do you expect your assets to change over the next ten years? (check one)

No Change                       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

**If you are an active employee or the spouse of an active employee, no further action is required. If you are not an active employee or spouse, this must be completed and signed and returned to Prudential in order for us to process your enrollment form.**

**Check one.**

- The answers to the questions above describe my financial situation.  
**or**  
 I choose not to complete this information.

**Please check the box.**

- I acknowledge that I have reviewed this form 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 coverage may increase in the future.**  
(This box must be checked).

Signed: \_\_\_\_\_  
(Applicant) (Date)

***Note: In order for us to process your enrollment form, please return this signed statement to Prudential along with your enrollment form.***

***However, if you are an active employee or the employee's spouse, you do not need to return this Personal Worksheet in order for Prudential to process your enrollment form.***

*Prudential may contact you to verify your answers.*





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Tel 1-800-732-0416

## 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 filed for an increase is \$ \_\_\_\_\_  
(fill in amount from Rate Sheet based on plan design and options you choose).

2. **The premium for this Certificate will be shown on the Schedule of Benefits you will receive together with your Certificate of Insurance.**

3. **Rate Schedule Adjustments:** The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.): No premium rate or rate schedule adjustments are scheduled for this coverage.

4. **Potential Rate Revisions:** This Certificate is Guaranteed Renewable. This means that the rates for this coverage may be increased in the future. Your rates cannot be increased due to your increasing age or declining health, but your rates may go up based on the experience of all insureds with coverage 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 coverage in force as is.
- Reduce your benefits to a level such that your premiums will not increase.  
(Subject to state law minimum standards.)
- Exercise your non- forfeiture option if purchased. (This option may be available for purchase for an additional premium.)
- Exercise your contingent non-forfeiture rights.\* (This option may be available if you do not purchase a separate non- forfeiture option.)

### **\*Contingent Non-forfeiture**

If the premium rate for your coverage goes up in the future and you didn't buy a non-forfeiture option, you may be eligible for contingent non-forfeiture. 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 coverage was first issued. If you have already received benefits, 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 benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

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

**Example:**

You bought the coverage 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 coverage (not pay any more premiums).

Your paid-up benefits are \$10,000 (provided you have at least \$10,000 of benefits remaining.)

**Contingent Non-forfeiture  
Cumulative Premium Increase over Initial Premium  
That qualifies for Contingent Non-forfeiture**

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

<b>Issue Age</b>	<b>Percent Increase Over Initial Premium</b>
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%

