2002

Long Term Care Planning Handbook

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Overview

This handbook is designed to help you – the Federal employee or retiree – understand long-term care and long-term care insurance so that you can make an informed decision about whether you need to purchase this type of insurance, and if so, the factors you should consider when buying a policy.

The handbook is divided into two sections. The first section explains long-term care and long-term care insurance generally – who needs it, how it differs from Medicare, Medicaid and other programs, and the various elements available in most long-term care insurance plans. The second section provides an explanation of the Federal Long Term Care Insurance Program (FLTCIP), which is available for purchase by those in the "Federal family," and is being administered by the U.S. Office of Personnel Management (OPM).

Defining "Long-Term Care"

Long-term care is the kind of care that you would need to help you perform daily activities if you had a chronic illness or disability. It also includes the kind of care you would need if you had a severe cognitive problem like Alzheimer's disease. It is help with eating, bathing, dressing, transferring from a bed to a chair, toileting, continence, and so forth. Long-term care can also include assistance with such tasks as shopping, transportation, housecleaning, or preparing meals. This type of care isn't received in a hospital and isn't intended to cure you. It is not acute care. It is chronic care that you might need for the rest of your life. It can be received in your own home, at a nursing home, or in another long term care facility. Long term care insurance is insurance that helps you pay for long term care services, such as home care or care in a nursing home or assisted living facility.

Many people do not think they will need long term care insurance because they are healthy. However, the odds are that you will need long term care at some point in your life, and you may need it sooner than you think. About 40% of people needing long term care are adults ages 18-64. They may have had an accident, a stroke, developed multiple sclerosis, or some other illness.

Approximately 60% of those Americans who reach the age of 65 will need long term care services at some point in their lives. Moreover, the longer you live, the higher the odds that you will need long term care eventually. While more than half of those going into a nursing home will have stays of fewer than ninety days, those who remain in nursing homes will stay an average of 2 ½ to 3 years. This is particularly true for women, who tend to live longer than men, and who consequently often develop chronic disorders that require long term care.

Health Insurance and Long Term Care

The problem with long-term care is that it can be quite expensive. It can easily exhaust your savings, which is one reason you might decide to buy long term care insurance. It is important for you to know that most health plans do not cover long term care. While health insurance plans generally cover hospital stays and doctors' bill, they often provide limited or no benefits for

nursing home care or home health care. And while they may cover some of the skilled medical services you may need when you can't care for yourself after an illness or injury, this is usually for a limited period and only as long as you are showing improvement. Health plans, including the Federal Employees Health Benefits Program (FEHBP) and TRICARE, typically do not cover ongoing chronic care such as an extended stay in an assisted living facility, or a continuing need for a home health aide to help you in and out of bed.

Medicare and Long Term Care

Medicare typically does not cover long term care. Medicare is a Federal health insurance program for people who are age 65 or older, some people with disabilities under age 65, people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant), and people with Lou Gehrig's disease (ALS, amyotrophic lateral sclerosis). Medicare will cover the first 100 days of care in a nursing home if: (1) you are receiving skilled care, and (2) you have a qualifying hospital stay of at least 3 days and enter the nursing home within 30 days of that hospital discharge. There are also some deductibles and copayments (meaning you have to pay part of the cost). Medicare also covers limited home visits for skilled care.

It's very important to realize a few things about long term care versus Medicare's coverage:

1. Most long term care is not skilled care;
2. Most long term care does not take place in a nursing home;
3. Most nursing home stays do not immediately follow a hospital stay;
4. Most people who require care in their home usually need more or different types of care than Medicare covers; and
5. Most people won't start Medicare coverage until age 65.

Therefore, don't expect that Medicare will cover your long term care needs.

Finally, while the Centers for Medicare and Medicaid Services recently made a decision to no longer exclude persons with Alzheimer's disease from accessing Medicare-covered services due to their diagnosis alone, be aware that Medicare still only covers skilled care under certain conditions for a limited period of time. All the restrictions on receiving nursing home care or home care, including a prior hospital stay and need for skilled care, as well as required deductibles and copayments, still apply. Alzheimer's disease is a chronic illness. Persons with this illness typically require non-skilled, custodial care for long periods of time. This type of care is still not covered under Medicare, but the change in Medicare's policy has left many with the impression that it might be.

Medicaid and Long Term Care

Many people also believe that Medicaid will cover their long term care needs. However, Medicaid (called "Medi-Cal" in California) is a state-based program supplemented by Federal funds that acts as a safety net to provide health services to the poor and impoverished. Medicaid covers long term care services and might cover you if you meet your state's poverty criteria and receive care that meets your state's guidelines. Usually this means expending all but $2,000 of your assets and savings (except for perhaps your house and your car). It also means receiving care from a limited number of state-approved caregivers (mostly institutions like nursing homes)

that are willing to accept Medicaid payments. People that you wouldn't consider poor sometimes qualify for Medicaid by "playing the game" and "beating the system," usually with legal help. States usually react with more rules.

If you don't have much in the way of assets and income, Medicaid is probably your best bet for long term care. If you can afford long term care insurance, want to control the type and location of care that you receive, and aren't interested in - or don't want to count on – "beating the system," you should consider purchasing long term care insurance.

What Long Term Care Costs

The cost of long-term care depends on where you live and the kind of care you receive. There are generally three kinds of long-term care: nursing home care, assisted living facility care, and in-home care. Nursing home care is the most intensive kind of care, and usually costs the most. Assisted living facility care is for people who don't need nursing home care, but who are unable to remain in their own homes. Home health care is the least expensive kind of care, and is generally for those who can still function well on their own as long as they have some assistance from a home care worker.

Nursing Home Care

For nursing home care, the national monthly average is now $4,654, which translates into $55,848 annually. This covers room and board, but not the cost of medication, therapy, rehabilitation, or incidental expenses. The average cost for nursing home care currently ranges from a low of $36,000 per year in Louisiana to a high of $163,000 per year in Alaska.

Major metropolitan areas can be expensive for nursing home costs. An average nursing home in the New York City metropolitan area costs $106,500 annually; Washington, D.C. costs $88,000; Hawaii costs $86,900; the Boston metropolitan area costs $82,200; New Jersey costs $80,900; and the Philadelphia metropolitan area costs $79,900. This means that based on current averages, the cost of an average nursing home stay totals more than $130,000.

The U.S. Department of Labor says that the cost of nursing home care will likely rise dramatically over the next thirty years, reaching $190,000 per year. By 2030, the average nursing home stay is expected to cost about $495,560.

Assisted Living Facilities

"Assisted living facilities" (which can also be called "Assisted Care Communities" or "Domiciliary Care") are a fairly new form of residential care intended for people who do not require skilled nursing care, but who cannot live on their own safely because they need assistance with their daily activities, such as bathing, dressing, or taking their medications. These types of facilities often bridge the gap between living at home and moving to a nursing home.

Assisted living facilities cover a wide range of possibilities, from group homes in which residents share rooms to luxurious private apartments. While services vary widely, a typical package may include a 24-hour on-call staff to help residents with bathing, toileting, dressing, and so forth; a call button in each unit for emergencies; help with managing medications; laundry and housekeeping services; meal service in a dining hall; and recreational and social activities.

Residents who develop health conditions that require closer monitoring may need to move from an assisted living facility to a nursing home.

The cost for assisted living facilities typically runs from approximately $1,300 - $3,200 or more per month. The cost of a facility will depend on its geographic location, the housing environment, and the extent of services provided. Some assisted living facilities offer Alzheimer's care, but others do not. Care for someone with Alzheimer's disease is more expensive, and typically ranges from $2,800 to $3,800 per month for a shared suite.

Home Care

Home care is another option for those who are unable to live at home completely independently. Home care can be an attractive option for those people who are able to function relatively well on their own, but who may need visits several times each week from a home care nurse, nurse's aide, or home worker who can help with chores and other needs. People who require lengthy, daily visits may find it more cost-effective to move to an assisted living facility.

The average annual cost for at-home long term care is currently approximately $20,000. Depending on the number of visits you need and your geographic location, that cost can be substantially higher. By the year 2030, it is estimated that the cost for at-home care will rise to about $68,000 annually.

Paying For Long Term Care

The bottom line is that many of us are going to need long term care at some point, and health insurance, Medicare, and Medicaid are most likely not going to pick up the tab. This means that there are generally three options for paying the cost of long term care – either "self-insuring," which means saving enough so that you can pay for your long term care needs out of your own assets and savings, relying on family members to provide care, or purchasing a long term care insurance policy.

If you are interested in "self-insuring," know that you are going to need to set aside a very large "nest egg" to provide for your long term care needs, as well as your normal retirement expenses. If you are married, be sure to consider the possibility that you or your spouse may eventually need long term care services in a facility, while the other remains at home. Therefore, you need to have enough saved to cover both the cost of a nursing home or assisted living facility and the cost of maintaining your home.

If you are interested in exploring this as an option, you must consult with a financial planning expert – preferably one who specializes in retirement planning - to determine whether you have (or can generate) sufficient savings and assets to self-insure. Considering the fact that long term care is already fairly expensive, and that these costs are rising, self-insuring is probably not going to be a viable alternative for most people.

Of course, the advantage to self-insuring is that you won't have to pay the cost of long term care insurance premiums. The downside is that you may require long term care services sooner than you expect and before you are able to generate sufficient savings to pay for your care out-of-pocket. Another problem is that you may run out of money to cover your long term care and

other retirement needs. Finally, you may exhaust your estate so that you have little to leave to your heirs.

Some people believe they don't need long term care insurance because they plan to rely on their family members to provide this care when the time comes. Unfortunately, this expectation is not always practical. Family members may not have the necessary training to provide such care, particularly if skilled nursing care is needed. Additionally, work schedules or their own ill health may interfere with their ability to provide such care over a lengthy period. There is also the possibility that the anticipated caregiver may die unexpectedly, leaving you too old or ill to qualify for an affordable long term care policy. Relying on family members to provide long term care may seem like a good solution in theory, but may not be the best plan in reality. In any event, if you intend to rely on family members to provide you with long term care, you need to sit down with them and have a frank talk about your expectations and plans. You don't want to be in a situation where you forego purchasing long term care insurance only to discover that your expected caregiver(s) are unwilling or unable to provide you with the necessary care.

The third option is to purchase long term care insurance. The two primary reasons for purchasing long term care insurance are: (1) so you can rest assured that you will receive the necessary care if you develop a chronic illness or disability, and (2) to protect your savings and assets for your own needs, your spouse's needs, if any, and/or for your heirs.

Be aware that there are a wide variety of long term care insurance plans available, so if you decide to buy long term care insurance, you need to spend some time looking for the best plan for you and your budget. Here are just a few general rules to keep in mind:

1. As with any other major purchase, shop around before you buy long-term care insurance. When evaluating different long-term care insurance plans, be sure you are making an "apples to apples" comparison. You need to understand each of the elements contained in the various plans, and how they compare to one another before you choose a particular plan.
2. Make sure that you can afford the premiums for life. It makes no sense to purchase long-term care insurance that you cannot afford after you retire. You do not want to have to drop the coverage just as you approach the time when you may need it most. There is usually enough flexibility in the various long term care insurance plans so that you can structure a plan that will cover your most vital long term care needs while keeping your premiums affordable. For instance, you can often customize your inflation protection or change the length of your waiting period before your benefits begin paying out in order to keep your premium lower, if need be.
3. If you decide to purchase the insurance, be sure you buy from a reputable company that has been in business for a significant period of time and has a good track record. You don't want to buy long-term care insurance from a company that may go out of business just when you need the benefits.
4. If you decide you want long-term care insurance, apply for the insurance while you are still healthy. As with any insurance product, you are not going to qualify for coverage if you need the benefits at the time you apply, or if it is apparent that you will need them shortly thereafter.

5. Lastly, be completely honest and forthright when answering questions about your health. If you lie on your application – or omit pertinent information about your health – the company can deny you benefits and cancel your coverage.

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Elements of a Long Term Care Insurance Plan

After consulting with your financial advisor, if you decide you should purchase long-term care insurance, you need to become familiar with all of the different elements that typically make up a long term care insurance plan. This chapter describes each of those elements, so that you can make an informed decision about which kind of plan is best for you.

Here are some terms you need to know when choosing a long term care insurance plan:

- Daily Benefit Amount
- Benefit Period
- Inflation Option
- Elimination Period
- Nonforfeiture Benefit
- Home Health Care
- Alternative Plan for Care
- Spousal Discount
- Gatekeepers, Qualifiers, or Triggering Events
- Premium
- Group versus Individual Plan
- Guaranteed Renewable

Daily Benefit Amount

The daily benefit amount is the amount of money that your long-term care insurance plan will pay for eligible care each day. Generally, when choosing a policy, you will have a choice of daily benefit amounts. They can go up to more than $240 per day for nursing home care, and up to $150 or more a day for home health care. Remember that the higher the daily benefit amount, the higher the cost of the insurance premium.

As explained in the last chapter, the national monthly average for nursing home care is now $4,654. This translates into approximately $155 per day ($4,654 divided by 30 days). But remember, this figure is a national average. The cost of nursing home varies widely, depending on your geographic area. Therefore, you need to research the cost of nursing home care in the area in which you plan to use those benefits.

Once you know the cost of nursing home care and home health care in the area in which you plan to use those benefits, you then need to decide how much of those costs you want your long term care insurance policy to cover. For example, if the cost of nursing home care in your area is $155 per day and you want your long term care insurance to cover 100 percent of your costs, then you would need to purchase a policy with a daily benefit amount of $155 or more. Alternatively, you could purchase a policy with a lower daily benefit amount, and plan to make up the difference using your savings.

Again, before choosing the daily benefit amount for your policy, you need to do some research to find out the daily cost for nursing home care and home health care in the area in which you plan to use those benefits. Some areas are much more expensive than others. If you anticipate using your long term care benefits in an area with a high cost of living, then you'll probably want to choose a higher daily benefit amount. A policy with a daily benefit amount of $150 may not cover your costs in a place such as New York City (where the average cost per day for nursing home care is $214) but may be more than enough if you plan to retire in Utah, where the average cost per day for nursing home care is $105.

Benefit Period

The benefit period is the length of time your long term care insurance will pay benefits. Some plans may pay benefits for just a few years, while others offer a lifetime benefit. Choosing a lifetime benefit is the ideal option. However, the longer the benefit period, the higher the premium cost. Bearing in mind that the average nursing home stay is just under three years, you should probably choose a benefit period of at least four years. But remember – this is a bare minimum. If you can afford it, you would be much better off choosing a longer benefit period in case you have a lengthy nursing home stay.

Inflation Protection

The cost of long term care is rising. On average, nursing home care now costs $55,848 annually. But the Labor Department estimates that over the next thirty years, that figure is expected to rise nearly four times – to $190,000 per year. That means that while a daily benefit amount of $150 may well cover 100 percent of your nursing home care today, it may only cover 20-25 percent of your nursing home costs 30 years from now, leaving you to pay the difference out of pocket. That's why inflation protection is such an important part of long term care insurance. As the cost of long term care rises, you want to make sure that your daily benefit amount rises too. Inflation protection in a long term care insurance policy is simply a provision that increases your daily benefit amount – or gives you the option to increase your daily benefit amount – to help keep pace with the rising cost of long term care. Therefore, when pricing your policy – or when comparing policies – pay close attention to the kind of inflation protection included in the plan.

The most common kind of inflation protection automatically increases your daily benefit amount by a certain percentage each year. Many plans offer an annual increase of 5 percent each year. You are usually given a choice of whether you want 5 percent simple interest or 5 percent compounded interest. Be aware that the compound interest option will give you more inflation protection than the simple interest option will. (See the table below entitled, "Comparison of Simple versus Compound Interest.") While both will increase your daily benefit amount to help you keep pace with inflation, the compound interest option will result in a higher daily benefit amount over time. Naturally, this means that the compound interest option is going to be more expensive than the simple interest option. Choose the compound interest option if you can afford it. If you can't, choose the simple interest option. Some policies will also permit you to purchase additional insurance in the future – but at your current age rate - so that you can increase your daily benefit amount at a later time. Others will let you purchase additional insurance in the future, but will base the cost on your age at the time you purchase the extra insurance.

Whichever kind of inflation protection you choose, pay attention to whether the policy imposes a cap on the growth of your inflation protection. Some policies will cap growth either through an age limitation or by a particular amount.

If money is no object, the ideal policy would have the compound interest inflation protection with no cap on age or amount. If you can't afford to do that, then choose simple interest or opt for the ability to purchase additional insurance in the future.

If you are over the age of seventy when buying long term care insurance, you may be better off purchasing a policy with a higher daily benefit amount and no inflation protection. If nursing home costs in your area are $93 per day, for example, it may make more sense economically to purchase a policy with a daily benefit amount of $150 and no inflation protection, rather than purchasing a policy with a daily benefit amount of $100 and inflation protection. The extra $50 in the daily benefit amount ($150 versus $100) may be sufficient to cover your inflation protection needs, since presumably you will use the benefits sooner rather than later. Proceed with caution if you choose this strategy – and be sure to consult with your financial advisor and long term care agent before going this route. And remember - this is not a good strategy for those under the age of 70! Those under 70 may not use their long term care benefits for many years, and no matter how large of a daily benefit amount you choose now, chances are that it won't be nearly large enough to protect you against inflation decades later. Those under 70 must have some kind of inflation protection as part of their policies.

The bottom line is that inflation protection is one of the most important elements of a long term care insurance policy. As explained in chapter 1, however, you must be able to afford the premium for the rest of your life. Whichever kind of inflation protection you choose, make sure you can continue to pay the premium.

Comparison of Simple versus Compound Interest

Year	$100 Daily Benefit Amount	5% Simple Interest	5% Compound Interest
1	$100	$100	$100
2	$100	$105	$105
3	$100	$110	$110
4	$100	$115	$116
5	$100	$120	$122
6	$100	$125	$128
7	$100	$130	$134
8	$100	$135	$141
9	$100	$140	$148
10	$100	$145	$155
11	$100	$150	$163
12	$100	$155	$171
13	$100	$160	$180

14	$100	$165	$189
15	$100	$170	$198
16	$100	$175	$208
17	$100	$180	$218
18	$100	$185	$229
19	$100	$190	$240
20	$100	$195	$252
21	$100	$200	$265
22	$100	$205	$278
23	$100	$210	$292
24	$100	$215	$307
25	$100	$220	$322
26	$100	$225	$338
27	$100	$230	$355
28	$100	$235	$373
29	$100	$240	$392
30	$100	$245	$412

Elimination Period

The elimination period is the period of time for which you need long term care but you do not receive paid benefits. It is something akin to a car insurance deductible. During the elimination period, you must cover the entire cost of your long term care out of your own pocket. When purchasing a long term care insurance plan, you typically get to choose how long you want the elimination period to be. They are generally between zero and ninety days. The longer the elimination period, the lower the premium cost.

It works like this. Say you have a long term care policy with an elimination period of ninety days. The cost of the nursing home you enter is $127 per day, and your stay lasts six months. Under the policy, you would be responsible for paying $11,430 for the stay – that's the daily cost of the nursing home ($127) times the elimination period of 90 days. After ninety days, the long term care policy would kick in, and assuming the daily benefit amount is $127 or more, you would no longer have to pay for your stay.

Thus, the rule is the shorter the elimination period, the better. The ideal policy would have a zero-day elimination period. Be sure to compare the premium cost of a shorter elimination period and a longer elimination period. If the cost of the shorter elimination period is not significantly higher, choose the shorter period.

One final note on elimination periods. Be sure to ask whether the elimination period applies to each stay, or if you need to satisfy it only once. If you have to go in and out of a nursing home or other long term care facility several times, you want a policy that requires you to satisfy the elimination period only once.

Nonforfeiture Benefit

A nonforfeiture benefit is a provision in the policy that says that if you do not use your long term care benefits after a certain amount of time, a portion of your premiums will be returned to you or your heirs. Some people like this benefit because they feel that it protects them from "wasting" their money on long term care insurance. If they don't end up using the long term care benefits, they get some of their money back. Be careful, though. Policies with nonforfeiture benefits can cost substantially more than those without a nonforfeiture benefit. Rather than paying the extra money for the nonforfeiture benefit, you are probably better off saving that money and investing it. Consult with your financial advisor to see what is best for you.

Home Health Care

"Home health care" – or "home care" – is a long term care benefit that covers the cost of visits to your home by a home health care worker, licensed therapist, chore worker, or homemaker. Care can range from visits by a health care worker to someone who cooks meals, does chores like grocery shopping, or helps with bathing or other needs.

Since the vast majority of people would rather receive care in their own homes rather than move to an assisted living facility or a nursing home, you should check to see if the long term care policy you're considering includes this benefit, and how much coverage it provides. Home health care tends to be less expensive than care provided in a nursing home, so most long term care insurance will pay a daily benefit of 50-80 percent of your skilled nursing care coverage for this type of benefit.

You should do some checking to determine how much home care costs in the area where you will likely be receiving benefits. A good rule of thumb is to get a policy that covers a minimum of two years' (or 730) worth of visits.

Alternative Plan for Care

Long term care insurance companies often permit you some flexibility in deciding where you will receive care – at home, in an adult day care center, an assisted living facility, a nursing home, or elsewhere. This provision allows you to choose where to receive care as long as you, the insurance company, and your health care provider are all in agreement. It is often a good provision to have in a policy because it gives you additional options for your care.

Spousal Discount

Couples purchasing long term care insurance from the same company can often get a 10 to 15 percent discount on their premiums. Be sure to ask about any spousal discount when shopping for a long term care insurance policy. You may still get the spousal discount even if you and your spouse purchase policies at different times from the same company, so be sure to ask.

Gatekeepers, Qualifiers, or Triggering Events

In order for your long term care policy to start paying benefits, you must satisfy certain requirements. These requirements are frequently called "gatekeepers," "qualifiers," or "triggering events." Some of the most common are:

- Activities of Daily Living (ADLs). The usual ADLs are bathing, feeding, dressing, transferring (which means moving into or out of a bed, chair, or wheelchair), continence,

and using the toilet. Many policies require that you not be able to perform two of the six ADLs in order for benefits to begin.
- Cognitive Impairment. You have a mental impairment, such as Alzheimer's disease, that prevents you from caring for yourself without supervision
- Medical Necessity. A doctor certifies that you need the care and makes a request for the care.

Find out what kind of triggering events your policy requires. As a general rule, a policy that allows you to begin receiving benefits when you satisfy any one of the three triggering events described above is best. Be sure to get a copy of the actual policy(ies) you are considering so you can see exactly what the triggering events are and how they are defined by that particular company. Long term care insurance companies often vary in how they define triggering events.

Premium

The premium is the amount of money you pay for your long term care insurance policy. The premium will depend on the kind of coverage you choose, your age and health status, and the insurance company you select.

Usually you will be able to choose whether you want to pay your premiums annually, semi-annually, quarterly, or monthly. Before you choose a payment term, do a few quick calculations to make sure you will not pay more if you opt to pay semi-annually, quarterly, or monthly. Since insurance companies usually prefer that you pay annually, some will charge you extra if you pay any other way.

Group versus Individual Plan

It is important for you to know whether you are planning to purchase a group or an individual long term care policy. Many people assume that purchasing a group plan will always be the better deal, but this isn't necessarily the case. Both group plans and individual plans have their advantages and disadvantages, so once again, you need to do your homework to be sure you purchase the best plan for you.

One advantage of an individual plan is that the contract (the insurance policy) is between you (the policyholder) and the insurance company. When you purchase the policy, you and the insurance company agree to particular benefits and requirements at a certain price. Because you are the policyholder, the insurance company cannot make any changes to the policy unless you consent.

In a group plan, however, you are not the policyholder. Rather, the contract is between the insurance company and some third party – usually your employer or an association to which you belong. You are covered under the plan as an "insured" and are listed on a certificate of insurance, but the policyholder is your employer, association, or some other entity. This means that the policyholder – your employer or association - and the insurance company can modify or even cancel the policy without your consent. One other potential problem with group plans is that they typically allow for little flexibility in coverage. Under a group plan, you may have to make due with lengthier elimination periods or less inflation protection than you would prefer.

The point is, if you have the opportunity to purchase a group plan, don't just buy it without shopping around. You still need to do your homework - you may find that you can get better coverage for a lower cost with an individual plan. And if the group plan ends up being the better buy, you can rest easy knowing you got the best deal available.

Guaranteed Renewable

A policy that is "guaranteed renewable" means that as long as you pay your premiums within the specified time frame, you will be insured for life. This is a must in any long term care insurance policy you purchase, particularly if it is a group plan. You want a plan that is guaranteed renewable each year for life.

3

Tips on Choosing an LTC Insurance Plan

Choosing An Insurance Company

One of the most important decisions you will make when shopping for a long term care insurance plan will be choosing an insurance company. Before you buy any policy, make sure you are working with a reputable company. You are going to spend thousands of dollars to purchase long term care insurance, so do a little digging to make sure you are working with a company that is financially sound. You may not need to start collecting benefits for many years, so you want to make sure the insurance company that sold you your policy is still going to be in business when you need those benefits.

A good rule of thumb is to look for a company that has been providing long term care insurance – and paying claims – for several years. Also, look for a company that has received a good financial rating from two or more of the independent rating services. Some independent rating services are:

- A.M. Best
- Standard & Poor's
- Moody's
- Duff & Phelps

For A.M. Best, you want a company with a rating of "A++". For Standard & Poor's and Duff & Phelps, look for a rating of "AA" or better. For Moody's, look for a rating of "Aa" or better.

The independent ratings services often provide ratings of insurance companies on their websites. The web site addresses for the four independent rating services mentioned above are:

A.M. Best	**http://www.ambest.com**
Standard & Poor's	**http://www.standardandpoors.com**
Moody's	**http://www.moodys.com**
Duff & Phelps	**http://www.duffllc.com**

Again, always compare several insurance companies, their benefits, limitations, exclusions, and premiums before you purchase a policy. Work only with an agent who answers all of your questions completely, and who makes you feel comfortable. Don't work with an agent who tries to pressure you into buying a policy quickly, or engages in other "hard sell" tactics.

Be sure to ask the agent for an "Outline of Coverage," which highlights the main features of the plan. This document should be provided to you upon your request, without you having to fill out an application or provide any personal information. If the agent or company gives you any trouble about providing you with this document, keep looking. You don't want to buy a policy from them.

Once you collect the "Outline of Coverage" for all of the plans you're interested in, compare the benefits, limitations on coverage, premiums, and any exclusions to see which is best for you.

Choosing A Plan

In addition to the standard elements of a plan covered in the previous chapter, check the policies you are considering to see how they stack up against each other on the following points.

1. Does the policy require a hospital stay before you can begin receiving benefits? The vast majority of policies these days don't, but be sure the ones you are considering don't have this as a precondition.

2. Does the policy cover home care, as well as care in a nursing home or other facility? You don't want to be forced to move to a nursing home or other facility in order to receive care.

3. Does the policy cover both adult day care and "personal care" (sometimes called "custodial care")? You probably want a policy that covers both these kinds of care.

4. Does the policy require that home health care be provided by someone from a certified home health care agency or a professional health care worker in order to be covered? Generally, you don't want this kind of limitation in your policy.

5. Ideally, you want a policy that does not exclude preexisting conditions at all. If you can't get that, then you want a policy that excludes preexisting conditions for no longer than six months.

6. The policy should allow you a "grace period" so that you do not have to pay premiums while you are collecting benefits. Once you are on your feet again (have left the nursing home, for instance, and are no longer collecting benefits), you begin paying premiums again.

7. The policy should require you to satisfy the elimination period just one time. If you have an elimination period of 30 days, for example, and enter a nursing home, you pick up the tab for the first thirty days, during the elimination period. After the 30-day elimination period ends, your long term care insurance benefits kick in, and the insurance company pays for the nursing home care. If you then leave the nursing home, but have to return for a second stay, you don't want to have to satisfy the 30-day elimination period again. You want a policy that requires you to satisfy the elimination period only once, with the insurance company picking up the entire tab if you have to reenter the nursing home (or receive another kind of care) multiple times.

8. Under the policy your premiums should not increase unless the increase is an across-the-board increase for all the insured in a particular area or group.

9. The policy must be "guaranteed renewable," which means that as long as you pay your premiums, you will be covered.

10. Check to see if the policy you are considering qualifies as a tax-deductible policy. You want a policy that is tax-deductible.

11. Look for a "restoration of benefits" feature, if you buy a policy that does not have a lifetime benefit. A restoration of benefits feature allows the full benefit period to be restored if you recover and do not use any benefits for a particular period of time. For example, say you have a policy with a six-year benefit period. You enter a nursing home, your long term care insurance kicks in, and the insurance company pays for your nursing home care for a year, which would normally leave you with five years remaining on your benefit period. After a year, you recover, leave the nursing home, and do not draw on any of your long term care benefits for two years. The restoration of benefits feature would require the insurance company to restore your original full benefit period – six years – since you did not draw on your long term care benefits for that two-year period after leaving the nursing home. Some companies offer policies that will restore your full benefits if you do not use any benefits for a certain period – often 180 days. (Of course, if you purchase a policy with a lifetime benefit, this is not a concern, since your benefits will never run out.)

12. Make sure the policy provides you with a "free look" period. This means that you are given a certain period of time to cancel the policy and get all of your money refunded if you decide you don't want the policy after purchasing it.

13. The policy should have a grace period for paying the premiums. This means that the policy should stay in effect even if you are a little late in paying your premium. This is crucial. You don't want the policy to be cancelled just because you forgot to pay a premium on time.

14. The policy should have a provision that allows you to designate some third party – a family member or your attorney, for instance – to receive notification from the insurance company if you fail to pay a premium. This is a good way to protect yourself from having your coverage dropped in the event you start becoming incapable of managing your own affairs. The designated third party can make sure the payments get made so you maintain your long term care insurance coverage.

Purchasing Your Policy

Some final advice before you purchase a long term care insurance policy:

1. Be sure you understand all aspects of the written policy before you purchase it. If you don't understand a particular paragraph, make your insurance agent explain it to you to your satisfaction. We say "written policy" because that is what you are actually purchasing. Don't rely on what the agent told you orally – what's important is what is in the written policy. Ideally, there should be no difference between what you were told and what is in the written policy – but read the policy carefully to be sure.

2. Consult with your financial planner and other professional advisors before you purchase the insurance to make sure you will be able to afford the premiums for life, and that you are buying a policy that fits your particular needs.

3. Be completely honest and forthright when answering medical questions. We've said it before, but it's important, so we're saying it again. If you lie on your medical questionnaire and the insurance company finds out about it, they can deny you benefits and cancel your coverage.

4. Never pay your agent in cash. Only make payments by check, and write out the check to the insurance company, not to the agent.

5. Keep a copy of your policy in a safe place, such as a safe deposit box. You want to be able to refer to it if you have any questions or disputes about coverage.

Worldwide Assurance for Employees of Public Agencies
7651 Leesburg Pike, Falls Church, VA 22043
Toll Free LTC (800) 243-5569
Website: www.waepa.org
Email: info@waepa.org

Protect yourself *today* with long-term care coverage

Nobody wants to think ahead to a time when they will need daily help due to illness or infirmity. However, this year alone, an estimated nine million individuals will need some form of long-term care (LTC),* and the average cost of one years stay in a nursing home is $46,000.**

Choosing WAEPA for your coverage

WAEPA offers coverage to Civilian Federal Retirees, Employees, and their spouses, as well as parents and parents-in-law. It is a non-profit association that has been serving Civilian Federal and U.S. Postal Service Employees and their families since 1943 and is governed by a Board of Directors composed of senior level government officials who serve on a voluntary basis.

Coverage includes:

- Automatic group sponsored discount
- Additional discounts based on your marital and health status
- Home Health Care Inflation Protection Options

Some more facts to consider:

- The Federal LTC program has recently become available and we recommend that you compare its prices and coverage options to those offered by WAEPA. In many instances you will find WAEPA offers lower premium rates for comparable coverage.
- LTC benefits under Medicare are limited and require a previous hospital stay
- Medicaid typically requires you to deplete most of your personal assets before qualifying you for LTC
- WAEPA premiums are level and cannot be increased due to a change in your health, age or claims history.

WAEPA has been offering long-term care insurance since 1998. Recently, the program was expanded to include parents and parents-in-law of WAEPA members. Visit our web-site at www.waepa.org for a large informational section devoted to LTC insurance and WAEPA's LTC program. The web site will also allow you to design your own personalized plan and request a premium quote, or you are welcome to contact one of our LTC representatives at 1-800-243-5569.

**Source: CNNfn, Aug. 26, 1999*
***Source: Health Insurance Association of America*

3

The Federal Long Term Care Insurance Program

The Federal Long Term Care Insurance Program (FLTCIP), available to Federal and Postal employees and annuitants, members and retired members of the uniformed services, and qualified relatives, is expected to become the largest employer-sponsored long term care insurance program in the country. OPM estimates that approximately 20 million people will be eligible to apply for the program.

The FLTCIP is a result of the Long Term Care Security Act (PL 106-265), which was signed into law on September 19, 2000. OPM awarded the FLTCIP contract to Long Term Care Partners, LLC on December 18, 2001. John Hancock and MetLife partnered to form Long Term Care Partners, LLC.

Coverage through the FLTCIP is being offered to the "Federal family" on a voluntary basis. Premiums will be paid fully by the enrollees – there is no government contribution, unlike the Federal Employees Health Benefits Program (FEHBP). Employees do not choose the company through which to purchase their long term care insurance. The insurance is provided through the MetLife and John Hancock partnership.

The initial contract between OPM and LTC Partners is for a term of seven years. By law, OPM cannot automatically renew the contract at the end of the 7-year term. OPM says that it will continually evaluate LTC Partners' performance against annual performance goals, and before the 7-year period ends, will perform an extensive review of LTC Partners' performance against that of the best performing providers of long term care insurance services. OPM will then determine whether it is in the best interests of the FLTCIP enrollees to renew the current contract for another 7 years. If OPM decides not to renew the current contract with LTC Partners, it will issue a new Request for Proposals and choose a new contractor. Even if there is a new contractor, OPM says that the new contractor will automatically assume the responsibilities for the current enrollees, and in the interim, LTC Partners would stay on until the transition to the new contractor is complete.

Open Season

The open season will be held from July 1 to December 31, 2002, with staggered 60-day enrollments within that time period. OPM says that it will release more details on this later.

To apply for coverage under the FLTCIP during open season, you will have to undergo underwriting (meaning you will be asked health-related questions). Employees and members of the uniformed services and their spouses will be subject to abbreviated underwriting. All other eligible groups will be subject to full (long form) underwriting. Anyone eligible to use the abbreviated underwriting application will have to answer additional questions if they want to

apply for the unlimited benefit period during open season. The abbreviated underwriting questions plus the additional questions for the unlimited benefit period are still fewer questions than full underwriting, but more than the abbreviated underwriting questions for the 3-year or 5-year benefit period. (See Appendix A to view the underwriting questions.)

All of the benefits available in the FLTCIP will be available during the open season. In addition to the limited benefits that were available during early enrollment, there will also be weekly benefits, an unlimited benefit period, a facilities-only option, non-standard insurance and a services-only non-insurance package. As indicated above, Federal and Postal employees and members of the uniformed services and their spouses who apply for the unlimited benefit period will have to answer more questions about their health than if they apply for the 3-year or the 5-year benefit period. OPM says it will have more details on these options at the end of June 2002.

During the open season, you will have three options for paying your premiums for the FLTCIP. You will be able to choose from payroll or annuity deduction, automatic debit from your checking or savings account, or direct billing from LTC Partners. In addition, during open season, your premiums will be calculated based on your age on July 1, 2002.

If you apply during the open season and your application is approved, your coverage will be effective on the later of October 1, 2002, or the 1st of the month after your application is approved (called your "original effective date"). Federal and Postal employees and members of the uniformed services must also be "actively at work" on that effective date. If you are not, the coverage will not become effective on that original effective date. Instead, it will become effective on the first day of the month after the day you return to being actively at work, provided that you are actively at work on this revised effective date. If your original effective date or your revised effective date is a weekend or holiday, you need to be actively at work on the last work-day before that date. You must notify Long Term Care Partners if you are not actively at work on your original or revised effective date. You must also notify Long Term Care Partners if your health or eligibility status changes in a way that would change your answer to a question on the application that you completed.

For Federal and Postal employees, "actively at work" means:

- You are reporting for work at your usual place of employment or other location to which government business requires you to travel;
- You are able to perform all the usual and customary duties of your employment on your regular work-schedule; and
- You are not absent from work due to sickness, injury, annual leave, sick leave or any other leave (for employees working an alternative work schedule, an "AWS" day off counts as a day you are "actively at work").

For members of the uniformed services, "actively at work" means that you are on active duty and are physically able to perform the duties of your position.

If you apply while you are in an eligible group, but then leave the eligible group before your insurance is effective, your insurance may still become effective. You must be in the same eligible group on the date you apply for the insurance and on the date the insurance is supposed

to become effective. Generally, if you leave the eligible group during this time period, your insurance will not become effective. But there are some exceptions:

- If you retire from active service after you apply but before the coverage effective date, you must reapply using the long form application, as a retiree.
- If you apply as an employee and are involuntarily separated from your Federal job (other than for gross misconduct) after you apply but before your coverage effective date, your coverage will still become effective.
- If you apply as a qualified relative and the eligible person that you are related to either dies or is involuntarily separated from Federal service after you apply but before your coverage effective date, your coverage will still become effective.

Open season applications will be available by July 1, 2002 by calling 1-800-LTC-FEDS (1-800-582-3337) or TDD 1-800-843-3557.

Benefits

Enrollees in the FLTCIP will be eligible for benefits after meeting the following conditions. Benefits are payable after these conditions are met and any required waiting period is satisfied. You will be eligible for benefits when:

1. A licensed health care practitioner certifies that (a) you are unable to perform 2 of 6 activities of daily living (ADLs) and your condition is expected to last at least 90 days, or (b) you need substantial supervision due to a severe cognitive impairment.
2. Long Term Care Partners agrees with the certification;
3. A licensed health care professional develops a plan of care for you and LTC Partners approves that plan of care.

Activities of Daily Living (ADL) are common activities that people perform every day, specifically:

- bathing: washing your hair, washing yourself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower;
- dressing: putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs;
- transferring: moving into or out of a bed, chair, or wheelchair;
- toileting: getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene;
- continence: maintaining control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, performing associated personal hygiene (including caring for catheter or colostomy bag); and/or
- eating: feeding yourself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

Severe Cognitive Impairment is an impairment or loss in:

- Short or long term memory; or
- Orientation as to person, place and time; or
- Deductive or abstract reasoning.

Such an impairment or loss places you in jeopardy of harming yourself or others, and therefore means that you are in need of substantial supervision by another person. The most common form of cognitive impairment is advanced Alzheimer's disease.

The FLTCIP offers a benefits package that pays benefits toward a variety of services, including but not limited to:

- nursing home care
- assisted living facilities
- home care (both formal and informal)
- adult day care
- hospice care
- respite care when your primary caregiver needs a rest (limited to 30 days times your Daily Benefit Amount per calendar year)
- bed reservations (payments to a nursing home or assisted living facility to hold a bed if you are a resident of that facility and need to be temporarily hospitalized or out of the facility on therapeutic leave - limited to 30 days times your Daily Benefit Amount per calendar year).

The FLTCIP provides reimbursement for the following covered services, as long as they are part of a written plan of care approved by LTC Partners, up to the percentage of your daily benefit amount listed next to the covered service:

Covered Services	Reimbursement Up To:
Nursing home, hospice facility, or assisted living facility	100% of your daily benefit amount
Hospice care at home	100% of your daily benefit amount
Home care provided by a formal caregiver	75% of your daily benefit amount
Adult day care center	75% of your daily benefit amount
Informal caregiver services**	75% of your daily benefit amount
Caregiver training**	100% of your daily benefit amount
Respite services**	100% of your daily benefit amount
Bed reservations**	100% of your daily benefit amount

**Specific lifetime or calendar year limitations apply to certain benefits as follows:

- Informal caregiver services provided by family members - benefits are limited to 365 days in your lifetime. (Note: Family members who provide the care may not live in your home at the time you become eligible for benefits.)
- Caregiver training - benefits are limited to 7 days multiplied by your daily benefit amount in your lifetime.
- Respite services - benefits are limited to 30 days multiplied by your daily benefit amount per calendar year.
- Bed reservations - benefits are limited to 30 days per calendar year.

Bear in mind that the FLTCIP won't pay for care given by people who normally live with you, such as your spouse. OPM says that there are several reasons for this restriction. First, persons who normally live with you are natural sources of long term care services. Insurance, by

definition, is not intended to cover services that would be provided without cost to the person receiving care in the absence of insurance. This helps to keep the cost of the insurance down. Second, the long term care insurance industry does not normally cover such services, and OPM says that it tried to follow standard industry practice for benefits whenever possible. OPM also says that it is possible that in the future, as the industry and the FLTCIP gain experience with the cost implications of how such services are utilized, coverage for care by family members could be expanded. Finally, the FLTCIP does provide a respite care benefit that is not subject to the waiting period. This benefit allows your regular caregiver (such as your spouse) to have a break from caring for you. The respite benefit will pay for services provided to you in a facility or by a formal or informal caregiver at home, for up to 30 times your daily benefit amount per calendar year. In addition, the FLTCIP provides a caregiver training benefit, also not subject to the waiting period. This benefit will pay up to 7 times your daily benefit amount in your lifetime for services to train someone to care for you - including spouses and other persons who normally live with you.

You can customize your long term care insurance in several areas:

- Facilities-Only or Comprehensive Coverage
- Daily Benefit Amount (from $50 to $300 in $25 increments)
- Weekly Benefits (available with the comprehensive coverage only)
- Benefit Period (3-year, 5-year, or unlimited)
- Waiting Period (30 days or 90 days)
- Inflation Protection (automatic compound or future purchase)

Alternatively, you can choose from four pre-packaged plans. If you choose a pre-packaged plan, you will only have to choose your inflation protection method. Details of the pre-packaged plans will be announced by OPM at the end of June 2002.

Note that the facilities-only plan and the comprehensive plan, as referenced above, differ in the kinds of care they cover. The facilities-only plan covers care in assisted living facilities, nursing homes and inpatient hospice care. The comprehensive plan covers care at home, in adult day care centers, in assisted living facilities, in nursing homes and hospice care (inpatient or at home).

Be aware that under the FLTCIP, Federal employees, members of the uniformed services, and their spouses will be offered "non-standard" insurance (or an "alternative insurance plan") if they cannot pass the underwriting requirements for the regular long term care insurance. This "non-standard" insurance is insurance that offers benefits that are more limited than the regular insurance offered under the FLTCIP. The non-standard/alternative insurance will also have higher premiums. Annuitants and others who use the full underwriting application are not eligible for the non-standard/alternative insurance plan. OPM will announce further details at the end of June 2002.

The "services-only" package is what Federal employees, members of the uniformed services and their spouses will be offered if their answer to any of questions 1 - 7 on the abbreviated underwriting application for open season is "yes." (See Appendix A to view the underwriting questions.) Anyone who uses the full underwriting application who is not approved for the regular insurance will also be offered this package. It is not insurance. It is a package of services,

including access to care coordination and discounts on care. OPM says that there will be a nominal annual fee to purchase this package, and it will announce further details at the end of June 2002.

Remember that you do not have to choose one of the pre-packaged plans. You may customize your long term care insurance plan to best suit your own needs and budget, as explained above. Some of the terms with which you need to be familiar are described below.

Daily Benefit Amount

The Daily Benefit Amount (DBA) is the maximum amount the plan will pay in any single day. Under the FLTCIP, if the cost of the care you receive in a single day costs less than your DBA, then the difference is carried over for you to use later.

You choose your daily benefit amount. You can choose a DBA from $50 to $300 in $25 increments. The cost of care in an assisted living facility or a nursing home or hospice care (whether in a facility or at home) will be reimbursed up to 100% of your DBA. Home care and adult day care will be reimbursed up to 75% of your DBA.

Weekly Benefits

Under the FLTCIP, you can choose whether you want your benefits reimbursed on a daily basis or on a weekly basis (equal to 7 times your DBA) for greater flexibility. Weekly benefits are available with the comprehensive coverage only. For example, if you elect a $100 daily benefit amount and choose to have your benefits reimbursed on a weekly basis, that would mean you have a weekly benefit amount of $700. Your reimbursement would not be limited to only $100 per day. Weekly benefits cost more than daily benefits.

Benefit Period

The Benefit Period is the length of time your Maximum Lifetime Benefit will last if you receive care every single day at a cost equal to or more than your Daily Benefit Amount (DBA). If you receive services that cost less than your DBA, or don't receive services every day, your benefits will last longer. You choose your benefit period. You can choose among a 3-year, a 5-year, or an unlimited benefit period. The Benefit Period is used as a multiplier, along with your DBA, to calculate your Maximum Lifetime Benefit.

Maximum Lifetime Benefit

The Maximum Lifetime Benefit is the maximum your plan will pay. Here is how it is calculated:

Daily Benefit Amount (DBA) x Benefit Period (in days) =
Maximum Lifetime Benefit

For example, if you choose a $100 DBA and a 3-year Benefit Period, your Maximum Lifetime Benefit would be $109,500 ($100 x 1095 days (which is 3 years at 365 days/year)) = $109,500.

If you receive services that cost less than your DBA, or you don't receive services every day, your benefits will last longer than your benefit period. This amount of money is available for reimbursement of approved long term care costs for as long as you're eligible for benefits, after

you meet the waiting period you selected. The maximum lifetime benefit is also commonly referred to as a "pool of money." An unlimited benefit period has no maximum lifetime benefit - it is unlimited.

Waiting Period

The Waiting Period is the number of days during which you must be eligible for benefits and receiving covered services before your benefits start. It works like a health insurance deductible. Under the FLTCIP, you only have to satisfy the waiting period once in your lifetime. Days applied toward satisfying the waiting period need not be consecutive or associated with the same episode of care. The days will be added together until the waiting period is satisfied. When you apply for coverage, you select the length of your waiting period - the standard is 90 days under the FLTCIP, but you may choose 30 days instead, at an additional cost.

The FLTCIP does not pay benefits during your waiting period. However, the waiting period does not apply to hospice care, respite care, and caregiver training. Because there is no waiting period for hospice care, respite care, and caregiver training, these covered services do not count toward meeting your waiting period.

Inflation Protection

To help your coverage keep pace with inflation, the FLTCIP lets you choose between the following two inflation protection options:

Automatic Compound Inflation Option

With this option, your Daily Benefit Amount (DBA) and the remaining portion of your maximum lifetime benefit will automatically increase by 5% every year with no corresponding increase in your premium. The benefit increases continue even if you are eligible for benefits. While the initial premium is higher with this option, you won't have to think about the cost of having to buy additional coverage or worry about whether your coverage (especially after you retire) will keep pace with inflation. Your benefits increase year after year, while your premium remains level.

Future Purchase Option

This allows you to buy additional coverage every two years at an extra cost. The increase offered in your Daily Benefit Amount and the remaining portion of your maximum lifetime benefit is based on increases in the Medical Consumer Price Index. With the Future Purchase Option, you can assess the costs of care in the future and make a decision to upgrade when you can afford to. Each time you buy additional coverage, your premium will increase. The premium for the additional coverage will be based on your age and premium rate at the time the increase takes effect. Every two years you will receive your Future Purchase Option notification, provided you are not eligible for benefits and have not declined three Future Purchase notifications in the past. One feature of the FLTCIP is your ability to switch to the Automatic Compound Inflation Option without proof of good health when you receive your Future Purchase notification, as long as you are not eligible for benefits and have not declined three Future Purchase notifications in the past.

Care Coordination

LTC Partners' care coordinators are available under the FLTCIP to:

- provide general information about long term care services;
- assess and approve your need for long term care services;
- develop a plan for your receipt of long term care services; and then
- monitor and reassess those services.

The care coordinators can tell you about any providers in your area who offer discounts for the services you need and provide other assistance such as locating community resources you may be eligible for. The care coordinators are registered nurses. Care coordination services are also available to your qualified relatives even if they aren't enrolled in the program, as long as you are enrolled in the FLTCIP. (Certain services for qualified relatives may be provided at an additional charge.)

Availability of the "Maximum Lifetime Benefit"

If you are eligible to receive benefits and have met your waiting period, the maximum lifetime benefit (or "pool of money") is available to you. It does not matter how long you have paid premiums. You do not have to pay premiums for a minimum length of time or wait for it to "build up" like you would if you were saving your own money to cover the costs of long term care.

Under the FLTCIP, if you claim benefits, but don't use all of your maximum lifetime benefit, you or your survivors do not receive the remaining money. The maximum lifetime benefit is not "yours" per se. It's a pool of financial resources that you have access to. You and your survivors do not have any right to the unspent dollars. The funds are available to you if benefits are payable. The possibility of unspent monies is taken into account to keep premiums as low as possible.

Similarly, under the FLTCIP, if you never use the long term care insurance, you do not get your premiums back. The long term care insurance product is analogous to homeowner's insurance. If your house never burns in a fire, you do not get your premiums back. Your premiums paid for the protection you had while you owned the house.

Some long term care insurance products have a feature called "return of premium on death," or a similar title. That provision would refund premiums to the enrollee's estate if the enrollee didn't file any claims and died before a certain age (e.g., 65). However, OPM says that this is an expensive feature because the people who set the premiums always assume that there will be some policies that never pay out benefits, and those dollars are used to reduce everyone's premiums. By its very nature, insurance has many cross subsidies among enrollees. The FLTCIP does not offer a return of premium feature.

One question that people often ask is whether under the FLTCIP they can increase their premiums if it looks as though their maximum lifetime benefit might run out. OPM says the answer is no. Permitting enrollees to do this would be contrary to insurance principles. It would be like allowing people to increase the amount of their homeowners' policy while their house

was on fire. The insurance company would be buying a guaranteed claim. The time to buy long term care insurance is when you are in good health, not when you are in a claim status.

Disputing A Claim

If you disagree with the insurance company's decision on your claim for benefits, you may ask for an independent third party review of the company's decision. When you enroll in the FLTCIP, you will receive more information on how to dispute a claim.

Disability and Long Term Care Benefits

Bear in mind that the long term care insurance program and the Federal disability retirement program are totally separate. Once you purchase a LTC policy, it's yours for life as long as you pay the premiums. Any future eligibility for disability retirement or compensation benefits will not affect the terms of your policy, including qualifying you for benefits. You must establish your eligibility for long term care benefits separately.

Benefits Available For Services Outside the U.S.

The FLTCIP provides benefits for covered services you receive outside the United States, its territories, and possessions. When you receive covered services internationally, the FLTCIP will pay benefits for such services up to 80% of the maximum amounts that would otherwise be payable. Only 80% of your maximum lifetime benefit can be used for covered services you receive internationally; the other 20% would be available only for covered services you receive in the U.S., its territories, and possessions.

For example, assume that you select a $150 daily benefit amount for a 5-year benefit period. Your daily benefit amount for covered services you receive internationally would be $120 ($150 x 80%) instead of $150. Out of your maximum lifetime benefit of $273,750, you could use up to 80% ($219,000) for all covered services you receive internationally. The other 20% ($54,750) of your maximum lifetime benefit would be available for covered services you receive in the U.S., its territories, and possessions.

Eligibility

As specified in the law, individuals eligible to apply for coverage under the FLTCIP are:

- **Employees** - Federal employees and members of the uniformed services. This includes employees of the U.S. Postal Service and Tennessee Valley Authority, but does not include employees of the District of Columbia Government. For Federal and Postal employees, the general rule is that if you are in a position eligible for FEHB coverage, then you are eligible for the FLTCIP. Remember – the key is whether you are eligible for the FEHBP. You do not actually have to be enrolled in the FEHBP to be eligible for the FLTCIP.
- **Annuitants** - Federal annuitants, surviving spouses of deceased Federal or Postal employees or annuitants who are receiving a Federal survivor annuity, individuals receiving compensation from the Department of Labor who are separated from the Federal service, members or former members of the uniformed services entitled to retired or retainer pay, and retired military reservists at the time they qualify for an annuity (also known as grey reservists). Retired employees of the D.C. Government are not included.

- **Current spouses** of employees and annuitants (including surviving spouses of members and retired members of the uniformed services who are receiving a survivor annuity).
- **Adult children** (at least 18 years old, including adopted children and stepchildren) of living employees and annuitants.
- **Parents, parents-in-law, and stepparents** of living employees (but not of annuitants).

There is no upper age limit for those who can apply for insurance under the FLTCIP. Anyone age 18 or older can apply for the insurance as long as they are in one of the eligible groups. Regardless of their age, however, they will still have to pass the underwriting.

Remember that the FLTCIP is totally separate and independent from the Federal Employees' Group Life Insurance (FEGLI) Program, the Federal Employees Health Benefits (FEHB) Program, TRICARE, Medicaid, or any other health or life insurance program. You do not need to be enrolled in the FEGLI, the FEHBP, TRICARE or any other program to apply for the FLTCIP. However, someone currently receiving Medicaid assistance should probably not be purchasing long term care insurance.

Employees

The long term care insurance law defines "Federal employees" the same way that the Federal Employees Health Benefits (FEHB) Program does, with two exceptions. Under the long term care insurance program, employees of the Tennessee Valley Authority are eligible, and employees of the D.C. Government are not. Here are the details:

Included as "employees" under the law governing the FLTCIP:

- Full-time employees;
- Part-time employees;
- Members of Congress;
- Congressional employees;
- The President;
- Employees of the U.S. Postal Service;
- Employees of the Tennessee Valley Authority;
- Employees of Gallaudet College;
- An individual employed by a county committee established under section 590h(b) of title 16, United States Code;
- An individual appointed to a position on the office staff of a former President or Vice President (see section 8901, U.S.C., for details related to this category); and
- Employees serving under interim appointments under the Whistleblower Act.

Not included as "employees" under the law governing the FLTCIP:

- Employees of the District of Columbia Government;
- An employee of a corporation supervised by the Farm Credit Administration, if private interests elect or appoint a member of the board of directors;
- An individual who is not a citizen or national of the United States and whose permanent duty station is outside the United States, unless the individual was an employee for the purpose of this chapter on September 30, 1979, by reason of service in an Executive

agency, the United States Postal Service, or the Smithsonian Institution in the area which was then known as the Canal Zone;

- An employee who is serving under an appointment limited to 1 year or less and who has not completed 1 year of current continuous employment, excluding any break in service of 5 days or less.
    - BUT the following employees are covered, even if they are serving on a temporary appointment: An acting postmaster, a Presidential appointee appointed to fill an unexpired term, and an appointee that meets other special conditions;
- An employee who is expected to work less than 6 months in each year
    - BUT the following employees are covered, even if they are expected to work less than 6 months in each year: employees who are employed under an OPM approved career-related work-study program under Schedule B of at least 1 year's duration and who are expected to be in a pay status for at least one-third of the total period of time from the date of the first appointment to the completion of the work-study program;
- An intermittent employee (a non-full-time employee without a prearranged regular tour of duty);
- A beneficiary or patient employee in a Government hospital or home;
- An employee paid on a contract or fee basis
    - BUT, the following employees are covered, even if paid on a contract or fee basis: employees who are citizens of the United States and are appointed by a contract between the employee and the Federal employing authority which requires their personal service and is paid on the basis of units of time;
- An employee paid on a piecework basis, except one whose schedule provides for full-time service or part-time service with a regular tour of duty.

Note that non-appropriated Fund (NAF) employees cannot apply for insurance under the FLTCIP. The law does not cover them.

Some federal employees wonder whether it is better to wait to retire before applying for long term care insurance coverage under the FLTCIP. Naturally, there are many things to consider when deciding to retire. But in terms of applying for long term care insurance, you should know that employees are asked fewer questions about their health than retirees. Therefore, it may be advantageous for you to wait to retire until after you apply as an employee, your application is approved, and your coverage becomes effective. By waiting, you could apply as an employee with fewer questions about your health.

The other thing to consider is the effective date of your coverage, if your application is approved. If you apply as an employee with abbreviated underwriting, you must also be an employee on the date your insurance coverage is supposed to become effective. If you retire before the date your insurance coverage is effective, you will have to reapply as an annuitant and answer more questions about your health.

If you have questions about your eligibility to apply for the FLTCIP, you should talk to someone in your agency's Human Resources office. If you are a Federal or Postal employee and are eligible for the Federal Employees Health Benefits Program (FEHBP), in general, you are

eligible for the FLTCIP. This doesn't mean that you need to be enrolled in the FEHBP, just that your current position conveys eligibility for FEHBP coverage.

Some employees are no longer Federal employees, but are now working for a private entity, and yet they still have eligibility for the FEHBP. Those employees are not eligible to apply for the FLTCIP. In order to be eligible to apply for the FLTCIP as an employee, you must be a current Federal or Postal employee. Employees who used to be Federal employees, but are now private sector employees with a grandfathered right to certain Title 5 federal benefits, are not eligible to apply for the FLTCIP.

As stated above, D.C. Government employees cannot apply for the FLTCIP. D.C. Government employees who retire (or are already retired) and are eligible for the Federal health benefits and/or the Federal life insurance program are not eligible for the long term care insurance program (unless they also fall into one of the other groups that are eligible, such as Federal employees or spouses of Federal employees). The definition of "annuitant" in the Long-Term Care Security Act refers back to the definition of "employee" in that Act. "Employee," as defined in the Act, excludes D.C. Government employees. Consequently, D.C. Government employees who retire or who are already retired are also excluded, regardless of their eligibility for the FEHB Program, the FEGLI Program, or other Federal benefits. Survivors of deceased D.C. Government employees and survivors of deceased D.C. Government retirees are also excluded.

Uniformed Services

Within the Uniformed Services, the following groups are eligible for the FLTCIP:

- Members on active duty or full-time National Guard duty for more than 30 days;
- Members of the Selected Reserve; and
- Members on retirement or retainer pay.

The "Selected Reserve" consists of those uniformed services members who are required to routinely train and are the first category liable for mobilization under the statutes governing mobilization. The Selected Reserve consists of Drilling Reservists and Guardmembers assigned to Reserve Component Units; all Individual Mobilization Augmentees who are Reservists assigned to Reserve Component billets in Active Component units (they may perform duty in a pay or non-pay status); and Active Guard and Reserve members who are full-time Reserve members on full-time National Guard duty or active duty in support of the National Guard or Reserves.

Reservists who are assigned to a Voluntary Training Unit in the Naval Reserve and Category E in the Air Force Reserve (although they may perform inactive duty training (drills) in a non-pay status) are not members of the Selected Reserve and therefore are not eligible. They are members of the Individual Ready Reserve.

Grey reservists are eligible to apply for the FLTCIP at any time after they reach age 60, when they start to receive retired pay from the uniformed services. They are not eligible to apply during the "grey" period after separation from active duty and before age 60.

In addition, surviving spouses who receive Dependency Indemnity Compensation (DIC) payments from the Department of Veterans Affairs are eligible to apply for this insurance because a DIC payment is a survivor annuity.

If you are receiving a "variable separation incentive" from the uniformed services, you are not eligible for the FLTCIP. A variable separation incentive payment does not qualify as retired or retainer pay for purposes of the Long-Term Care Security Act. Therefore, you do not have retirement status that would qualify you to apply for the program.

Annuitants and Compensationers

If you are retired from the military but are also a retired Federal employee receiving a Federal annuity, it does not matter whether you apply as one or the other. All annuitants - whether uniformed services, Federal or Postal - will need to answer the same questions about their health.

If you are retired from the Federal government but are also a Federal employee, you are eligible to apply as an annuitant or as an employee. It is more advantageous for you to apply as an employee because you will be asked fewer questions about your health. And since you are a Federal employee, your parents, parents-in-law, and stepparents are also eligible to apply. They can apply whether or not you decide to apply, or whether you apply as an employee or annuitant.

Federal deferred annuitants are eligible to apply for the FLTCIP when they satisfy all requirements (age and service) for title to their annuity, and have filed the application for that annuity. They are not eligible to apply during the time period after they separate from service and before they begin receiving their annuity.

Disability annuitants are also eligible to apply for the insurance. However, like all annuitants, they must pass full underwriting.

In addition, compensationers - Federal employees or former employees who are receiving monthly compensation and whom the Secretary of Labor determines are unable to return to duty - are eligible to apply for the FLTCIP.

The bottom line is that if you are still on the rolls of your agency, you are still an employee. In that case, you must complete the abbreviated underwriting application. However, your coverage would not become effective until you meet the "actively at work" requirements. (For Federal and Postal employees, "actively at work" means you are reporting for work at your usual place of employment or other location to which government business requires you to travel; you are able to perform all the usual and customary duties of your employment on your regular work-schedule; and you are not absent from work due to sickness, injury, annual leave, sick leave or any other leave. For employees working an alternative work schedule, an "AWS" day off counts as a day you are actively at work. For members of the uniformed services, "actively at work" means that you are on active duty and are physically able to perform the duties of your position.)

If you are no longer on the rolls of your agency, you are separated from service and are considered an annuitant. In that case, you must complete the full underwriting application. (See Appendix A to view the underwriting questions.)

Lastly, employees who separate from service with title to an annuity under the Federal Employees Retirement System's Minimum Retirement Age plus 10 years service provision (FERS' "MRA+10") are eligible to apply for the FLTCIP. This is true even if they decide to postpone receipt of their annuity. That's because an MRA+10 annuity is an immediate annuity, not a deferred annuity. Actual receipt of the annuity for those separating with title to an immediate annuity is not a requirement for eligibility.

Qualified Relatives

There are three categories of qualified relatives under the law governing the FLTCIP:

- Current spouses of living employees and annuitants (surviving spouses of deceased members and retired members of the uniformed services who are receiving a survivor annuity are also eligible as "spouses");
- Adult children (at least 18 years old, including natural children, adopted children and stepchildren) of living employees and annuitants; and
- Parents, parents-in-law, and stepparents of living employees (but not of annuitants).

If you are a Federal employee or annuitant, or a member or retired member of the uniformed services, your qualified family members can apply for coverage under the FLTCIP. Remember that each eligible person applies in his or her own right. You – the Federal employee or annuitant - cannot sign your qualified relatives up yourself. Unlike the FEHBP, there is no "self and family" coverage. Be aware that each eligible person in the "Federal Family" has an independent right to apply for the insurance on their own, and the person they are related to (the Federal employee, for instance) need not apply. Additionally, survivors of Federal employees who are receiving a survivor annuity and survivors of Federal annuitants who are receiving a survivor annuity can apply for the insurance.

Unfortunately, a widow(er) of a Federal annuitant who never elected a survivor annuity is not eligible to apply for the FLTCIP. In order for a surviving spouse of a Federal employee or a surviving spouse of a Federal annuitant to be eligible to apply for the FLTCIP, he or she must be receiving a Federal survivor annuity. Obviously, this is another item to consider when deciding whether to elect a Federal survivor annuity. Of course, if you had enrolled in the FLTCIP while your spouse was alive, you would keep the coverage as long as you continued to pay premiums - even if your Federal annuitant spouse later died without electing a survivor annuity.

Surviving spouses of deceased members or retired members of the uniformed services are also eligible to apply for this insurance if they are receiving a survivor annuity. If a surviving spouse of a deceased member or retired member of the uniformed services is not receiving a survivor annuity, however, he or she is not eligible. The surviving spouse must be receiving a survivor annuity to be eligible.

A surviving spouse of a deceased member or retired member of the uniformed services who is not receiving a survivor annuity, but who is eligible for military health benefits, is not eligible for the FLTCIP. Again, the surviving spouse must be receiving a survivor annuity to be eligible.

Former spouses who are not eligible in their own right (for example, as an employee or retiree) are not eligible to apply for this insurance, even if they are receiving a survivor annuity.

Stepparents of living Federal and Postal employees and members of the uniformed services are eligible to apply for the FLTCIP. A "stepparent" is defined as the person currently married to your natural parent. If your natural parent is dead, your stepparent is the person married to your natural parent at the time of his or her death. Bear in mind that if your stepparent divorced your natural parent, he or she is not eligible for the insurance. However, if your stepparent was married to your natural parent at the time of your natural parent's death, then your stepparent is eligible to apply for the insurance.

OPM has said that it is not considering adding any additional qualified relative groups other than those mentioned in the law so that it can focus its efforts on a successful rollout of the FLTCIP. The law makes a limited set of qualified relatives eligible to apply for the long term care insurance (spouses and adult children of both employee and retiree groups, and parents/parents-in-law/stepparents of the employee groups). While the law provides OPM with a limited amount of discretionary authority to designate other groups as qualified relatives, OPM will not add any additional groups beyond those specified by Congress. Given the size of the program and the education and communication challenges the existing program represents, OPM has said it does not want to jeopardize the program launch by making coverage provisions more complex.

Continuing the Insurance After Leaving a Qualified Group

If you have already enrolled in the FLTCIP and your insurance coverage is effective, your insurance coverage continues even if you leave your eligible group (e.g., you move from the Selected Reserve to the Individual Ready Reserve, or you resign from the Federal Government, or you divorce your Federal spouse). Your insurance coverage is fully portable. As long as you continue paying premiums, your insurance coverage will continue. If you were paying premiums by payroll deduction and you leave the government, you'll have to make arrangements with LTC Partners to start paying premiums directly or by automatic debit from your checking account. But you get to keep the insurance at the same premiums as if you never left the eligible group.

Qualified relatives are eligible to apply for the FLTCIP while you are a Federal or Postal employee or annuitant, or member or retired member of the uniformed services. However, if you are no longer in an eligible group, the eligibility of your qualified relatives changes as well. The rule is that they are qualified relatives as long as you are in one of the groups eligible to apply for this insurance. And if they enroll while you are eligible (whether you enroll or not), they will keep the coverage even if you leave an eligible group. However, if they do not apply for the insurance while you are in an eligible group, and you subsequently leave an eligible group, then they can no longer apply for the insurance.

For example, while you are a Federal employee, your mother is eligible to apply for the FLTCIP. If she applies and gets coverage, she'll keep the insurance even if you quit working for the Federal government. However, if she does not apply while you are a Federal employee, she is not eligible to apply after you quit working for the Federal government. Remember that parents of retirees are not qualified relatives.

Simply put, if you are no longer in any of the eligible groups, your qualified relatives are no longer eligible to apply for this insurance. But if they obtained the insurance before you left the eligible group, they get to keep it as long as they continue paying premiums.

In some circumstances, you may apply while you are in an eligible group, but then leave the eligible group before your insurance is effective. The question of whether your insurance will still become effective depends on the particular situation. The rule is that you must be in an eligible group on the date you apply for the insurance and on the date the insurance is supposed to become effective. Generally, if you leave the eligible group during this time period, your insurance will not become effective. But there are some exceptions. If you retire from active service after you apply but before the coverage is effective, you must reapply using the long form application, as a retiree. And if you apply as an employee and are involuntarily separated before your coverage is effective, it will still become effective as if you hadn't separated.

Enrollment

As stated earlier, open season to apply for the FLTCIP begins July 1, 2002 and runs through December 31, 2002. There will be staggered 60-day enrollment periods during that time. OPM says that it will have more details on this later.

At this time, OPM has not yet scheduled open seasons for 2003 and beyond. OPM has indicated that it will make that decision at a later date.

Applying After Open Season

Anyone in any of the eligible groups can still apply for the FLTCIP after open season ends by submitting a full underwriting application. Federal employees, members of the uniformed services and their spouses cannot use the abbreviated application outside of an open season, except as provided below.

Newly hired employees or those who are newly eligible for coverage can apply even if open season has ended. New or newly eligible Federal employees, members of the uniformed services and their spouses will be able to apply for the program using the abbreviated application within 60 days of becoming eligible. After that time, they can still apply, but will have to use the full underwriting application.

Additionally, a Federal employee or member of the uniformed services who gets married after open season can have his or her new spouse apply using the abbreviated application form as long as the new spouse applies within 60 days of the marriage. After that time, he or she can still apply, but will have to use the full underwriting application.

Be aware that you can request a decrease in your coverage at any time. You can decrease your coverage to anything that is available under the FLTCIP, and your premiums (which will be based on your original age) will also decrease. For example, if you have the 5-year benefit period, you can decrease to a 3-year benefit period. But you could not decrease to a 2-year benefit period, because a 2-year benefit period is not available under the FLTCIP. You do not have to undergo new underwriting in order to decrease your coverage.

If you decrease your coverage, you cannot ever get "paid-up benefits," even though you may have paid for higher benefits for a long period of time. The FLTCIP does not offer paid-up benefits. At the time you paid for your higher benefits, you were insured for those higher benefits and received that protection for all the years you held the old policy. Even though you didn't use them doesn't mean they didn't have a cost from an insurance point of view. But your premiums will decrease when your benefits decrease.

Underwriting

"Underwriting" is the process of reviewing medical and health-related information furnished in an insurance application process to determine if the applicant presents an acceptable level of risk and is insurable.

Under the FLTCIP, Federal employees, members of the uniformed services, and their spouses will be subject to "abbreviated underwriting." In this type of underwriting, the application has several health-related questions designed to determine who may be immediately eligible for benefits, or eligible for benefits within a short period of time. Spouses will answer nine questions, and employees and members of the uniformed service will answer seven questions. There will be additional questions for the unlimited benefit period. (See Appendix A to view the underwriting questions.)

All applicants other than Federal employees, members of the uniformed services, and their spouses will be subject to "full underwriting." This means that they will have to answer numerous health-related questions. The full underwriting process may also include a review of medical records and/or a personal interview. (Again, see Appendix A to view the underwriting questions.)

Bear in mind that employees with disabilities can certainly apply for the FLTCIP, but whether they will have their applications approved will depend on whether they can meet the underwriting requirements. OPM says that because the Federal government has made a particular effort to recruit individuals with disabilities, it employs significantly more employees with disabilities than many private sector employers. Without some form of underwriting, OPM says that it could not offer affordable long term care insurance.

During open season, employees who are unable to pass underwriting will be offered something like non-standard coverage or a package of services (e.g., care coordination and discount arrangements). OPM notes that these individuals would probably not be able to receive any long term care benefits from the private sector.

Pre-existing Conditions

Pre-existing conditions may prevent you from obtaining the long term care insurance coverage under the FLTCIP. However, if you do qualify for the insurance coverage, your pre-existing conditions won't affect your eligibility for benefits. You will have to pass underwriting to enroll in the FLTCIP (answering health questions, possibly authorizing access to medical records, possibly being interviewed by a registered nurse). But if your application is approved, and you become eligible for benefits, your pre-existing condition won't matter. OPM says that this is one

advantage to the FLTCIP, since some private policies limit access to benefits based on pre-existing conditions.

As noted earlier, if you are an employee, member of the uniformed service or a spouse, and your pre-existing condition prevents you from being approved for the FLTCIP, there are possible alternatives for you, such as non-standard insurance and/or a services-only non-insurance package. "Non-standard" insurance (or an "alternative insurance plan") is insurance that offers benefits that are more limited that the regular insurance offered under the FLTCIP. The non-standard/alternative insurance will also have higher premiums. Annuitants and others who use the full underwriting application are not eligible for the non-standard/alternative insurance plan.

The "services-only" package will also be offered to employees, members of the uniformed services and their spouses if their answer to any of questions 1-7 on the abbreviated underwriting application for open season is "yes." (See Appendix A to view the underwriting questions.) Anyone who uses the full underwriting application and who is not approved for the regular insurance will also be offered this package. It is not insurance. It is a package of services, including access to care coordination and discounts on care. There will be a nominal annual fee to purchase this package. More details on both non-standard insurance and the "services-only" package should be available from OPM at the end of June 2002.

The FLTCIP can also help Federal employees caring for a parent with Alzheimer's disease. If you enroll, the program can help you coordinate care for your parent, receive discounts on certain long term care services or supplies, and provide advice and support for you as caregiver. Bear in mind, however, that anyone who enrolls must be insurable based on the underwriting criteria for the program. Parents of employees will undergo more underwriting than employees will. Employees' qualified relatives who already need long term care services will probably not qualify for the FLTCIP.

Finally, be aware that the FLTCIP will not provide retroactive benefits. There are no provisions in the law for retroactive benefits. Anyone who already needs long term care services is not going to qualify for this insurance.

Cost

Premium Increases

While OPM says that it cannot guarantee that the premiums for the FLTCIP will never increase, it says that the premiums it accepted from LTC Partners are realistically priced and follow the National Association of Insurance Commissioners rate stability guidelines. The premiums are expected to be level for life (unless you choose the future purchase option for inflation protection, which by definition has an increase in premium whenever your benefits increase). If LTC Partners requests an increase in premiums, OPM says it will look for alternatives before agreeing to a rate increase. OPM has said it does not expect a rate increase since MetLife and John Hancock have never increased their group rates for long term care insurance.

Premium Costs

As far as the cost of premiums for the FLTCIP is concerned, OPM has posted the premiums on its web site at http://www.opm.gov/insure/ltc/calculator. You can use the premium rate calculator on that web page to determine the premiums for your age and preferred benefits. The calculator will also give you the ability to compare premiums with various options.

Factors for Premium Rates

In choosing coverage under the FLTCIP, your premiums will be based on the following factors:

- Your premiums will be based on your age when you buy the coverage (the younger you are when you buy, the lower the premiums, everything else being equal.) During open season, you will pay premiums based on your age on July 1, 2002.
- Your premiums will also vary based on the benefits you choose.
- When you choose the automatic compound inflation option, the premium is designed to be level for life. When you choose the future purchase option for inflation protection, your premiums will increase as your benefits increase.
- Premiums are the same for all purchasers of the same coverage at the same age - employees, annuitants, and all the other eligible groups.
- The coverage is guaranteed renewable. That means that the insurance carrier cannot cancel your coverage unless you stop paying premiums (or unless you commit fraud when completing your application).

It is always advisable to do some comparison shopping among different long term care insurance plans before you choose one. When comparing two different plans, be sure that you are comparing the exact same benefits. Be sure to do a detailed comparison of each plan's coverage and benefits to ensure you are making an "apples to apples" comparison. Then look at the premiums and determine which plan is best for you.

OPM says it is true that for some people rates in the retail marketplace can be reduced by spousal and preferred health discounts. The FLTCIP chose not to target discounts to select groups because OPM's goal was to offer the lowest possible rates to all who qualify under the underwriting standards. Therefore, before purchasing any long term care insurance product – either through the FLTCIP or a private insurer – be sure to do your homework to get the insurance that best fits your needs and your wallet.

Catastrophic Coverage

Unlike many other long term care insurance plans, the FLTCIP has a Catastrophic Coverage Limitation instead of a war/terrorism exclusion. The Federal Long Term Care Insurance Program is different from other long term care insurance programs in that a large number of individuals are becoming insured during a short window of time. OPM has said that it is this fact (combined with other factors such as the unique nature of the insured population, especially the military) that has led to using a Catastrophic Coverage Limitation to protect the FLTCIP from an unusual event in the early years before Program assets have accumulated.

Only a real catastrophic event that affects such a significant number of enrollees that it threatens to undermine the financial stability of the FLTCIP can trigger the Limitation, and both LTC Partners and OPM must agree that the event meets this definition. If a catastrophic event triggers

the Limitation and the Limitation affects your claim, your Daily Benefit Amount would remain the same, but your Benefit Period would be shortened.

OPM predicts that the likelihood of the Limitation ever being triggered is low. As assets increase, the risk also decreases over time. Conversely, since the likelihood that you will have a long term care claim starts very low but increases over time, most of your premium is paying for protection for claims far in the future. The way it is structured, as Program assets grow, the claim threshold that would trigger defining an event as a catastrophe grows as well. So OPM says the likelihood of this catastrophic provision having an impact on the Program should decrease significantly over the next several years.

Only enrollees who become eligible for benefits as a result of a catastrophic event are affected by this Limitation. Enrollees who file a claim not related to the event are not affected, nor are enrollees who are already on claim at the time. Also, anyone whose claim is denied has the right to an independent third party review of their claim. In addition, Long Term Care Partners will restore any benefits reduced under the catastrophic provision if the Program later develops sufficient reserves to cover those reductions.

Lastly, OPM contends that its Catastrophic Coverage Limitation is better than a war/terrorism exclusion. A war/terrorism exclusion, common to other long term care insurance policies, excludes payment of benefits for anyone whose claim arises due to a war or terrorism. There is no threshold or requirement that the claim threaten the financial stability of the Program - if a claim is due to war, it is not paid.

Waiving Premiums

Under the FLTCIP, you will not have to pay premiums if you are eligible for benefits and have satisfied your waiting period. Premiums are also waived if you are eligible for benefits and receiving hospice care, even though no waiting period applies to hospice care. If you satisfy the requirements for waiver of premium on the first day of a month, the waiver will take effect on that date. Otherwise, the waiver will take effect on the first day of the following month. If, at a later date, you are no longer eligible for benefits (e.g., you recover) and you wish to maintain your coverage, you will have to resume paying premiums.

Withholding Premiums

Beginning October 1, 2002, at an employee's or annuitant's request, an agency can withhold premiums from his or her salary or annuity.

Employees and annuitants can also pay for their qualified relatives' insurance premiums out of their salaries or annuities beginning on October 1, 2002. However, both parties must agree to this arrangement - the employee or annuitant and the relative who was approved for the insurance coverage. In order to pay for the insurance premiums from your Federal salary or annuity for qualified relatives, you, the Federal employee or annuitant, do not have to be enrolled in the FLTCIP yourself.

If your Federal salary or annuity isn't big enough to pay for the premiums, you pay the insurance premiums by either authorizing a debit from your bank account or paying the insurance company directly.

If a parent or spouse of a Federal employee enrolls in the program, the parent or spouse can pay premiums either by authorizing a debit from his or her bank account or by paying the insurance company directly. Alternatively, the Federal employee to whom the parent or spouse is related may be willing to pay the premiums out of his or her salary. This last option begins October 1, 2002.

Note that the Federal government does not pay any part of the cost of long term care insurance. By law there is no government contribution. Participants in the FLTCIP will be responsible for 100% of the premium costs.

Canceling Coverage

Within 30 days after you receive your Benefit Booklet from Long Term Care Partners (which you will get automatically if your FLTCIP application is approved), you may cancel your coverage and you will receive a full refund of any premium you may have already paid for the coverage. This is called a "30 Day Free Look." You may also cancel your coverage anytime after the "30 Day Free Look" period, but you will not receive a full refund of your premiums. You will receive a refund of any premium that you paid to cover any period after the effective date of your cancellation.

Transferring with Credit

Many Federal employees who already have long term care insurance have asked whether they can convert that policy to the FLTCIP and receive "credit" for the premiums they have already paid. Others who have a John Hancock or MetLife policy or who have a policy from a sponsoring organization that uses John Hancock or MetLife as the underwriter also want to know whether they can convert it to the FLTCIP and/or get some credit for it. Unfortunately, the answer to all of these questions is no. Existing policies (from John Hancock or MetLife or any other company) cannot be converted to the Federal program. And you also cannot get "credit" for any existing long term care insurance policy, even if your policy happens to be with John Hancock or MetLife.

The reason the answer is no is because of the way long term care insurance policies are designed and priced. When an insurance company calculates premiums for long term care insurance, it must make a number of assumptions. One important assumption is how many people will, over time, "lapse" - that is, drop their insurance and stop paying premiums. When someone lapses without ever using the benefit, the money that person has paid is used to help pay the costs of the remaining insured people.

The lapse assumption used when pricing existing plans did not contemplate an insured being able to receive credit for his or her policy to convert to a different one. To allow it now would mean that the original lapse assumption would no longer be valid. This could mean that the premium

rates for existing policies would need to be raised, which is contrary to the intent that long term care insurance premiums remain level.

In order for an insurer to change the pricing assumptions after a policy has been issued, it must demonstrate that the change (that is, letting insureds convert with credit to the Federal program) would not work to the disadvantage of any remaining insureds. This is a requirement of the various state insurance departments. OPM says that insurers would be hard pressed to demonstrate that existing insureds would not be disadvantaged in favor of those allowed to convert with credit.

In addition, insurance companies need to maintain equity between different groups of insureds. If John Hancock or MetLife were to allow eligible members of the Federal Family to somehow "transfer" to the FLTCIP with credit, they would need to allow all other insureds to do that with any other program for which they are eligible. This could result in lapse rates far different than those originally assumed, which would make it even more likely that premium rates for existing policies would need to be changed.

Of course you can always drop your current coverage in favor of the FLTCIP, even though "transferring" or receiving "credit" is not possible. However, if you decide to apply for enrollment in the FLTCIP, OPM advises that you not cancel your existing insurance until you have been informed in writing that your FLTCIP application was accepted and your enrollment is effective.

Federal employees who already have long term care policies with John Hancock or MetLife have questioned why the companies can't simply transfer their premiums and the built-up reserves from their current policies to the new FLTCIP. Unfortunately, it doesn't work that way. Current policies were priced using the assumption that the reserves built up would always remain in their original risk pool. They cannot move monies from one pool to another pool. Doing so would be contrary to the pricing assumptions, and could result in the need to raise rates on the policies left in the original risk pool.

Another issue is whether those applying for the Federal program can pay premiums using the same age they were when they bought their other long term care insurance policy (either from John Hancock or MetLife or any other company). The short answer is no. People joining the Federal program will pay premiums based on their current age, even if they already have a policy with John Hancock or MetLife or any other company. They cannot preserve that "original" age. The reason that you cannot preserve your "original" age when you bought another long term care insurance policy has to do with how long term care insurance is priced.

The insurance is priced with the expectation that each person will pay a level premium as long as they have the insurance, and that the sum of all of the premiums paid (together with investment income earned by the program) will be sufficient to pay claims and all other program expenses. The amount of premium varies with issue age, and is higher with increasing age. This is because, as issue age increases, the amount of time before claims are expected to occur gets shorter.

As explained above, other long term care policies cannot be "converted" to the Federal program. Therefore, even those with existing policies must pay premiums based on their current age.

Furthermore, those who recently went through underwriting for a John Hancock or MetLife policy (or any other long term care insurance policy) and who then apply for the FLTCIP have to pass underwriting again. All applicants must go through the underwriting process for the FLTCIP, even if they recently applied for a John Hancock or MetLife or other long term care insurance policy.

MetLife, John Hancock, and OPM jointly developed the underwriting process that will be used for the FLTCIP. Because the program is unique, the underwriting requirements will differ from those of any other program. To maintain fairness among participants, all that apply must go through the underwriting process that has been designed for the Federal program.

Also, an applicant must go through this process to know what plan options are available to him or her. For example, employees who request an unlimited (lifetime) benefit must meet requirements that are different from someone who does not. In addition, the process is designed to identify those applicants who do not qualify for the standard insurance, but, depending on the eligible group, may still qualify for something else such as non-standard insurance or a service plan.

Tax Benefits

Purchasing long term care insurance can have Federal tax benefits. Purchasing long term care insurance under the FLTCIP offers Federal tax benefits because the FLTCIP is designed to be a "tax-qualified plan" under the Internal Revenue Service Code. This means that:

- benefits (claims) will not be taxable; and
- you can deduct long term care insurance premiums as medical expenses to the extent that your total qualified medical expenses exceed 7.5% of your annual adjusted gross income. The amount of the deduction is also subject to other IRS limits by age.

In addition, there may be further Federal tax benefits in the future if the IRS code is amended. The Long-Term Care and Retirement Security Act of 2001, H.R. 831 and S. 627, proposes to "amend the Internal Revenue Code of 1986 to allow individuals a deduction for qualified long term care insurance premiums, use of such insurance under cafeteria plans and flexible spending arrangements, and a credit for individuals with long term care needs."

There may also be state tax benefits for those purchasing long term care insurance policies. Click on http://www.opm.gov/insure/ltc/state_incentives/index.htm to see if your state offers any tax benefits.

Be aware that while the FLTCIP is a tax-qualified plan, Federal employees cannot pay their long term care insurance premiums on a pre-tax basis. There is no "premium conversion" in this case. Section 125 of the Internal Revenue Code specifically excludes from the definition of qualified benefits "any product which is advertised, marketed, or offered as long term care insurance."

Consumer Protections

The FLTCIP includes several consumer protections, including a contingent nonforfeiture provision, the option to purchase inflation protection, complete portability, and guaranteed renewability (meaning the insurance company can't cancel coverage except for non-payment of premiums or fraud).

"Contingent nonforfeiture" means that if the insurer increases premiums beyond a specified percentage, an enrollee can choose to stop paying premiums and elect a policy with a shortened benefit period. OPM says that it does not expect this scenario to happen, but contingent nonforfeiture is built into the coverage offered and you won't have to make any decisions about it.

"Complete portability" means that once you enroll in the program, you will remain enrolled as long as you pay the premiums. It doesn't matter if you leave Federal service, divorce your Federal spouse, or otherwise lose your affiliation to the Federal Family.

Canceling Coverage
The only times the insurance company may cancel coverage is if you don't pay the premiums or if you commit fraud in completing your application.

Reducing Coverage
You might find that after many years of paying premiums, you can no longer afford a given premium because your circumstances have changed. Under the FLTCIP, you can reduce your coverage at any time and your premiums will be reduced accordingly.

Increasing Coverage
During open season you can apply to change any of your benefits, including increasing coverage. After open season, you can increase your daily benefit amount, if you provide satisfactory evidence of good health.

Claims Dispute
If you disagree with the insurance company's decision on your claim for benefits, you may ask for an independent third party review of the company's decision.

Miscellaneous

Dropping Health Insurance
Do not under any circumstances drop your health insurance coverage (FEHBP, TRICARE, etc.) if you enroll in the FLTCIP or any other long term care insurance program. Long term care insurance is not health insurance and does not replace health insurance coverage, such as that provided by the Federal Employees Health Benefits Program (FEHBP) or TRICARE. The FLTCIP provides insurance to cover long term care needs such as nursing home care, assisted living facility care, formal and informal care in the home, adult day care, and so forth - care that is generally not covered by health insurance.

Long Term Disability Insurance

Long term care insurance is different from long term disability insurance. Long term disability insurance or disability income insurance pays you a percentage of your gross income (for example, 45% or 60%) should a sickness or illness prevent you from working for an extended period of time. Policies may define "working" as working in your current occupation or perhaps doing any type of work that you're qualified to perform. Thus, the benefits are tied to your salary, and you "trigger" the benefits by being unable to work. Many such insurance policies stop paying benefits after 5 years or when you reach age 65.

The FLTCIP and long term care insurance generally provides insurance to help you pay for assistance you may need due to a chronic illness or injury (such as bathing, getting in and out of bed, and so forth). There is no correlation to your job or your salary and there is no age cut-off for receiving benefits. For the FLTCIP, you "trigger" benefits one of two ways - by needing help with at least two activities of daily living with an expectation that you'll continue to need the help for at least 90 days, or by having a severe cognitive impairment. It is entirely unrelated to whether you are still working. In fact, most people have retired by the time they qualify for long term care benefits.

A long term disability insurance benefit helps replace part of your lost income (salary). The FLTCIP benefits help you pay for long term care you may need because you are unable to take care of yourself. While it's possible that a given illness could trigger both benefits, OPM reports that less than 5 percent of the working population would ever qualify for disability benefits, but more than half will need some form of long term care.

Spousal Discount or Spousal Benefit

The FLTCIP does not offer a spousal discount or any spousal benefits or any other targeted discounts. FLTCIP rates are designed to be as low as possible for the entire eligible population. If a spousal discount or any other discount targeted to a specific segment of the group were offered, rates for the rest of the group would have to be raised to compensate for the discounts.

Unused Sick Leave

Unused sick leave cannot be applied toward paying for the long term care insurance.

Partnership Plan

Some Federal employees have asked whether the FLTCIP will offer Medicaid protection benefits under a Partnership Plan. While OPM says that the FLTCIP hopes to do so eventually, it will not do so in 2002. OPM is working with the Robert Wood Johnson Foundation Partnership for Long-Term Care and the four states that currently offer Partnership policies - California, New York, Indiana and Connecticut – to be able to offer these benefits. OPM says that it needs to make the necessary adjustments to the FLTCIP - and those states need to make necessary adjustments to their regulations - to allow certain combinations of benefit options under FLTCIP to qualify as Partnership policies in those states.

The Partnership program is a unique venture sponsored by the Robert Wood Johnson Foundation to link private long term care insurance and Medicaid (called "Medi-Cal" in California). It is, as a practical matter, limited by Federal law to four states - California, New York, Indiana and

Connecticut. In those states, individuals who buy a Partnership long term care insurance policy are entitled to keep more of their assets if they do eventually have to go on to Medicaid after using up their insurance. Without Partnership protection, a person who goes on to Medicaid in one of the Partnership states would have to "spend down" to $4,000 or less in savings for an individual, or $6,000 or less for a couple. (However, it should be noted that Partnership rules do not eliminate Medicaid/Medi-Cal income eligibility rules.)

Appendix A – Underwriting Questions for the Federal Long Term Care Insurance Program (FLTCIP)

Federal and Postal employees and members of the uniformed services have to answer the following 7 health-related questions to apply for the FLTCIP during this open season (from July 1 – December 31, 2002), if they are electing either the 3-year or the 5-year benefit period. Spouses answer these 7 questions, and then 2 additional ones also shown below:

(1) Do you currently reside in, or has a health professional advised you to enter, a nursing home or any type of assisted living facility?

(2) Are you currently receiving home health care services or attending adult day care?

(3) Do you currently require or receive human help or supervision with any of these activities?
- Bathing
- Dressing
- Eating
- Transferring yourself from bed to chair
- Toileting (getting to and using the toilet, completing hygiene-related functions after use)
- Continence (changing protective undergarments, managing ostomy bags and catheters, completing hygiene-related functions)

Note: If the answer any of questions 1 – 3 is "yes," then the applicant will not be eligible for insurance, but will be offered a services-only, non-insurance package. OPM plans to announce more details on this package at the end of June 2002. If the answer is "no" to all of questions 1 – 3, then the applicant continues with question 4.

(4) Do you currently have, or have you been diagnosed with, or been treated for, any of the following conditions?
- Alzheimer's Disease, Organic Brain Syndrome, or Dementia
- Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)
- Diabetes with amputation or ongoing complication affecting the kidney
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's Disease
- Schizophrenia
- Stroke (CVA): multiple
- Stroke (CVA): within 5 years
- Stroke (CVA): with residual impairment (e.g., paralysis, weakness, gait disturbance, vision disturbance, mental impairment)
- Transient Ischemic Attack (TIA): multiple
- Transient Ischemic Attack (TIA): within 3 years

(5) Do you currently use any of the following medical devices, aids, or treatments?
- Hospital bed
- Motorized scooter
- Oxygen

- Stair lift
- Dialysis
- Wheelchair
- Walker

(6) Do you currently require or receive human help or supervision with any of these activities because of mental retardation?
- Living independently
- Taking medications
- Shopping
- Preparing meals
- Using transportation
- Walking
- Making decisions about your money

(7) Have you been diagnosed with any mental or nervous disorder for which you have been hospitalized in the past 2 years or for which you have had 3 or more hospitalizations in the past 10 years?

If the answer is "yes" to any of questions 4-7, the applicant will not be eligible for any of the standard insurance options. He or she will be offered a choice of non-standard insurance (different benefits at higher premiums) or a services-only, non-insurance package. OPM will announce more details on both packages by the end of June 2002.

Spouses of Federal and Postal employees and spouses of members of the uniformed services must also answer the following two, additional questions about their health. Spouses who answer "yes" to either or both questions must explain and then sign an authorization to release medical records and give contact information for their primary physician. A registered nurse may call or visit them to get more information on their questions.

(8) Do you currently require or receive human help with any of these activities?
- Preparing meals
- Taking medications
- Shopping
- Making decisions about your money
- Using transportation
- Walking

(9) Do you use crutches and/or a multi-prong cane?

In addition to the questions for the 3-year and 5-year benefit period, those using the abbreviated underwriting application must also answer the following questions if they are requesting the unlimited benefit period:
(1) Do you currently have, or have you been diagnosed with, or treated for, any of the following conditions?
- AIDS or AIDS-related complex

- Cirrhosis
- HIV
- Kidney failure
- Mental retardation
- Organ transplant (excluding cornea or bone marrow transplant)
- Spinal Cord Injury (e.g., paraplegia, quadriplegia)

Note: If the answer to this question is "yes," the applicant is not eligible for the unlimited benefit period. If the answer to this question is "no," the applicant continues with question 2 below.

(2) Do you currently require or receive human help or supervision with any of these activities?
- Preparing meals
- Taking medications
- Shopping
- Making decisions about your money
- Using transportation
- Walking

(3) Do you currently use crutches and/or a multi-prong cane?

(4) Are you currently receiving disability income such as disability retirement annuity payments, VA disability compensation, worker's compensation, any Federal or state disability payments, or any other type of disability payment?

(5) Within the last 10 years, have you had, been diagnosed with or been treated for any of the following conditions?

A. Stroke or Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Carotid Artery Disease
B. Peripheral Vascular Disease
C. Coronary Artery Disease (e.g., heart attack, angina), Heart Arrhythmia, Cardiomyopathy, Congestive Heart Failure, Aneurysm, Valvular Disease
D. Diabetes (excluding gestational diabetes)
E. Cancer (excluding basal cell cancer or squamous cell cancer of the skin)
F. Chronic Kidney Disease (e.g., nephritis)
G. Liver Disorder (e.g., hepatitis)
H. Any Psychiatric Disorder (e.g., depression, bipolar disorder)
I. Disorder of the Brain (e.g, tremor, seizure disorder, head injury, tumor, infection), Neuropathy, Syncope, Paralysis, any Chronic or Progressive Neurological disorder
J. Chronic Lung Disease (e.g., COPD, emphysema, sarcoidosis, chronic bronchitis, asbestosis, asthma (excluding seasonal asthma), bronchiectasis)
K. Memory Loss
L. Rheumatoid Arthritis, any other type of arthritis, Osteoporosis, Back Disorder, Scoliosis, Spinal Stenosis, Disc Disease
M. Connective Tissue Disorder (e.g., scleroderma, systemic lupus, CREST syndrome)
N. Muscle Disorder (e.g., fibromyalgia, polymyalgia rheumatica, chronic fatigue syndrome)

If the answer is "yes" to any of questions 2 - 5, the applicant explains in a chart:

- Diagnosis or Disorder
- Date of Onset
- Treatment Dates
- Name, Address, Phone Number of Treating Health Professional

(6) Have you taken any prescription medications over the past 6 months? If yes, the applicant explains in a chart:

- Medication
- Dosage
- Frequency
- Reason Prescribed
- Name, Address, Phone Number of Prescribing Health Professional

There are three sets of questions about health in the full underwriting application during this open season, for all groups other than Federal and Postal employees, members of the uniformed services and their spouses. In addition, everyone completing the full underwriting application must sign a release of medical records, give contact information for their primary physician, and may have a telephone or in-person interview with a registered nurse.

During open season, anyone using these full underwriting questions who is declined coverage will not be eligible for insurance, but will be offered a services-only, non-insurance package. OPM will provide more details on this package at the end of June 2002.

THE FIRST SET OF QUESTIONS

(1) Do you currently reside in, or has a health professional advised you to enter, a nursing home or any type of assisted living facility?

(2) Are you currently receiving home health care services or attending adult day care?

(3) Do you currently require or receive human help or supervision with any of these activities?

- Bathing
- Dressing
- Eating
- Transferring yourself from bed to chair
- Toileting (getting to and using the toilet, completing hygiene-related functions after use)
- Continence (changing protective undergarments, managing ostomy bags and catheters, completing hygiene-related functions)

(4) Do you currently have, or have you been diagnosed with, or been treated for, any of the following conditions?

- AIDS or AIDS related Complex
- Alzheimer's Disease, Organic Brain Syndrome, or Dementia
- Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)
- Cancer within 2 years

- Cirrhosis
- Diabetes with amputation or complication affecting the kidney
- HIV
- Multiple Sclerosis
- Muscular Dystrophy
- Organ Transplant (excluding kidney, bone marrow or cornea transplants)
- Parkinson's Disease
- Schizophrenia
- Spinal Cord Injury (e.g. paraplegia, quadriplegia)
- Stroke (CVA): multiple
- Stroke (CVA): within 5 years
- Stroke (CVA): with residual impairment (e.g., paralysis, weakness, gait disturbance, vision disturbance, mental impairment)
- Transient Ischemic Attack (TIA): multiple
- Transient Ischemic Attack (TIA): within 3 years

(5) Do you currently use any of the following medical devices, aids, or treatments?
- Hospital bed
- Motorized scooter
- Oxygen
- Stair lift
- Dialysis
- Wheelchair
- Walker
- Multi-prong cane

(6) Do you currently require or receive human help or supervision with any of these activities because of mental retardation?
- Living independently
- Taking medications
- Shopping
- Preparing meals
- Using transportation
- Walking
- Making decisions about your money

If the answer is "yes" to any of questions 1 - 6, the applicant will not be eligible for insurance, but will be offered a services-only, non-insurance package. OPM will provide more details on this package at the end of June 2002.

THE SECOND SET OF QUESTIONS

(1) Do you currently have, or have you been diagnosed with, or treated for, any of the following conditions?
- Kidney transplant

- Mental retardation
- Paralysis of the extremities
- Kidney failure

(2) Do you currently require or receive human help or supervision with any of these activities?
- Preparing meals
- Taking medications
- Shopping
- Making decisions about your money
- Using transportation
- Walking

(3) Do you currently use crutches, cane, prosthetics, braces, or catheter?

(4) Are you currently receiving disability income such as disability retirement annuity payments, VA disability compensation, worker's compensation, any Federal or state disability payments, or any other type of disability payment?

(5) Within the last 10 years, have you had, been diagnosed with or been treated for any of the following conditions?

A. Stroke or Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Carotid Artery Disease
B. Peripheral Vascular Disease
C. Coronary Artery Disease (e.g., heart attack, angina), Heart Arrhythmia, Cardiomyopathy, Congestive Heart Failure, Aneurysm, Valvular Disease
D. Diabetes (excluding gestational diabetes)
E. Cancer (excluding basal cell cancer or squamous cell cancer of the skin)
F. Chronic Kidney Disease (e.g., nephritis), Incontinence, Prostate Disorder
G. Liver Disorder (e.g., hepatitis), Ulcerative Colitis, Crohn's Disease
H. Any Psychiatric Disorder (e.g., depression, bipolar disorder),
I. Disorder of the Brain (e.g., tremor, seizure disorder, head injury, tumor, infection), Neuropathy, Syncope, Paralysis, any Chronic or Progressive Neurological Disorder
J. Chronic Lung Disease (e.g, COPD, emphysema, sarcoidosis, chronic bronchitis, asbestosis, asthma (excluding seasonal asthma), bronchiectasis
K. Memory Loss
L. Rheumatoid Arthritis, any other type of Arthritis, Osteoporosis, Back Disorder, Scoliosis, Spinal Stenosis, Disc Disease
M. Connective Tissue Disorder (e.g., scleroderma, systemic lupus, CREST Syndrome), Hemochromatosis
N. Muscle Disorder (e.g., fibromyalgia, polymyalgia rheumatica, chronic fatigue syndrome)
O. Fracture or Amputation
P. High Blood Pressure
Q. Macular Degeneration, Glaucoma, Retinitis Pigmentosa, Meniere's Disease
R. Anemia, Polycythemia Vera, Thrombocytopenia, Hemochromatosis
S. Alcoholism, Drug Dependency

If the answer is "yes" to any of questions 1 - 5, the applicant explains the following in a chart:

- Diagnosis or Disorder
- Date of Onset
- Treatment Dates
- Name, Address, Phone Number of Treating Health Professional

(6) Have you taken any prescription medications over the past 6 months? If yes, the applicant explains in a chart:

- Medication
- Dosage
- Frequency
- Reason Prescribed
- Name, Address, Phone Number of Prescribing Health Professional

THE THIRD SET OF QUESTIONS

(1) Enter height and weight.

(2) Are you employed outside the home or engaged in any hobbies, social activities or volunteer work? If yes, describe.

(3) Do you exercise regularly? If yes, describe.

(4) Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months? If yes, give type and frequency.

(5) Within the past 2 years, have you had a complete physical exam? If yes, give Month, Year, and Physician's Name.

(6) Do you currently drink alcoholic beverages on a daily basis? If yes, enter number of drinks/day.

(7) Have you ever had an application for Life, Health, or Long Term Care Insurance declined, postponed, modified or rated (offered insurance at a higher premium rate than the standard premium rate)?

(8) Within the last 5 years, has a health professional recommended that you should have any surgeries, tests, or procedures that you have not had performed?

(9) Have you ever resided in a nursing home or any type of assisted living facility?

(10) Have you ever attended adult day care or received home health care services?

(11) Within the last 5 years (excluding childbirth without complications, the common cold, flu or routine exams), have you ever been hospitalized, consulted with, or received treatment from a health professional for a disease or condition not previously stated?

If the answer is "yes" to any of questions 8 - 11, the applicant explains the following in a chart:

- Diagnosis or Disorder
- Date of Onset
- Treatment Dates
- Name, Address, Phone Number of Treating Health Professional

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