PHYSICIANS MUTUAL INSURANCE COMPANY
PHYSICIANS LIFE INSURANCE COMPANY
LONG-TERM CARE POLICY APPLICATION
2600 Dodge Street Omaha, Nebraska 68131

THIS POLICY IS NOT APPROVED FOR MEDICAID ASSET PROTECTION UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP PROGRAM. HOWEVER, THIS POLICY IS AN APPROVED TRADITIONAL LONG-TERM CARE POLICY UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES APPROVED UNDER THE ILLINOIS TRADITIONAL LONG-TERM CARE PARTNERSHIP PROGRAM, CALL THE SENIOR HELPLINE AT THE DEPARTMENT ON AGING AT 1-800-252-8966.

(Home Office Use Only) Franchise/List Bill # _____)

APPLICANT INFORMATION - PLEASE PRINT

EMPLOYER/ASSOC. NAME AND NUMBER (If Applicable)	☐ Employee: date of hire_____ ☐ Employee's spouse ☐ Family member: Relationship_____ (Employee/Member Name:_____)

PERSONAL INFORMATION (Please note each box must be marked Individually)

Applicant's Name _____
(Please Print) (First) (Middle Initial) (Last)

Street Address _____
(Apt. No.)

City _____ State _____ Zip Code _____ SS# ____/____/____

Birthdate _____ Age _____ Height _____ Weight _____ Sex _____
(Month) (Day) (Year) (Ft/In) (Lbs)

Applicant's Telephone No.	**Best time to call**	**E-mail address (Optional)**
Area Code _ _	☐ _____ A.M. ☐ _____ P.M.	

Beneficiary	**Applicant Status**
Name:	☐ Single
Relationship:	☐ Married, Spouse NOT Applying
Address:	☐ Married, Spouse currently has a Physicians Mutual Long-Term Care Policy or is applying today. Spouse's Name:_____

YES	**NO**	
☐	☐	Are you a U.S. citizen?
☐	☐	If no, have you resided in the United States for more than 2 years and are you a permanent resident? (If yes, please provide a copy of your green card.)
☐	☐	**1. Are you covered by Medicaid (not Medicare)?**
☐	☐	2. A. Do you have another Long-Term Care Insurance Policy or certificate in force (including health care service contract, health maintenance organization contract); or do you have an Application pending for that type of coverage with this or any other company? If so, with which company? _____ Daily Benefit: $_____ Type of coverage☐ Comprehensive ☐ Facility Care ☐ Home & Community Care ☐ Other _____ B. If you currently have Long-Term Care coverage with Us, please list Policy Number: _____
☐	☐	3. Did you have another Long-Term Care Insurance Policy or certificate in force during the past 12 months? If so, with which company? _____ If that Policy lapsed, when did it lapse? _____/_____/____
☐	☐	4. Do you intend to replace any of your Long-Term Care, medical, or health insurance coverage with this Policy? If so, please list name and address of insurer being replaced: _____
☐	☐	5. Within the past three years have you: Been declined, postponed, restricted, rated, or charged an extra premium for disability, long term care, or health insurance? If yes, explain why: _____

BENEFIT SELECTION

Yes ☐ **No** ☐ Have you used any tobacco products in the last 12 months? If answered "Yes", Preferred rates do not apply.

Plan Applied For: _____

Rate Class Applied for:

Pref. _____ Std. _____ Rated _____

Facility Care Benefit $ _____

Home & Community Care Benefit $ _____

H&CC _____ 50% _____ 75% _____ 100%

Elimination Period _____ days

Maximum Benefit $ _____ / _____ (Minimum No. of years)

Initial Premium Paid $ _____

Renewal Premium $ _____

Premium Payment Period:

☐ Lifetime ☐ 10 Pay ☐ 20 Pay

☐ Paid up at Age 65

Check (✓) Mode:

☐ Annual ☐ Semi-annual ☐ Quarterly

☐ Monthly ABW

Specify Effective Date:

☐ Date of Application

☐ Date Policy is Approved & Issued

☐ Requested Effective Date - (Specify) _____ (Month) (Day) (Year)

Optional Riders (check if applying)	Rider #'s	EDP Codes:	
☐ Home and Community Care Rider			$
☐ Inflation Protections			$
☐ Guaranteed Purchase Option			$
☐ Spousal Discount			$
☐ Married Discount			$
☐ Family Member Discount			$
☐ Return of Premium Rider			$
☐ Home Cash Benefit Rider			$
☐ Shared Care Benefit Rider			$
☐ Restoration of Benefits Rider			$
☐ Calendar Day Elimination Rider			$
☐ Waiver of the Elimination Period for Home & Community Care			$
☐ Shortened Benefit Period Non-Forfeiture Rider			$
☐ Joint Waiver of Premium Rider			$
☐ Surviving Spouse Waiver of Premium Rider			$
Administrative Riders (For Home Office Use Only)			
50% HCC			
75% HCC			
100% HCC			
10 Pay			
20 Pay			
Paid up @ age 65			
Medicare Supplement / LTC Discount			
Other			

SECTION A

YES **NO**

☐ ☐ 1. Have you had, do you currently have, or have you been diagnosed by a medical professional as having any of the following conditions?

Acquired Immune Deficiency Syndrome (AIDS)
HIV Positive
Organic Brain Syndrome
Metastatic Cancer (spread from original organ)
Multiple Strokes (CVA's)
Multiple Sclerosis
ALS (Lou Gehrig's Disease)
Chronic Memory Loss
Liver Cirrhosis
Muscular Dystrophy
COPD (Emphysema)
with oxygen use
with current medications
with current tobacco use
Alzheimer's Disease
Parkinson's Disease
Senility/Dementia

☐ ☐ 2. Have you had, do you currently have, or have you been diagnosed by a medical professional as having any of the following conditions within the past 48 months? Congestive Heart Failure (CHF); Stroke; Transient Ischemic Attack (TIA)? Cancer of Stomach, Pancreas, Liver, Bone, Testes, Lung, or Brain?

☐ ☐ 3. Have you had, do you currently have, or have you been diagnosed by a medical professional as having any of the following conditions within the past 24 months? Disabling Back or Spine Injury

☐ ☐ 4. Do you currently use or have you been recommended to use a Walker or Wheelchair; Oxygen; or require Kidney Dialysis?

☐ ☐ 5. Do you currently need the assistance or supervision of another person in performing any of the following activities: Moving in/out of bed or chair; Bathing; Dressing; Toileting; Bowel/Bladder Control; Eating?

STOP **If any part of Section A is answered "YES," DO NOT SUBMIT THIS APPLICATION. Otherwise, please continue.**

SECTION B

For questions 6 - 9, if Yes, circle applicable condition, give details in question 10.

YES	NO	
☐	☐	6. Are you currently taking or been prescribed any prescription drugs or medications?
		If Yes, please list **all**:_____
		_____
☐	☐	7. Within the past five years have you: received medical advice or treatment; taken any medications; been medically diagnosed; been confined to a convalescent care facility, hospital; or nursing facility; or consulted with a health professional for any of the following conditions: (If "YES", please circle any that apply).
☐	☐	A. Paralysis; Stroke; Transient Ischemic Attack (TIA); Hodgkin's Disease; Leukemia; Lymphoma; Cancer; Heart Surgery; Angioplasty; Heart Attack; High Blood Pressure; Congestive Heart Failure (CHF); Disabling Back or Spine Injury?
☐	☐	B. Emphysema; Shortness of Breath; Fainting Spells; Blacking Out; Injury due to Falls or Imbalance?
☐	☐	C. Brain Disorder; Mental Illness; Depression; Alcoholism; Drug Addiction?
☐	☐	D. Epilepsy; Seizures; Convulsions; Tremor; Diabetes; Skin Ulcers; Macular Degeneration?
☐	☐	E. Osteoporosis; Arthritis; other conditions causing Crippling or Limited Motion?
		8. During the past three years have you:
☐	☐	A. Been advised by a medical professional to have surgery which has not been performed?
☐	☐	B. Consulted with or been treated by a medical professional for any reason not previously stated?
☐	☐	C. Received home care; used an adult day care facility; been advised by a medical professional to enter a nursing home; or been confined to a hospital or other health care facility? (If "YES," please circle any that apply).
☐	☐	9. Do you use a handicap sticker, handicap placard, or handicap license plate?

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

Applicant:	**If more space is needed, attach a signed and dated additional sheet.**		
Question #	**Nature of Condition/Medication**	**Date Last Treated/ Medication Taken**	**Name of Physician Seen/ Physician's Address and Phone Number**

Please show name and address of your personal physician, if not listed above, or other doctors/clinics seen on a regular basis

Doctor's Name	Address	
City	**State**	**Zip Code**
Doctor's Medical Specialty	**Phone Number**	
	Area Code - -	
Date Last Seen (MM/DD/YYYY)		

SECTION C

PERSONAL PROFILE

YES NO

☐ ☐ 1. Do you drive at least 1,500 miles per year?

Driver's License # _____ State _____ Expiration Date _____

☐ ☐ 2. In the last 6 MONTHS have you actively worked? If Yes, how many hours per week? Describe your occupation and duties? _____

_____

If retired, date of retirement: _____

☐ ☐ 3. If you have actively worked during the last 6 MONTHS, have you missed more than five consecutive days of work due to accidents, injury, sickness, or any physical or cognitive impairment? If Yes, please describe:

_____

☐ ☐ 4. During the last 12 months, have you ever required assistance or supervision of any kind to perform any everyday activity, such as mobility (including the use of pronged canes), taking medications, dressing, eating, walking, bathing, transferring, or toileting? Please circle any that apply. Please explain. _____

_____

☐ ☐ 5. Do you currently do volunteer work or participate in outside activities on a regular basis? If Yes, please describe:

_____

☐ ☐ 6. Are you receiving disability income, workers' compensation or any state or Social Security Disability Benefits?

If YES, please give details: _____

☐ ☐ 7. Do you use a Quad Cane, Hospital Bed, or any other mechanical device? Do you need assistance with: Shopping; Walking; Using Transportation; Housekeeping or Cooking? Please circle any that apply. Please explain: _____

_____

8. With whom do you live? ☐ Alone ☐ Spouse ☐ Other ☐ Family (relationship) _____

How long have you lived together? _____

SECTION D

Protection Against Unintended Lapse

I understand that I have the right to designate at least one person other than myself to receive notice of cancellation of this Long-Term Care insurance policy for non-payment of premium. I understand that the notice to my designee will not be given until 30 days after a premium is due and unpaid. I understand that I may elect NOT to designate any person to receive such notice.

☐ **I elect NOT to designate any person to receive such notice.**

☐ **Please notify the following person in the event my policy premium is not paid within 30 days of any premium due date.**

NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE _____ ZIP CODE: _____

The designate is not responsible for payment of the premium for unintended lapse.

SECTION E

Disclosure

The information provided here is not intended as legal or tax advice. Clients are advised to consult with their own attorney, accountant or tax advisor regarding the tax implications of purchasing Long Term-Care insurance.

The Health Insurance Portability and Accountability Act of 1996, also known as the "Kennedy-Kassebaum Act" amended the Internal Revenue Code to provide federal income tax advantages for long term care insurance policies that meet certain requirements. Policies that meet these requirements are called QUALIFIED Long-Term Care Insurance policies. Subject to limitations under the law, certain premium payments for QUALIFIED policies are tax deductible and long term care benefits received under these policies will be treated as non-taxable income.

I understand and acknowledge that A QUALIFIED LONG-TERM CARE INSURANCE POLICY AS DEFINED UNDER SECTION 7702B OF THE INTERNAL REVENUE CODE WILL BE ELIGIBLE FOR CERTAIN TAX ADVANTAGES. I also understand that A NON-QUALIFIED LONG-TERM CARE POLICY MAY NOT BE ELIGIBLE FOR THESE TAX ADVANTAGES.

I am applying for a QUALIFIED _____ NON-QUALIFIED _____ Long-Term Care Policy.

SECTION F

AGREEMENT:

I agree that: (1) the answers contained herein are full, complete and true to the best of my knowledge and belief; (2) this application will be a part of the contract of insurance under which I am applying; and (3) the insurance will become valid and effective only if: (a) this application is approved by the Company; (b) a policy is issued during my lifetime; (c) the first premium has been paid; and (d) until the effective date set by the Company, I remain at a level of health that qualifies me for the insurance as determined by the Company. If approved, the effective date will be stated in the policy issued to me.

RECEIPT:

I received the following when I applied for insurance under this policy with Physicians Mutual Insurance Company:

1. **Outline of Coverage**
2. **(If eligible for Medicare) "Guide to Health Insurance for People with Medicare"**
3. **"A Shopper's Guide to Long-Term Care Insurance"**
4. **"Long-Term Care Insurance Potential Rate Increase Disclosure Form**

I have reviewed the Shortened Benefit Period Non-Forfeiture Rider and I ☐ accept or ☐ decline.

☐ I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of the Policy with or without inflation protection. I realize that, based on current health care cost trends, the benefits provided by a Long-Term Care plan which does not have meaningful inflation protection may be significantly diminished in terms of real value, depending on the amount of time which elapses between the date I purchase the policy and the date on which I first become eligible for benefits. Specifically, I have reviewed the option for the Compound Inflation Protection Benefit Plan(s) _____, and I reject this inflation protection.

Caution: If your answers on this application are incorrect or untrue, Physicians Mutual Insurance Company may have the right to deny benefits or rescind your policy.

No agent may: change, waive, or alter the terms and conditions of this application; accept risks; guarantee insurability; make or modify contracts or waive any of the Company's rights or requirements.

Date Application Completed: _____ Dated At: _____
Month Day Year City State

Signature of Applicant – Owner _____

Licensed and Appointed Agent _____

Agent License # _____

A-LTC-RFIL

Do Not Write Below This Line
HOME OFFICE USE ONLY

Policy Kind	Submitted Premium	Region	Division	Repl	
Split %	**Agent 1**	**Profile**	**Split %**	**Agent 2**	**Profile**
Split %	**Agent 3**	**Profile**	**Split %**	**Agent 4**	**Profile**

POLICYOWNER'S PROXY (for Physicians Mutual Insurance Company)

I hereby appoint the Board of Directors of Physicians Mutual Insurance Company, or a majority of such of them as actually are present, as my proxy with full power and authority to vote and otherwise act for me in my behalf at all annual and special meetings of the policyholders at which I am not present, and I also direct that this proxy shall not expire but shall continue in force until withdrawn by me by written notice mailed to the Company.

Sign Here **X** _____ Date _____

AGENT REPORT

YES	NO	Please provide **complete details** to ensure against delays in processing.
☐	☐	1. Did you personally interview the proposed insured face to face and witness his or her signature? If "NO," give details: _____
☐	☐	2. Did you observe any physical or mental impairments with regard to walking or talking, or any kind of tremor? If "YES," please explain: _____
☐	☐	3. Did you observe any disorientation as to time, place, space; or did the applicant show any signs of confusion? If "YES," please explain: _____
☐	☐	4. Does the applicant have other health or life insurance coverage with Physicians Mutual or Physicians Life Insurance Company or coverage currently pending? If Yes, please provide the following information: Name:_____ Policy Kind(s) (LTC, HMS, etc):_____ Policy Number(s):_____ Date Issued (if applicable):_____
		5. Please list other health insurance policies sold by you to the applicant:_____ _____
		6. List health insurance policies sold in the last five years by you to the applicant that are no longer in force. _____ _____
☐	☐	7. Does the Proposed Insured speak and understand English? a) If no, who translated and in what language?_____ b) If no, who should we call to translate for the telephone interview? Name:_____ Telephone Number:_____
☐	☐	8. Are you related to the proposed insured by blood or marriage? If Yes, what is your relationship?_____ _____

AGENT'S STATEMENT

I certify that I have truly and accurately recorded in this application all information supplied by the applicant and personally witnessed (his/her) signature. I certify that I have interviewed and observed the applicant to obtain all information on this application. Considering all Underwriting requirements, _____ appears to be eligible for this Long-Term Care Policy.

Date ____/____/____
Month Day Year

Signature of Agent(s) _____

PRINT or TYPE Agent(s) Name _____

Agent's State License I.D. Number _____

BGA Name _____

AUTOMATIC BANK-WITHDRAW AUTHORIZATION

Pay Your Premiums The Easy Way With The Automatic Bank-Withdraw Plan

AUTHORIZATION TO WITHDRAW FUNDS BY PHYSICIANS MUTUAL INSURANCE COMPANY, OMAHA, NEBRASKA. As a convenience to me, I authorize you to make payments to Physicians Mutual Insurance Company, Omaha, NE, by withdrawing funds from my account by check, draft or automatic debit entry. I agree that your rights with respect to each such charge will be the same as if it were personally executed by me. The payment of premiums by this method may be discontinued by the Company or myself upon 30 days written notice. This authorization is to remain in effect until you receive notice from me to revoke it.

DEPOSITORY NAME	ACCOUNT NUMBER (Attach a voided check)	
CITY STATE	ZIP	☐ Checking
SIGNATURE (As it appears on bank records)	DATE	☐ Savings
SPOUSE'S SIGNATURE (If joint account)		

PHYSICIANS MUTUAL INSURANCE COMPANY
PHYSICIANS LIFE INSURANCE COMPANY

NOTICE OF INFORMATION PRACTICES UNDER STATE LAW

Your state of residence requires us to provide you with this Notice.

We may collect nonpublic personal information about you and others to be insured in connection with an application for insurance, a reinstatement of insurance or a claim for benefits under the policy or other insurance transaction.

Such information may be collected from sources other than you and others to be insured. These sources include physicians, other medical personnel and institutions, employers, neighbors, schools, insurers, information collection agencies, insurance support organizations and other investigative agencies.

We may request information concerning such matters as health, prescription drug use, medical opinions regarding disability, employment status, normal occupational duties and ability to perform them, attendance, ability to perform activities of daily living, status as a student, finances, other insurance coverage, accident reports and any other information necessary for proof of loss.

Our techniques to obtain such information include telephone, Internet, written and personal contacts.

We can disclose information about you, without your authorization, in certain circumstances. These situations include but are not limited to disclosure:

1) to someone we employ to perform the same functions we perform as your insurer. They would also be bound by the contents of this Notice.
2) to an insurance regulatory agency.
3) as allowed by law for the detection and prevention of fraud.
4) to medical providers to verify insurance coverage.
5) of the financial information we collect, to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

However, we do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

With certain limitations you have the following rights about information we have about you.

1) The right to inspect and copy such information.
2) The right to know to whom we disclosed this information.
3) The right to know the source of the information if the source is an institution.
4) The right to the steps you must take to request an amendment of this information.

For the specific procedures regarding these rights, please send a written request to:

ATTN: POS Administration Privacy Desk
Physicians Mutual Insurance Company
P.O. Box 3313
Omaha, NE 68172-4005

OR: 1-866-939-8889

An Insurance Support Organization may be asked to prepare a report for us regarding you and others to be insured. That organization can retain a copy of the report and disclose it to others.

We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with applicable regulations to guard your nonpublic personal information.

Things You Should Know Before You Buy
Traditional Long-Term Care Insurance

Traditional Long-Term Care Insurance

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

Medicare

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

Medicaid

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

Shopper's Guide

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

Counseling

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

Physicians Mutual®

2600 Dodge Street
Omaha, NE 68131-2671

Authorization to Process Application

My agent has explained to me that my personal financial circumstances are an important consideration in determining whether or not long-term care insurance is an appropriate purchase for me.

My agent has also given me a copy of "Things You Should Know Before You Buy Long-Term Care Insurance" and has explained the importance of completing the Long-Term Care Insurance Personal Worksheet.

I hereby confirm that I elect not to complete the Long-Term Care Insurance Personal Worksheet. However, I request that you continue to process my application for Long-Term Care Insurance coverage.

_____ _____

Applicant's Signature Date

Note: If Applicant elects not to complete the Long-Term Care Personal Worksheet, this signed form must be submitted with the Application along with the Long-Term Care Personal Worksheet marked to indicate the election not to complete.

Physicians Mutual®

2600 Dodge Street
Omaha, NE 68131-2671

Authorization to Process Application

My agent has explained to me that my personal financial circumstances are an important consideration in determining whether or not traditional long-term care insurance is an appropriate purchase for me.

My agent has also given me a copy of "Things You Should Know Before You Buy Long-Term Care Insurance" and has explained the importance of completing the Long-Term Care Insurance Personal Worksheet.

I hereby confirm that I elect not to complete the Long-Term Care Insurance Personal Worksheet. However, I request that you continue to process my application for Traditional Long-Term Care Insurance coverage.

_____ _____

Applicant's Signature Date

Note: If Applicant elects not to complete the Long-Term Care Personal Worksheet, this signed form must be submitted with the Application along with the Long-Term Care Personal Worksheet marked to indicate the election not to complete.

PLEASE CHECK THE APPROPRIATE UNDERWRITING COMPANY:

☐ **PHYSICIANS MUTUAL INSURANCE COMPANY**

☐ **PHYSICIANS LIFE INSURANCE COMPANY**

HIPAA AUTHORIZATION FOR UNDERWRITING PURPOSES

I, the undersigned, authorize any health plan, licensed physician, medical practitioner, hospital, clinic, medical or medical related facility, pharmacy, pharmacy benefit manager, the Veteran's Administration, insurance company, the Medical Information Bureau, Inc. (MIB), consumer reporting agency, employer or Government agency to disclose medical and non-medical information about me or my minor children.

This authorization was prepared for the purpose of obtaining medical and non-medical information necessary to underwrite the application for insurance submitted with this authorization. The information subject to this authorization includes any and all medical and non-medical information being requested by Physicians Mutual Insurance Company or Physicians Life Insurance Company for the purpose stated above, as well as any information provided to Physicians Mutual Insurance Company or Physicians Life Insurance Company on previous applications. This authorization includes information about drug and alcohol use, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease, and mental illness, but excludes psychotherapy notes.

Persons or entities employed by or authorized by Physicians Mutual Insurance Company or Physicians Life Insurance Company to perform tasks related to the underwriting process are hereby authorized to use the medical and non-medical information covered by this authorization. I understand that if the person or entity who receives this information is not a health care provider or health plan covered by federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Physicians Mutual Insurance Company or Physicians Life Insurance Company or, so long as Physicians Mutual Insurance Company or Physicians Life Insurance Company has a legal right to contest a claim under the coverage or contest the coverage itself. Revocation requests must be sent in writing to: ATTN: Underwriting Department, Physicians Mutual or Physicians Life Insurance Company, 2600 Dodge Street, Omaha, NE 68131-2671.

I understand that my application for insurance may be declined if I choose not to sign this authorization. This authorization is valid for a period of twenty-four (24) months from the date of my signature. A copy of this authorization may be used in place of the original. I acknowledge that I or my authorized representative has received a copy of this authorization.

If this authorization is signed by my personal representative, that individual's authority to act on my behalf is described below.

☐ I elect to be interviewed if an investigative consumer report is prepared. I understand that upon written request, I may obtain a copy of this report.

_____ _____

(Print) Name Applicant #1 Whose Information is Covered by This Authorization — Date of Birth

_____

Signature of Applicant #1or Personal Representative — Date

_____ _____

(Print) Name of Applicant #2 Whose Information Is Covered by This Authorization — Date of Birth

_____

Signature of Applicant #2 or Personal Representative — Date

_____ _____ _____ _____

(Print) Name of Minor Child — Date of Birth — (Print) Name of Minor Child — Date of Birth

_____ _____ _____ _____

(Print) Name of Minor Child — Date of Birth — (Print) Name of Minor Child — Date of Birth

_____

(Print) Name of Personal Representative of Applicant(s)/Minor(s) Whose Information is Covered by This Authorization

_____

Personal Representative's Relationship to Applicant(s)/Minor(s) or Description of Authority

LEAVE ONE COPY WITH APPLICANT/ RETURN A COMPLETED COPY WITH APPLICATION

Physicians Mutual®

2600 Dodge Street
Omaha, NE 68131-2671

TRADITIONAL LONG TERM CARE INSURANCE
PERSONAL WORKSHEET

People buy traditional long-term care insurance for many reasons. Some don't want to use their own assets to pay for traditional Long-Term Care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care, or don't want to go on Medicaid. But traditional long term care insurance may be expensive, and may not be right for everyone.

The company will ask you to fill out this worksheet to help you and the company decide if you should buy this policy. By State law, the insurance company must fill out part of the information on this worksheet.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be $_____ per month, or $ _____ per year.

Type of Policy (guaranteed renewable):_____

The Company's Right to Increase Premiums: We may change your renewal premium only if we make the same change for all policies of this form and class in the state where you live.

Rate Increase History

The company has sold traditional long-term care insurance since 1988 and has sold this policy since 2004. The company has never raised its rates for any traditional long-term care policy it has sold in this state or any other state.

Questions Related to Your Income

How will you pay each year's premiums?

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

☐ Have you considered whether you could afford to keep this policy if the premium went up, for example, by 20%?

What is your annual income? (check one)

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

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

☐ No Change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

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

The national average annual cost of care in 2004 was $61,700, but this figure varies across the country. In ten years the national average annual cost would be about $100,550, if costs increase 5% annually.

What elimination period are you considering? Number of days _____ Approximate cost $_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

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

Questions Related to Your Savings and Investments

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

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

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

☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your traditional long-term care.

Disclosure Statement

☐ The answers to the questions above describe my financial situation. (check one) ☐ I choose not to complete this information.
☐ I acknowledge that the carrier and/or its agent (below) has reviewed this form with me, including the premium, premium rate increase history, and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked)

Signed: _____ _____
(Applicant) (Date)

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

Signed: _____ _____
(Agent) (Date)

Agent's Printed Name: _____

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

Signed: _____ Date _____

Long-Term Care New Business Checklist

Physicians Mutual Insurance Company®

Please return this form to Physicians Mutual.

- ❑ P103 – Non-Tax Qualified
- ❑ P104 – Tax Qualified
- ❑ P105 – Home Health Care
- ❑ P109 – Basic Tax Qualified

- ❑ P145 – Non-Tax Qualified
- ❑ P146 – Tax Qualified
- ❑ P147 – Home Health Care
- ❑ P148 – Basic Tax Qualified

- ❑ Application
    1. Please check website for State Approval List for appropriate state application.
    2. Answer all questions in full.
    3. Be sure to leave all applicable forms with the proposed insured.
    4. Sign and date in all places indicated.
    5. To save age, effective date on application must be dated 30 days back or 60 days forward from the signature date.

- ❑ Outline of Coverage
- ❑ Collect Premium

    At least two month's premium, or a full modal premium if other than pre-authorized checking, needs to be submitted with the application. In CA, one month premium.
- ❑ Inform Client of the Telephone Interview or may require ordering APS
- ❑ Personal Worksheet (Form Number may vary per state. Some states may not require a Personal Worksheet. Please check website under LTC forms section)
- ❑ Attach Copy of Quote
- ❑ HIPAA Authorization (ALL645-1103) Doctor may require their own form.
- ❑ 10 Pay, 20 Pay or Paid to Age 65 Option Form - If Chosen
- ❑ PAC or ABW Form (Also attached blank check)- If Chosen
- ❑ Attach Replacement Notice - If Applicable

Agent Name: _____

Address:_____

Phone: _____

Additional Contact Person: _____

Additional Phone: _____

BGA Name: _____

Overnight Address:
Attn: LTC New Business
Physicians Mutual Insurance Company
2600 Dodge St
Omaha, NE 68131

Mailing Address:
Attn: LTC New Business
Physicians Mutual Insurance Company
PO Box 2316
Omaha, NE 68172

Physicians Mutual®

2600 Dodge Street
Omaha, NE 68131-2671

Agent Training Statement

I have completed Physicians Mutual training material on their Long Term Care products and suitability requirements. Also, I have clearly and completely explained all features, benefits and limitations in this policy to the applicant.

_____

Agent Name Printed and Agent Number

_____

Agent Signature Date

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LONG-TERM CARE INSURANCE

PHYSICIANS MUTUAL INSURANCE COMPANY
2600 Dodge
Omaha, NE 68131

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

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

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

STATEMENT TO APPLICANT BY AGENT

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

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar periods to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only you right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Signature of Agent

Typed Name and Address of Agent

The above “Comparison of Benefits/Notice to Applicant” was delivered to me on:

Date

Applicant’s Signature

Spouse Signature
(if listed on same application)

Physicians Mutual Insurance Company
2600 Dodge Street
Omaha, Nebraska 68131
800-645-4300

TRADITIONAL LONG TERM CARE INSURANCE
OUTLINE OF COVERAGE
POLICY P146IL

THIS POLICY IS NOT APPROVED FOR MEDICAID ASSET PROTECTION UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP PROGRAM. HOWEVER, THIS POLICY IS AN APPROVED TRADITIONAL LONG-TERM CARE POLICY UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES APPROVED UNDER THE ILLINOIS TRADITIONAL LONG-TERM CARE PARTNERSHIP PROGRAM, CALL THE SENIOR HELPLINE AT THE DEPARTMENT ON AGING AT 1-800-252-8966.

NOTICE TO BUYER: This Policy may not cover all of the costs associated with Long-Term Care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy Limitations.

CAUTION: The issuance of this long-term care insurance Policy is based upon your responses to the questions on your Application. A copy of your Application will be attached to the Policy. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address:

Physicians Mutual Insurance Company
2600 Dodge Street
Omaha, Nebraska 68131

The Policy is an individual Policy of insurance.

PURPOSE OF OUTLINE OF COVERAGE - This outline of coverage provides a very brief description of the important features of the Policy. You should compare this outline of coverage to outlines of coverage for other Policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY CAREFULLY!

THIS POLICY IS INTENDED TO BE A FEDERALLY TAX-QUALIFIED LONG-TERM CARE INSURANCE CONTRACT UNDER SECTION 7702B (b) OF THE IRS CODE OF 1986, AS AMENDED.

TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED - RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. Physicians Mutual cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

WAIVER OF PREMIUM - After you have been eligible for benefits for a period of at least six months, We will waive all future premiums coming due according to the Premium Payment Mode in effect at the time you become eligible for Waiver of Premium. Premiums will be waived until you are no longer eligible for benefits. Waiver of Premium can only be retroactive up to six months prior to the date on which We receive notice of eligibility. As noted, Waiver of Premium does not apply to the International Coverage Benefit.

TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS: **We may change your Renewal Premium only if We make the same change for all Policies of this form and class in the State where you live.**

TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED - If you are not satisfied with your Policy, you have 31 days to return it to Us or our agent for a full refund of any premium you have paid. The Policy is then void as if no Policy had been issued. The Policy does not contain a provision for a refund of premium upon death or surrender of the Policy.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE - If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from your agent. Neither Physicians Mutual Insurance Company nor its agents represent Medicare, the federal government, or any state government.

TRADITIONAL LONG-TERM CARE COVERAGE - Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services. Coverage for these services may be provided in a setting such as in a nursing home, in an assisted living facility, in the community or in the home but not in an acute care unit of a hospital. The Policy pays the expenses incurred for any services as shown in the Policy, subject to the Policy Limitations, Exclusions and Elimination Periods.

BENEFITS PROVIDED BY THIS POLICY - When you meet the definition of a "Chronically Ill Individual," We will pay the expenses you incur for the services of a skilled, intermediate or custodial Nursing Home, Assisted Living Facility, or Hospice Facility while you are confined, or We will pay the expenses you incur for the services of the following alternatives: (1) Home Health Care; (2) Hospice Care; (3) Respite Care; (4) Adult Day Care; or (5) Alternative Plan of Care. "Chronically Ill Individual" means any individual who has been certified within the preceding 12 month period by a Licensed Health Care Practitioner as: (1) being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living (which are bathing, eating, dressing, continence, transferring and toileting) for a period of at least 90 days due to a loss of Functional Capacity; (2) having a similar level of disability; or (3) requiring Substantial Supervision to protect such individual from threats to health and safety due to severe Cognitive Impairment.

ELIGIBILITY FOR PAYMENT OF BENEFITS: If you are certified as a Chronically Ill Individual, you are receiving Qualified Long-Term Care Services, and a Plan of Care has been prescribed by a Licensed Health Care Practitioner, these benefits are available to You. The benefits are subject to the Elimination Period and Maximum benefit shown in your Policy's Schedule, our Claims Evaluation Process and all other Policy provisions.

FACILITY CARE BENEFIT - The most We will pay for a Nursing Home (skilled, intermediate, or custodial), an Assisted Living Facility or Hospice Facility for expenses you incur in any month is $ _____.

HOME AND COMMUNITY CARE BENEFIT – The most We will pay for Home Health Care, Hospice Care, Adult Day Care, and Respite Care (one month) for expenses you incur in any month is $_____.

ALTERNATIVE PLAN OF CARE BENEFIT - If you would otherwise be eligible to receive benefits, We may pay the expenses you incur for services provided under a written Alternate Plan of Care. For this Alternate Plan of Care to be approved: (1) it must be agreed upon in advance by you, your Licensed Health Care Practitioner and Us; and (2) it must be a cost effective manner to provide benefits for your claim.

BED RESERVATION BENEFIT - If you are temporarily absent while receiving Facility Care Benefits, and the Elimination Period has been met, We will pay the expenses you incur to reserve your bed We will pay Bed Reservation Benefits for up to 60 days of absence during a Calendar Year.

EXTENSION OF BENEFITS - Termination of this Policy shall be without prejudice to any benefits payable for Facility Care Benefits under this Policy if such confinement began while this Policy was in force and continues without interruption after termination

RESTORATION OF BENEFITS - If the Maximum Benefit has not been paid, We will restore the Maximum Benefits of this Policy listed in your Policy's Schedule including increases from any rider or endorsement, subject to the following conditions: (1) you must be certified by a Licensed Health Care Practitioner that you are not Chronically Ill; (2) that status has been maintained for at least six consecutive months from the date of the certification; and (3) you have not received services covered by this Policy for a period of at least six months.

ELIGIBILITY FOR PAYMENT OF ADDITIONAL BENEFITS: If you are eligible for benefits, these Additional Benefits are available to you. The Elimination Period does not apply to these Additional Benefits and they will not count toward satisfying the Elimination Period. These Additional Benefits will not count toward your Maximum benefit. These Additional Benefits are also subject to our Claims Evaluation Process and all other Policy provisions.

AMBULANCE SERVICE BENEFIT - We will pay for services provided by a local licensed ambulance service for transportation to or from a Nursing Home, an Assisted Living Facility, a Hospice Facility or a hospital in accordance with the following: (1) expenses incurred by you, not to exceed $75 per trip; and (2) Lifetime Maximum of $300.

FIRST-TIME CASH BENEFIT - The first time you are eligible for benefits, We will pay you a one-time lump sum of $1,000. This benefit will only be paid once in your lifetime.

NOTICE: Since First-Time Cash Benefit is made without regard to expenses you incur, part of the benefits could be considered taxable income. You should consult with a tax advisor for more information concerning the tax implications.

HOME FIRST BENEFIT - This is a Home First Benefit Lifetime Maximum of $_____which may be used for the expenses you incur for the following services: (1) Medical Alert System; (2) Durable Medical Equipment; or (3) Home Safety Check.

HOME MODIFICATION BENEFIT - This is a Home Modification Benefit Lifetime Maximum of $ _____ which may be used for expenses you incur for modifications to your Home that are primarily being made to improve your ability to perform the Activities of Daily Living and allow you to live safely in your Home

INFORMAL CAREGIVER TRAINING BENEFIT - This is an Informal Caregiver Training Benefit Lifetime Maximum of $_____ which may be used for the expenses you incur in training your Informal Caregiver to take care of you in your Home.

INTERNATIONAL COVERAGE BENEFIT – This is an International Coverage Benefit Lifetime Maximum of $_____which may be used for care outside the United States of America, its territories and possessions provided by a Nursing Home while you are confined as a resident inpatient. We will pay the expenses you incur if the following conditions are met:

(1) We will not provide Care Coordination Advisor in connection with this benefit;
(2) Waiver of Premium does not apply to this benefit;
(3) We receive Proof of Loss proving admittance to a Nursing Home that is satisfactory to Us. At your own expense, you must obtain and furnish Us with complete documentation in English. Such documentation includes, but is not limited to:
    (a) certification as a Chronically Ill Individual;
    (b) a Plan of Care prescribed by a Licensed Health Care Practitioner;
    (c) properly completed claim forms, billing statements, and supporting medical and care documentation; and
    (d) a copy of your passport, airline ticket or other proof acceptable to Us that you are outside the United States of America, its territories and possessions; and
(4) payment will only be made to you, in the lawful money of the United States of America. Any foreign exchange rate will be as determined by Us.

OPTIONAL RESOURCE ADVISOR - A Resource Advisor is available to assist you with questions concerning the following: (1) eligibility of benefits; (2) availability of resources in your area; or (3) any other questions you may have about a claim for benefits.

OPTIONAL CARE COORDINATION ADVISOR - After you have spoken with your Resource Advisor and in the event you require additional care coordination assistance, We will arrange, at not cost, for a Care Coordination Advisor, to contract you, who will: (1) be a Licensed Health Care Practitioner; (2) assess and coordinate appropriate care and services; (3) prescribe a Plan of Care appropriate for your condition; (4) monitor your Plan of Care, including periodic assessments of your situation; and (5) assist with necessary claims documentation.

CONTINGENT NON-FORFEITURE BENEFIT: This Contingent Non-Forfeiture Benefit applies during the first three years after the Policy Effective Date. It also applies after the first three years if a Shortened Benefit Period Non-Forfeiture Rider is not attached to your Policy.

We will provide you a Contingent Non-Forfeiture Benefit when all of the following take place:

(1) We have notified you of a Substantial Premium Increase; and

(2) your Policy lapses within 120 days following the due date of the Substantial Premium Increase.

A Substantial Premium Increase is a cumulative percentage increase over your initial premium. The cumulative percentage needed to trigger the Contingent Non-Forfeiture Benefit will vary depending upon your age at issue. Any increase in premium due to an increase in benefits is excluded from calculating a Substantial Premium Increase. The following lists the Substantial Premium Increase percentages.

SUBSTANTIAL PREMIUM INCREASE TABLE

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

We will notify you of your Contingent Non-Forfeiture Benefit option at least 30 days prior to the due date of a Substantial Premium Increase.

Once you are eligible for the Contingent Non-Forfeiture Benefit, you may select one of the following options:

(1) To reduce Policy benefits provided by your current coverage without the requirement of additional underwriting so that required premium payments are not increased; or

(2) To convert your coverage to paid-up status and your new Maximum Benefit will be the greater of:
   (a) 100% of the sum of all premiums paid for your Policy and any attached riders; or
   (b) your Facility Care Benefit in effect on the date of the lapse, including any increases resulting from an Inflation Protection Benefit Rider or Guaranteed Purchase Option Rider.

If the Contingent Non-Forfeiture Benefit is in effect and you do not notify Us to the contrary at the time of lapse, We will apply option 2.

LIMITATIONS AND EXCLUSIONS - the Policy does not provide benefits for expenses incurred:

(1) while your Policy is not in force, except as provided in the Extension of Benefits provision;
(2) due to intentional, self-inflicted injury or attempted suicide;
(3) that are payable by Medicare or any other Federal or State program, except Medicaid;
(4) outside the United States, its territories or possessions; except as described in the International Coverage Benefit;
(5) that are payable under any workers' compensation or employer's liability laws;
(6) due to treatment for alcoholism or drug addiction;
(7) for hospital or physician services, prescription drugs, x-rays, and lab work;
(8) due to injuries or sickness resulting from an act of declared or undeclared war; or
(9) for services provided by a Family Member, unless: (a) the Family Member is a Licensed Health Care Practitioner; (b) the Family Member is a regular employee of the organization furnishing the service of care; (c) the organization receives the payment for the services; and (d) the Family Member receives no compensation other than the normal compensation for employees in his or her job category.

THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

RELATIONSHIP OF COST OF CARE AND BENEFITS - Because the costs of Long-Term Care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. The benefit levels of the base Policy will not increase over time, unless you have elected to purchase inflation protection. For an additional premium payment, you may purchase one of the following optional riders: Compound Inflation Protection Benefit Rider; Compound Inflation Protection Benefit Rider – 2X Maximum; Simple Inflation Protection Benefit Rider; and Guaranteed Purchase Option Rider.

OPTIONAL COMPOUND INFLATION PROTECTION BENEFIT RIDER (B182) - For an additional premium payment, this rider will automatically increase the benefits listed under the Covered Services of this policy and the remaining Maximum Benefit by 5%. These increases will be compounded annually on each Policy anniversary date for the lifetime of your Policy, even when you are receiving benefits.

Inflation protection coverage can only be purchased at the time of Application for this Policy.

OPTIONAL COMPOUND INFLATION PROTECTION BENEFIT RIDER – 2X MAXIMUM (B183) - For an additional premium payment, this rider will automatically increase the benefits listed under the Covered Services of this policy and the remaining Maximum Benefit by 5%. These increases will be compounded annually on each Policy anniversary date, even when you are receiving benefits, until the benefits listed under the Covered Services of this policy equal two times the amount of the original benefits in effect on the Rider Effective Date.

Inflation protection coverage can only be purchased at the time of Application for this Policy.

OPTIONAL SIMPLE INFLATION PROTECTION BENEFIT RIDER (B184) - For an additional premium payment, this rider will automatically increase the benefits listed under the Covered Services of this policy and the remaining Maximum Benefit by 5% of your original benefit levels on each Policy anniversary for the lifetime of your Policy, even when you are receiving benefits.

Inflation protection can only be purchased at the time of Application for this Policy.

OPTIONAL GUARANTEED PURCHASE OPTION RIDER (B185) - For an additional premium payment, on any anniversary date of your Policy, you may, at your option, increase the benefits listed under the Covered Services of this policy and remaining Maximum Benefit by 5%. No additional underwriting or health screening is required. An additional premium will be charged for the additional coverage. The additional premium will be based upon your age at that time you elect to exercise your option to increase your benefits, premium rates then in effect and the dollar amount of increase in the Facility Care Benefit on that option date.

This rider can only be purchased at the time of Application for this Policy.

OPTIONAL SHORTENED BENEFIT PERIOD NON-FORFEITURE RIDER (B186) - For an additional premium payment, this rider provides for your coverage to remain in force as paid-up status if you lapse your Policy and this rider after the 3rd Policy anniversary. Your new Maximum Benefit during the paid-up status will be the greater of: (1) 100% of the sum of all premiums paid for the Policy and any attached riders, or (2) your Facility Care Benefit on the date of the lapse, including any increase resulting from an inflation protection rider or Guaranteed Purchase Option Rider. However, no benefits will be paid in excess of the Maximum Benefit that would have been in effect if you had continued to pay premiums as required.

This rider can only be purchased at the time of Application for this Policy.

OPTIONAL SURVIVING SPOUSE WAIVER OF PREMIUM RIDER (B187) - For an additional premium payment, this rider will waive the premium that comes due for this Policy and all riders attached to this Policy for the remainder of your lifetime beginning the latter of: (1) the date of the death of your spouse; or (2) the 10th anniversary date of this rider, if the death of your spouse occurs before the rider's 10th anniversary.
The Waiver of Premium provision provided by this rider will only apply if:

(1) you and your spouse have the same Policy Effective Date and Rider Effective Date for coverage with Us under the same Policy form with this rider form attached to both Policies; and
(2) your coverage is continuously in effect from the Rider Effective Date until the date that We begin to waive your premiums under the Waiver of Premium provision of this rider; and
(3) your spouse's coverage is continuously in effect from the Rider Effective Date until the earlier of;
    (a) the date of death of your spouse, or
    (b) the date your spouse's Policy terminates after We have paid out the Maximum Benefit.

This rider can only be purchased at the time of Application for this Policy.

OPTIONAL JOINT WAIVER OF PREMIUM RIDER (B188) - For an additional premium payment, this rider will waive the premium that comes due for your Policy and all riders attached to your Policy during the time that your spouse qualifies for the Waiver of Premium provision under his or her Policy.
Waiver of Premium will no longer apply and premium payments will resume at the next premium due date according to the Premium Payment Mode in effect at the time, if:

(1) your spouse's coverage terminates for any reason, including complete payment of the Maximum Benefit; or
(2) your spouse's coverage remains in effect, however, he or she no longer qualifies for the Waiver of Premium provision under his or her Policy.

The Waiver of Premium provision provided by this rider will only apply if:

(1) you and your spouse have the same Policy Effective Date and Rider Effective Date for coverage with Us under the same Policy form with this rider attached to both Policies; and
(2) you and your spouse's coverage are continuously in effect from the Rider Effective Date until the date that We begin to waive your premiums under the Waiver of Premium provision of this rider.

This rider can only be purchased at the time of Application for this Policy.

OPTIONAL FULL RETURN OF PREMIUM RIDER (B189) – For an additional premium payment, upon your death, this rider will pay your beneficiary, or your estate if no beneficiary has been designated, a Return of Premium Benefit equal to the total premiums paid for your Policy and all riders attached to your Policy.

This rider can only be purchased at the time of Application for this Policy.

OPTIONAL RETURN OF PREMIUM RIDER (B190) – For an additional premium payment, upon your death, this rider will pay your beneficiary, or your estate if no beneficiary has been designated, a Return of Premium Benefit equal to the total premiums paid for your Policy and all riders attached to your Policy, reduced by the total of benefits paid. If the total of benefits exceeds the total of premiums paid, this Return of Premium Benefit will be zero. This rider can only be purchased at the time of Application for this Policy.

OPTIONAL HOME CASH BENEFIT RIDER (B191) – For an additional premium payment each month, We will pay you the Home Cash Benefit shown on your Policy schedule if: (1) if you meet the eligibility of benefit requirements on your Policy; (2) you have satisfied your Elimination Period; and (3) you have received Home

Health Care at least one day during the calendar month. Benefits paid under the Home Cash Benefit will not reduce the Maximum Benefit. If your Policy has an Inflation Protection Rider or Guaranteed Purchase Option Rider, it will also apply to the Home Cash Benefit amount. Payment of the Home Cash Benefit will end on the earlier of the following: (1) the date that you are no longer eligible for benefits under your Policy; or (2) the date the Maximum Benefit has been exhausted.

The Home Cash Benefit provision provided by this rider will not apply if; (1) you have been confined in a Nursing Home, an Assisted Living Facility, or a Hospice Facility for any part of the calendar month; or (2) you are receiving care or services outside the United States of America, its territories and possessions.

This rider can only be purchased at the time of Application for this Policy.

NOTICE: Since Home Cash Benefits are made without regard to expenses you incur, part of the benefits could be considered taxable income. You should consult with a tax advisor for more information concerning the tax implications.

OPTIONAL WAIVER OF THE ELIMINATION PERIOD FOR HOME AND COMMUNITY CARE RIDER (B192) – For an additional premium payment, We will waive your Elimination Period requirement while you are receiving services covered under your Home and Community Care Benefit. The Elimination Period must still be satisfied, if any, before benefits are payable under your Facility Care Benefit. However, each day counted under the Elimination Period definition in your Policy will count toward the Elimination Period for the Facility Care Benefit.

This provision will not apply if: (1) you are confined in a Nursing Home, an Assisted Living Facility, or a Hospice Facility; or (2) you are receiving care or services outside the United States of America, its territories and possessions. This rider can only be purchased at the time of Application for this Policy.

OPTIONAL SHARED CARE BENEFIT RIDER (B193) – For an additional premium payment, if you or your spouse exhaust the Maximum Benefit of your Policy, We will continue to pay benefits until the Shared Care Maximum is exhausted. Benefit will be paid at the same Monthly Maximum and, if applicable, same Daily Maximum, subject to the provisions of your Policy. If your Policy has an Inflation Protection Rider or Guaranteed Purchase Option Rider attached, the remaining Shared Care Maximum will increase in the same manner as the Maximum Benefit. The Restoration of Benefits provision in your Policy, if applicable, does not apply to the Shared Care Maximum. If you and your spouse are eligible to receive benefits from the Shared Care Maximum at the same time, We will pay benefits for both spouses until the Shared Care Maximum is exhausted. In the case of divorce or termination of your spouse's Policy by non-payment of premium, half of the Shared Care Maximum amount remaining will be added to your Maximum Benefit with no increase in premium. If your Spouse dies while his or her Policy is in force, the Shared Care Maximum amount remaining will be added to your Maximum Benefit with no increase in premium.

The Shared Care Benefit provision provided by this rider will only apply if:

(1) you and your spouse have the same Policy Effective Date and Rider Effective Date for coverage with Us under the same Policy form with this rider attached to both Policies; and
(2) you and your spouse's coverage are continuously in effect from the Rider Effective Date until the date that We begin providing benefits under the Shared Care Benefit provision of this rider.

This rider can only be purchased at the time of Application for this Policy.

OPTIONAL SPOUSE PREMIUM DISCOUNT RIDER (B198) - We will reduce the premium of your Policy and all attached riders by an amount equal to 30% of the total premium charged for your Policy and all attached riders. In order to qualify for such discount: (1) you must be married on the first day this rider becomes effective; and (2) your spouse must have a Long-Term Care Policy with Us, which is in effect on the first day this rider became effective.

OPTIONAL MARRIED PREMIUM DISCOUNT RIDER (B200) - We will reduce the premium of your Policy and all attached riders by an amount equal to 10% of the total premium charged for your Policy and all attached riders. In order to qualify for such discount you must be married on the first day this rider becomes effective.

OPTIONAL FAMILY MEMBER PREMIUM DISCOUNT RIDER (B211) – We will reduce the premium of your Policy and all attached riders by an amount equal to 10% of the total premium charged for your Policy and all

attached riders. In order to qualify for such discount: (1) you must currently be living with a Family Member in you Home; (2) you must have lived with the above mentioned Family Member for at least two years before the Rider Effective Date; and (3) you and the above mentioned Family Member must have a Long Term Care Policy with Us, which is in effect on the first day this Rider becomes effective.

ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS - Subject to any applicable Elimination Period, Limitations or exclusions described above, the Policy provides coverage if you are clinically diagnosed as having Alzheimer's disease, and other forms of senile dementia or mental disorders caused by demonstrable, structural brain damage.

ANNUAL PREMIUM

P146IL Premium	$_____
Compound Inflation Protection Benefit Rider – B182	$_____
Compound Inflation Protection Benefit Rider – 2X Maximum-B183	$_____
Simple Inflation Protection Benefit Rider – B184	$_____
Guaranteed Purchase Option Rider – B185	$_____
Shortened Benefit Period Non-Forfeiture Rider – B186	$_____
Surviving Spouse Waiver of Premium Rider – B187	$_____
Joint Waiver of Premium Rider – B188	$_____
Full Return of Premium Rider – B189	$_____
Return of Premium Rider – B190	$_____
Home Cash Benefit Rider – B191	$_____
Waiver of Elimination Period for Home and Community Care Rider – B192	$_____
Shared Care Benefit Rider – B193	$_____
Spouse Premium Discount Rider – B198	$_____
Married Premium Discount Rider – B200	$_____
Family Member Premium Discount Rider – B211	$_____
TOTAL ANNUAL PREMIUM	$_____

MEDICAL UNDERWRITING - Your insurability for the Policy will be determined by the answers given in your Application and any other authorized medical information We obtain regarding your current state of health.

GRACE PERIOD - There is a 31 day grace period for all premiums falling due after the initial premium. Your Policy will continue in force during the grace period.

SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM: **Contact the Senior Health Insurance Program if you have general questions regarding traditional long-term care insurance. Write or call: Senior Health Insurance Program, Illinois Department of Insurance, 320 West Washington Street, Springfield, Illinois 62767; 1-800-548-9034 (Toll-free in Illinois); 217-785-9021 (outside Illinois). Contact Physicians Mutual Insurance Company at 1-800-645-4300 if you have specific questions regarding your traditional long-term care insurance policy.**

The example below is an illustration of the premium and benefits for a non-increasing Policy without an Inflation Protection Benefit Rider or Guaranteed Purchase Option Rider versus an increasing Policy with an Inflation Protection Benefit Rider or Guaranteed Purchase Option Rider. The illustrations are based on a $3000 initial monthly Facility Care Benefit, 100% Home and Community Care Benefit, 90 day Elimination Period, three year Benefit Multiplier, issued to a 60 year old individual and Annual Premium Payment Mode.

INFLATION PROTECTION BENEFIT RIDER COMPARISON