NPFBA Long Term Care Plan

The #1 Plan of Choice for Active Law Enforcement and Fire Service Members and Their Spouses

NPFBA

NATIONAL PEACE OFFICERS AND FIRE FIGHTERS BENEFIT ASSOCIATION

A Nonprofit Mutual Benefit Trust

Trustees

Ken Blanton
Kern Co. Fire

David Boffi
Sonoma Co. DA Investigations

Dennis Campanale
West Sacramento Fire (Ret.)

Joe Chirillo
Beverly Hills Police

Gene Dangel
San Ramon Valley Fire (Ret.)

Jim Galvin
Los Angeles City Fire (Ret.)

Jerry Hall
Santa Clara Co. Sheriff's Dept. (Ret.)

Ken Marlin
San Leandro Police (Ret.)

Roger Mathias
San Diego Co. Sheriff's Dept.

Bob Perez
Santa Barbara Co. Fire

Brain Pinomaki
Pacifica Fire

Darin Ryburn
Burbank Police

NPFBA is a jointly sponsored LTC trust of the California Law Enforcement Association (CLEA) and the California Association of Professional Firefighters (CAPF).

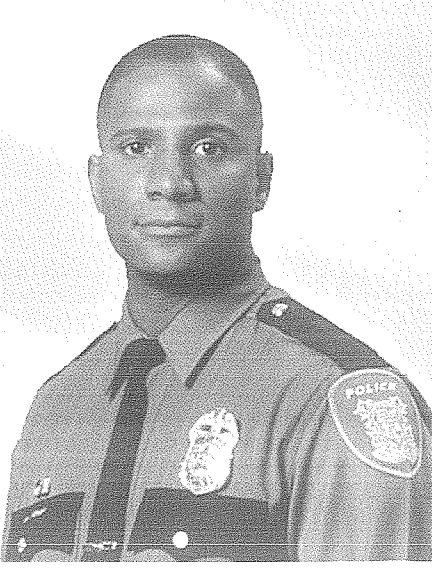
What Would Happen If You or Your Spouse Suddenly Faced the Need For Long Term Care?

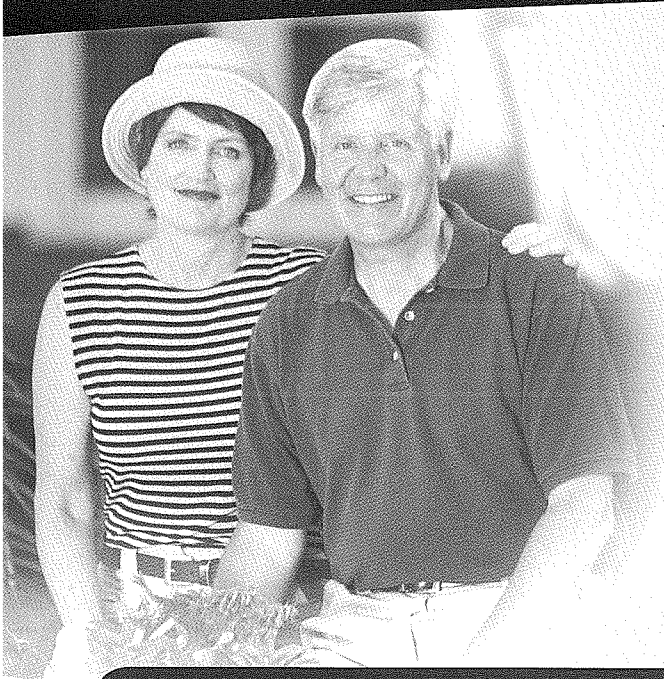
Consider the Following Facts:

- The average **annual cost** of convalescent care is **over $64,000.**
- In 20 years, the average annual cost is expected to exceed **$170,000.**
- The average lifetime expense to care for an Alzheimer's patient is **$230,000.**
- **Three out of every five people over age 65** will require three years or more of long term care assistance.
- **One in five patients** over age 65 can expect to spend more than **five years in a nursing home.**

Are You Prepared?

You can be... with an affordable long term care plan from NPFBA!





Are You Prepared to Face the Costs of Long Term Care?

Medicare isn't enough, and Medi-Cal requires you to spend down your assets. The NPFBA Long Term Care Plan protects your independence, your standard of living and your financial legacy. More importantly, it preserves your family's peace of mind and your dignity.

The NPFBA Long Term Care Plan was developed by public safety personnel to protect those who protect others. It is managed by experienced law enforcement and fire service personnel dedicated to providing the best benefits at the lowest rates.

Competitive Analysis

Comparable Monthly Costs ($150/Day Plan)

AGE	NPFBA	CALPERS	JOHN HANCOCK	GENWORTH	METLIFE
35	39	106	219	233	238
45	60	170	293	262	287
50	79	212	315	284	311
55	110	248	364	346	338
60	168	305	434	401	432
PAYMENT SCHEDULE	25-40 YEARS*	LIFETIME	LIFETIME	LIFETIME	LIFETIME
ELIMINATION PERIOD	60 DAYS	90 DAYS	60 DAYS	90 DAYS	45 DAYS

**Payment period may depend on age at enrollment. Additional payment options may be available. Illustration only. Refer to Plan documents for specific details. Rates as of September 2007.*

The NPFBA Plan Includes the Following Benefits:

- Lifetime coverage
- Nursing, convalescent, and Alzheimer's facility care
- Residential care (assisted living)
- Home health care
- Respite care
- 5% compounded inflation protection
- 60-day elimination (preferred rating)
- Waiver of payment
- Death benefit through the return of up to $5,000 in payments
- No lifetime payment requirement — policy is completely paid in 40 years or less

What Triggers Long Term Care Benefits?

Activities of Daily Living (ADLs) are the functions we do every day. Long term care benefits become available when certain ADLs can no longer be accomplished by an individual without assistance due to physical or cognitive impairment. Examples of these ADLs include bathing, dressing, using the bathroom, transferring (moving from a bed to chair without assistance) and eating.

You become eligible for home care with the loss of two ADLs, one of which must be the ability to transfer. For residential (assisted living) care, you must experience the loss of any two ADLs; for nursing home care, three ADLs must be lost.

150 Comprehensive Plan 2007-2008 LTC Cost Schedule

NPFBA is a jointly sponsored LTC trust of the California Law Enforcement Association (CLEA) and the California Association of Professional Firefighters (CAPF).

AGE	20-Year Plan			25-Year Plan		30-Year Plan		35-Year Plan		40-Year Plan	
	Monthly	20 Years	30% Discount	Monthly	25 Years	Monthly	30 Years	Monthly	35 Years	Monthly	40 Years
21	$43	$10,320	$7,224	$35	$10,500	$31	$11,160	$29	$12,180	$28	$13,440
22	43	10,320	7,224	35	10,500	31	11,160	29	12,180	28	13,440
23	43	10,320	7,224	35	10,500	31	11,160	29	12,180	28	13,440
24	43	10,320	7,224	35	10,500	31	11,160	29	12,180	28	13,440
25	43	10,320	7,224	35	10,500	31	11,160	29	12,180	28	13,440
26	43	10,320	7,224	35	10,500	31	11,160	29	12,180	28	13,440
27	45	10,800	7,560	36	10,800	32	11,520	30	12,600	29	13,920
28	45	10,800	7,560	36	10,800	32	11,520	30	12,600	29	13,920
29	47	11,280	7,896	38	11,400	34	12,240	31	13,020	30	14,400
30	49	11,760	8,232	39	11,700	35	12,600	33	13,860	32	15,360
31	52	12,480	8,736	42	12,600	38	13,680	35	14,700	34	16,320
32	54	12,960	9,072	44	13,200	39	14,040	37	15,540	35	16,800
33	56	13,440	9,408	46	13,800	41	14,760	38	15,960	37	17,760
34	58	13,920	9,744	47	14,100	42	15,120	39	16,380	38	18,240
35	60	14,400	10,080	49	14,700	44	15,840	41	17,220	39	18,720
36	64	15,360	10,752	52	15,600	47	16,920	43	18,060	42	20,160
37	66	15,840	11,088	53	15,900	48	17,280	45	18,900	43	20,640
38	68	16,320	11,424	55	16,500	49	17,640	46	19,320	44	21,120
39	70	16,800	11,760	57	17,100	51	18,360	47	19,740	45	21,600
40	72	17,280	12,096	58	17,400	52	18,720	48	20,160	47	22,560
41	78	18,720	13,104	63	18,900	56	20,160	52	21,840	50	24,000
42	81	19,440	13,608	66	19,800	59	21,240	55	23,100	53	25,440
43	87	20,880	14,616	71	21,300	63	22,680	59	24,780	57	27,360
44	91	21,840	15,288	74	22,200	66	23,760	62	26,040	59	28,320
45	93	22,320	15,624	75	22,500	68	24,480	63	26,460	60	28,800
46	99	23,760	16,632	80	24,000	72	25,920	67	28,140		
47	103	24,720	17,304	83	24,900	75	27,000	69	28,980		
48	109	26,160	18,312	88	26,400	79	28,440	73	30,660		
49	113	27,120	18,984	91	27,300	82	29,520	76	31,920		
50	116	27,840	19,488	94	28,200	85	30,600	79	33,180		
51	124	29,760	20,832	100	30,000	90	32,400				
52	132	31,680	22,176	107	32,100	96	34,560				
53	138	33,120	23,184	111	33,300	100	36,000				
54	147	35,280	24,696	119	35,700	107	38,520				
55	151	36,240	25,368	122	36,600	110	39,600				
56	161	38,640	27,048	130	39,000						
57	173	41,520	29,064	140	42,000						
58	184	44,160	30,912	149	44,700						
59	194	46,560	32,592	157	47,100						
60	208	49,920	34,944	168	50,400						

Illustration only. Refer to Plan documents for specific details.

- Comprehensive Plan
- Lifetime Coverage
- Lump Sum Payment Discount
- Death Benefit up to $5,000
- 5% Compounded Inflation Protection
- Waiver of Payment
- 60-Day Elimination Period (Preferred)
- Optional Payment Terms (20, 25, 30, 35 and 40 years)

Modified payment plan may be available.
Level payment for member and spouse (see illustration for details).

NPFBA NATIONAL PEACE OFFICERS AND FIRE FIGHTERS BENEFIT ASSOCIATION

Call Toll Free (877) 582-0003 or visit WWW.NPFBA.ORG

California Administration Insurance Services, Inc.
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P.O. Box 702 • Jackson, CA 95642 • CA Insurance License #0544968

130 Comprehensive Plan 2007-2008 LTC Cost Schedule

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AGE	20-Year Plan			25-Year Plan		30-Year Plan		35-Year Plan		40-Year Plan	
	Monthly	20 Years	30% Discount	Monthly	25 Years	Monthly	30 Years	Monthly	35 Years	Monthly	40 Years
21	$35	$8,400	$5,880	$28	$8,400	$25	$9,000	$24	$10,080	$23	$11,040
22	35	8,400	5,880	28	8,400	25	9,000	24	10,080	23	11,040
23	35	8,400	5,880	28	8,400	25	9,000	24	10,080	23	11,040
24	35	8,400	5,880	28	8,400	25	9,000	24	10,080	23	11,040
25	35	8,400	5,880	28	8,400	25	9,000	24	10,080	23	11,040
26	35	8,400	5,880	28	8,400	25	9,000	24	10,080	23	11,040
27	37	8,880	6,216	30	9,000	27	9,720	25	10,500	24	11,520
28	37	8,880	6,216	30	9,000	27	9,720	25	10,500	24	11,520
29	39	9,360	6,552	31	9,300	28	10,080	26	10,920	25	12,000
30	41	9,840	6,888	33	9,900	30	10,800	28	11,760	26	12,480
31	43	10,320	7,224	35	10,500	31	11,160	29	12,180	28	13,440
32	45	10,800	7,560	36	10,800	32	11,520	30	12,600	29	13,920
33	47	11,280	7,896	38	11,400	34	12,240	31	13,020	30	14,400
34	49	11,760	8,232	39	11,700	35	12,600	33	13,860	32	15,360
35	50	12,000	8,400	41	12,300	37	13,320	34	14,280	33	15,840
36	52	12,480	8,736	42	12,600	38	13,680	35	14,700	34	16,320
37	54	12,960	9,072	44	13,200	39	14,040	37	15,540	35	16,800
38	56	13,440	9,408	46	13,800	41	14,760	38	15,960	37	17,760
39	58	13,920	9,744	47	14,100	42	15,120	39	16,380	38	18,240
40	60	14,400	10,080	49	14,700	44	15,840	41	17,220	39	18,720
41	64	15,360	10,752	52	15,600	47	16,920	43	18,060	42	20,160
42	68	16,320	11,424	55	16,500	49	17,640	46	19,320	44	21,120
43	72	17,280	12,096	58	17,400	52	18,720	48	20,160	47	22,560
44	76	18,240	12,768	61	18,300	55	19,800	51	21,420	49	23,520
45	78	18,720	13,104	63	18,900	56	20,160	52	21,840	50	24,000
46	81	19,440	13,608	66	19,800	59	21,240	55	23,100		
47	85	20,400	14,280	69	20,700	62	22,320	58	24,360		
48	89	21,360	14,952	72	21,600	65	23,400	60	25,200		
49	93	22,320	15,624	75	22,500	68	24,480	63	26,460		
50	97	23,280	16,296	79	23,700	71	25,560	66	27,720		
51	103	24,720	17,304	83	24,900	75	27,000				
52	111	26,640	18,648	89	26,700	80	28,800				
53	114	27,360	19,152	93	27,900	83	29,880				
54	122	29,280	20,496	99	29,700	89	32,040				
55	126	30,240	21,168	102	30,600	92	33,120				
56	134	32,160	22,512	108	32,400						
57	144	34,560	24,192	116	34,800						
58	153	36,720	25,704	124	37,200						
59	161	38,640	27,048	130	39,000						
60	173	41,520	29,064	140	42,000						

Illustration only. Refer to Plan documents for specific details.

- **Comprehensive Plan**
- **Lifetime Coverage**
- **Lump Sum Payment Discount**
- **Death Benefit up to $5,000**
- **5% Compounded Inflation Protection**
- **Waiver of Payment**
- **60-Day Elimination Period (Preferred)**
- **Optional Payment Terms (20, 25, 30, 35 and 40 years)**

Modified payment plan may be available.
Level payment for member and spouse (see illustration for details).

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Expanded Competitive Analysis

Comparable Costs ($150/Day Plan)

Genworth*		
Age	Monthly Cost	40-Year Cost Total
35	$233	$111,840
45	$262	$125,760
50	$284	$136,320
55	$346	$166,080
60	$401	$192,480

John Hancock*		
Age	Monthly Cost	40-Year Cost Total
35	$219	$105,120
45	$293	$140,640
50	$315	$151,200
55	$364	$174,720
60	$434	$208,320

MetLife*		
Age	Monthly Cost	40-Year Cost Total
35	$238	$114,240
45	$287	$137,760
50	$311	$149,280
55	$338	$162,240
60	$432	$207,360

CalPERS*		
Age	Monthly Cost	40-Year Cost Total
35	$106	$50,880
45	$170	$81,600
50	$212	$101,760
55	$248	$119,040
60	$305	$146,400

NPFBA**			
Age	Monthly Cost	Total Cost	Payment Term
35	$39	$18,720	40 years***
45	$60	$28,800	40 years***
50	$79	$33,180	35 years***
55	$110	$39,600	30 years***
60	$168	$50,400	25 years***

Illustration for comparative purposes only.
Refer to Plan documents for specific details.
Rates as of September 2007.

* *All companies require lifetime payments beyond 40 years except NPFBA.*

** *NPFBA is paid up after 40 years with the option of lump sum payment at up to a 30% discount.*

*** *Shorter payment terms may be available depending upon age at enrollment.*

NPFBA

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Benefits	NPFBA	CalPERS
LIFETIME COVERAGE	✔	Available
NURSING HOME CARE *$130/day or $150/day*	✔	Other Options Available
RESIDENTIAL CARE (Assisted living) *70% of $130 Plan ($91/day)* *70% of $150 Plan ($105/day)*	✔	✔
HOME HEALTH CARE *50% of $130 Plan ($65/day)* *50% of $150 Plan ($75/day)*	✔	Other Options Available
5% COMPOUNDED INFLATION PROTECTION	✔	✔
40-YEAR PAID-UP PLAN	✔	Lifetime Premiums
DEATH BENEFIT IS THE RETURN OF PAYMENTS UP TO $5,000 *To age 70: Up To $5,000* *Ages 71–75: Up To $2,500* *Thereafter: $0*	✔	Prorated Return of Payments Based on Percentage 75 or Older: $0
RESPITE CARE – ADULT SITTING *15 days max per year*	✔	✔
60-DAY ELIMINATION PERIOD*	✔	90-Day
WAIVER OF PAYMENT	✔	✔

**90-day elimination period if rated Standard.*

The Power of 5% Compounded Inflation Protection

With NPFBA's inflation protection, your benefits increase each year based on the year you join.

Future Benefit Projections
(Daily benefits have been rounded to the nearest whole number)

Year End	Daily Benefit *$130 Plan*	Monthly *$130 Plan*	Yearly *$130 Plan*
Current	$130	$3,954	$47,450
10	$212	$6,448	$77,380
20	$345	$10,494	$125,925
40	$915	$27,831	$333,975
Year End	**Daily Benefit** ***$150 Plan***	**Monthly** ***$150 Plan***	**Yearly** ***$150 Plan***
Current	$150	$4,563	$54,750
10	$244	$7,422	$89,060
20	$398	$12,106	$145,270
40	$1,056	$32,120	$385,440

Monthly benefit equals daily benefit multiplied by 365 days divided by 12 months.

	With Your NPFBA LTC Plan	Without an LTC Plan
Care Planning	A professional coordinator helps you and your family plan a care program	Your family must find providers, arrange payment and decide who will take care of you
Asset Protection	Benefits pay for quality care without depleting your assets	You and your family may have to spend $40,000 to $100,000 annually for your care
Impact on Your Family	Professional care allows family members to attend to your needs out of love as they continue to live their lives	Family members may become full-time caregivers, sacrificing personal and professional opportunities
Your Independence	You can afford the care needed to stay at home when physically possible	Finances and care obligations may force you to enter a skilled nursing facility prematurely
Financial Legacy	You'll have a greater opportunity to protect your life's savings and leave money to your spouse, children or charity of your choice	You may be forced to "spend down" assets to qualify for low-income care in a nursing home under Medi-Cal
Peace of Mind	You'll have more choice of the type of care and who will provide it, and know that your family won't face a financial burden	Limited choices for you and your family, all while draining the financial resources created through a lifetime of work

Important Considerations

A long term care plan is as vitally important as health, auto or life insurance. It's your protection from the devastating costs of care that can drain your family's financial resources.

- The cost of long term care for you or your spouse could exceed $5,000 per month. Are you prepared?
- Have you discussed with your family how you will pay for months or years of care if illness strikes?
- Would you rather leave your financial legacy to your spouse and children – or use it to pay for your care?
- Are you aware that other insurance plans don't cover custodial care or other long term care needed due to illness or injury? (Medicare provides only limited coverage – up to 100 days – for skilled care facilities.)
- Is there a greater value than the peace of mind that comes from protecting your family's financial future – usually for a monthly cost that's less than one nice dinner out?

Over 10,000 satisfied public safety agency members and their spouses rely on NPFBA for comprehensive long term care coverage at competitive rates. You can, too!

NPFBA NATIONAL PEACE OFFICERS AND FIRE FIGHTERS BENEFIT ASSOCIATION

Call Your Local Field Service Manager

Call Toll-Free:

(877) 582-0003

or Visit our Website:

WWW.NPFBA.ORG

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United We Insure

Long Term Care Application

Plan Administrators California Administration Insurance Services, Inc.

A Jointly Sponsored Trust . California Law Enforcement Association . California Association Of Professional Firefighters

National Peace Officers and Fire Fighters Benefit Association™

INSTRUCTIONS FOR COMPLETING YOUR APPLICATION

NOTE: Employee and Spouse must complete a separate application.

Eligibility requirements for the National Peace Officers and Fire Fighters Benefit Association (NPFBA) Long Term Care Plan are as follows:

- You must be actively employed by, or a spouse of a member employed by, a Law Enforcement Agency or Fire Department (additional family members are not eligible).
- You must be age 60 or younger to apply.
- If you are retired, you must apply within one year of the date of your retirement or separation or you will not be eligible.
- You must be a resident of California and provide a California address where we can mail your policy (address may be changed after policy is issued as long as you reside in the United States or one of its territories).

NOTE: All Incomplete Applications will be returned.

An application will be considered incomplete for any of the following reasons:

- The signature blocks are not signed.
- The medical questions are not thoroughly explained.
- The appropriate payment is not received with the application (direct billing only).
- ***Please make checks payable to NPFBA.***
- Any question or field is left blank.

All applications will be individually underwritten. If necessary, we will obtain your medical records or request a short paramedical exam to assist us in the underwriting process.

Please mail your completed application in the postage-paid envelope provided.
If this envelope was not provided to you, please mail to:

NPFBA Long Term Care Plan
P.O. Box 31
Martell, CA 95654-0031

If you have any questions about this plan or if you need assistance in completing your application, please call toll free 877-582-0003. Our office hours are Monday through Friday 8:00 a.m. to 5:00 p.m

OFFICE USE ONLY

Field Service Manager: Brett Shirkey

Field Service Manager #: _____

APPLICANT INFORMATION (Please Print)

I am applying as: (check the appropriate box below)

EMPLOYEE	*SPOUSE*
☐ **Active Full Time Firefighter**	☐ **Spouse of Active Full Time Firefighter**
☐ **Active Full Time Law Enforcement Officer**	☐ **Spouse of Active Full Time Law Enforcement Officer**
☐ **Volunteer / Paid Call Firefighter**	☐ **Spouse of a Volunteer / Paid Call Firefighter**
☐ **Volunteer Law Enforcement Member**	☐ **Spouse of a Volunteer Law Enforcement Member**
☐ **Reserve Law Enforcement Officer**	☐ **Spouse of a Reserve Law Enforcement Officer**
☐ **Non-Safety Fire Dept Employee**	☐ **Spouse of a Non-Safety Fire Dept Employee**
☐ **Non-Safety Law Enforcement Dept Employee**	☐ **Spouse of a Non-Safety Law Enforcement Dept Employee**
☐ **Retired? Date of Retirement: _____** (You are ineligible if retired longer than one year)	☐ **Spouse of a Retiree**

Name of Agency that "**Employee**" is employed with or retired from: _____

Job Title of **Employee**: _____

Employee Name: _____ **Employee SS#:** _____

Applicant's Name Last	First	M.I.	**Height**	**Weight**	**Sex**	**DOB** / /	**Age Last Birthday**

Mailing Address	**City**	**State & Zip**

Physical Address	**City**	**State & Zip**

Home Phone Number ( )	**Best Time to Call**	**Social Security Number** / /	**Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Widow
Alternate Phone Number Cell, Pager, Work, etc. ( )	**Best Time to Call**	**Email**	

PLAN OPTIONS – CHECK APPLICABLE BOX

☐ **Plan 130/70/50**
$130 /Day Nursing Home
70% Residential Care
50% Home Health Care
5% Inflation Protection per year

☐ **Plan 150/70/50**
$150 /Day Nursing Home
70% Residential Care
50% Home Health Care
5% Inflation Protection per year

☐ **Group Plan / Negotiated Benefits Plan /Modified Payment Plan, may be available.**

PAYMENT TERM – CHECK APPLICABLE BOX

☐ **20 Years** ☐ **25 Years** ☐ **30 Years** ☐ **35 Years** ☐ **40 Years**

The maximum payment term is based on your age at time of application. Please see the published cost (rate) schedule to determine the length of time that you are allowed to make payments.

BENEFICIARY

_____ / _____

Full Name/Relationship Alternate (Contingent)

PAYMENT OPTIONS

Note: Each Applicant will be billed on an individual basis (surcharges are per applicant). Combined billing is not available.

Please select one of the following three methods of payment:

1) ☐ **Monthly Bank Draft** ($1.00 surcharge per transaction)

I hereby authorize NPFBA or its designated agent and the financial institution named below to initiate monthly withdrawals from my checking/savings account. This authority will remain in effect until I provide written notification to cancel this Plan or my affiliation with NPFBA, its designated agent or my financial institution.

I understand that if the required funds are not on deposit in my account on the day designated to execute the automatic deduction, I will be subject to the payment collection provision shown in the Evidence of Coverage and that any charges for overdraft or insufficient funds may be charged to me along with any service charges applied by NPFBA.

X _____

Signature **Date**

Please deduct my monthly payment from (choose one):

☐ Checking Account Number _____ Routing Number _____

Attach VOIDED check here. We are unable to process your application without this information.

☐ Savings Account Number _____ Routing Number _____

_____

Financial Institution Name Telephone

_____

Financial Institution Address (City, State, Zip)

2) ☐ **Credit Card** ☐ Annual ☐ Semi-Annual ($1.00 surcharge per transaction) ☐ Lump Sum

Type of Credit Card ☐ Master Card ☐ Visa ☐ Discover Card Number_____

Expiration Date _____/_____

X _____

Signature

3) ☐ **Billing** (Please direct bill me in one of the following ways):

☐ Annually ☐ Semi-Annual ($1.00 per transaction) ☐ Quarterly ($2.00 per transaction) ☐ Lump Sum

Note: One month of payment must accompany your application if billing is selected.
We are unable to process your application without the initial payment.
Please make checks payable to NPFBA.

4) ☐ **Other:** _____

Part I – MEDICAL INFORMATION

Please answer all the following questions by placing an "X" in either the "Yes" or "No" block

1. Are you employed or do you engage in hobbies, social activities, or volunteer work? *Explain*: _____ ☐ Yes ☐ No
2. Have you gained or lost more than 5 pounds in the past twelve (12) months? *If yes please explain below.* ☐ Yes ☐ No
3. a. Are you receiving any type of Disability Benefits? ☐ Yes ☐ No
   b. Are you now, or have you ever received benefits from Medi-Cal? ☐ Yes ☐ No
   c. Due to any present or past mental or physical disability, is any person or institution currently authorized to act on your behalf? ☐ Yes ☐ No
   d. Are you dependent on the use of a walker or wheelchair? ☐ Yes ☐ No
   e. Are you confined to your bed, home, hospital, or nursing home? ☐ Yes ☐ No
   f. Do you use any medical appliance such as a catheter, oxygen equipment, respirator, or a dialysis machine? ☐ Yes ☐ No
4. Do you require assistance, supervision or are you limited in any way in performing any of the following daily activities: bathing, dressing, toileting, meal preparation, eating, mobility, housekeeping or managing medications? ☐ Yes ☐ No
6. Have you been diagnosed or treated by a health care professional within the last 3 years for Transient Ischemic Attack (TIA)? ☐ Yes ☐ No
7. During the past 5 YEARS, have you been diagnosed or treated by a member of the medical profession for any of the following conditions? *(If YES, place an X in the box next to those that apply)* ☐ Yes ☐ No

- ☐ Acquired Immune Deficiency Syndrome (AIDS)
- ☐ AIDS Related Complex (ARC)
- ☐ Alcoholism or Drug Abuse
- ☐ ALS (Lou Gehrig's Disease)
- ☐ Alzheimer's Disease
- ☐ Aneurysm
- ☐ Arthritis treated with Steroids or Gold
- ☐ Cerebral Vascular Disease
- ☐ Cirrhosis of the Liver
- ☐ Congestive Heart Failure
- ☐ Dementia
- ☐ Diabetes with Insulin
- ☐ Emphysema or COPD
- ☐ Heart Attack
- ☐ HIV Positive
- ☐ Internal Lupus Erythematosis
- ☐ Kidney Failure
- ☐ Memory Loss
- ☐ Multiple Sclerosis
- ☐ Multiple Transient Ischemic Attacks (TIA's)
- ☐ Osteoporosis with Fractures
- ☐ Parkinson's Disease
- ☐ Stroke

☐ ***Check this box if you have had <u>none</u> of the conditions listed above in the last 5 years.***

If you answered <u>yes</u> or checked a box to any question on this page please explain below, giving full details including: Name and <u>address</u> of Physician, Condition, Treatment dates, and any resulting limitations (Additional room on page 8)

Item #	Description - Dates - Details – Narrative

Part II – MEDICAL HISTORY

1. Within the past **15 years** have you been diagnosed or treated by a member of the medical profession for any of the following conditions? (If YES, place an X in the block next to those that apply and explain in full detail below)

- ☐ Amputation
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Arthritis (Prescription Drugs)
- ☐ Atrial Fibrilation
- ☐ Bypass surgery or angioplasty
- ☐ Cancer (External)
- ☐ Cancer (Internal)
- ☐ Carotid Artery Disease
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema or COPD
- ☐ Fractures
- ☐ Heart Valve Impairment
- ☐ High Blood Pressure
- ☐ Hypertension
- ☐ Incontinence/Bladder or Bowel Control
- ☐ Joint Disorder or Replacement
- ☐ Macular Degeneration
- ☐ Melanoma
- ☐ Mental/Nervous Disorder
- ☐ Osteoporosis
- ☐ Peripheral Vascular Disease
- ☐ Phlebitis
- ☐ Seizure Disorder
- ☐ Single Transient Ischemic Attack (TIA)
- ☐ Sleep Apnea or Sleep Disorders
- ☐ Spine or Back Disorders

☐ ***Check this box if you have had <u>none</u> of the conditions listed above in the last 15 years.***

2. Within the past **5 YEARS**, have you been medically advised that you will need surgery, which has not been performed? ☐ Yes ☐ No

3. During the past **5 YEARS**, have you:
   a. Sought medical advice or treatment for any of the following conditions? ☐ Yes ☐ No

   - ☐ Confusion/Disorientation
   - ☐ Deterioration of vision
   - ☐ Fainting
   - ☐ Falling
   - ☐ Loss of appetite
   - ☐ Numbness
   - ☐ Tremors
   - ☐ Unstable gait

   b. Used any of the following: ☐ Yes ☐ No

   ☐ Braces ☐ Cane ☐ Wheelchair ☐ Walker ☐ Scooter
   ☐ Other: _____

4. When you walk 4 blocks at a normal pace or climb a flight of stairs, do you experience any difficulties such as shortness of breath, dizziness or leg cramps? ☐ Yes ☐ No

5. Have you ever been diagnosed, advised of, or received medical treatment by a member of the medical profession for any condition not named above (other than routine physical exams with normal findings)? ☐ Yes ☐ No

6. Do you now, or have you during the past **3 YEARS**, used any tobacco products including cigarettes, cigars, pipes, chewing tobacco, etc? ☐ Yes ☐ No

If you answered <u>yes</u> or checked a box to any question on this page please explain below, giving full details including: Name and <u>address</u> of Physician, Condition, Treatment dates, and any resulting limitations (Additional room on page 8)

Item #	Description - Dates - Details – Narrative

Part III - PRESCRIPTION MEDICATION

☐ **Check this box if you have not taken prescription medications for more than six months.**

List ALL Prescriptions you are currently using **OR** have used within the past FIVE years.

Medication	Reason

Part IV – PHYSICIAN INFORMATION

Please list the Name, Address and phone numbers of your treating physician.

Name _____ Telephone # (____) _____

Address _____
Street City State Zip Code

Applicant's Kaiser or HMO I.D. Number: _____

Have you seen any other physician in the past two years? ☐ Yes ☐ No
Please provide physician's names and addresses and reason for visit

1. _____

2. _____

Part V – OTHER LONG TERM CARE

1. Do you now have in force, or are you applying for, any other long term care, nursing home or home health care policy, rider or certificate (including a health care service contract or a health maintenance organization contract)?
   ☐ Yes ☐ No

2. Other than the above, did you have a long term care policy, rider or certificate in force during the last 12 mos?
   ☐ Yes ☐ No

3. Have you ever had an application for Life, Health or Long Term Care insurance declined, postponed, modified or rated?
   If yes please explain in the area provide on the previous page. ☐ Yes ☐ No

Part VI – PROTECTION AGAINST UNINTENDED LAPSE

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

☐ I designate the following person(s) to receive notice prior to cancellation of my policy for nonpayment of premium:

Full Name: _____

Address: _____

Telephone Number: _____

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

APPLICANT CERTIFICATION

I certify that I have reviewed all the information and notices contained in this application and that all information supplied on this form is true to the best of my knowledge.

I also understand and agree that the coverage for which I am applying, if issued, shall be subject to these statements and will take effect on the effective date stated on the schedule of benefits. If statements in this application are fraudulent or materially untrue, sanctions that could include rescission of my coverage or a benefit denial may be applied. If I have submitted intentionally fraudulent statements, I understand that my name may be submitted to the relevant authority for criminal prosecution.

I understand that the Plan I am applying for has been approved by the Trustees of the National Peace Officer and Fire Fighters Benefit Association (NPFBA), but does not qualify for Medi-Cal spend-down protection under the California Partnership for Long Term Care.

I understand that based on the medical information provided, I may receive a preferred, standard, or modified rating. The standard rating will have an elimination period of 90 days, while the preferred rating will have an elimination period of 60 days. A modified rating will be an elimination period agreed upon by the applicant and the Trust. Modified ratings are sometimes offered in lieu of a denial of coverage. Certain other riders and exclusions may be added to the certificate with agreement of both parties. I will have the opportunity to accept or deny the certificate if it is not issued on a preferred basis. If I deny the certificate of coverage, I will receive my full-prepaid payment within approximately 30 days of my decision.

Additionally, I understand that if I use or if I have used any tobacco products within the last 36 months, I will be issued a certificate on a standard basis and I will automatically have a 90-day elimination period.

This coverage will not be effective until the 'Statement of Continuing Good Health" has been signed and returned on a form provided by the Administrator. This Statement of Good Health confirms that all information on the initial application continues to be correct and that nothing has changed since the original application was submitted.

I have read and understand the above statements concerning information that may be fraudulent, and the probable penalty of making such statements.

X_____

Signature of Applicant **Date**

This certification is made in connection with the application for Long Term Care (LTC) coverage with the National Peace Officers and Fire Fighters Benefit Association Trust.

_____

Print Name as it appears on the face page of Application

_____ / / _____

Social Security Number **Date of Birth**

ADDITIONAL SIGNATURE REQUIRED ON FOLLOWING PAGE

AUTHORIZATION FOR RELEASE OF INFORMATION – HIPAA COMPLIANT

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, care provider, care manager or evaluator, insurance company, employer, workers' compensation administrator, consumer reporting agency, or insurance support organization to give to the National Peace Officers and Fire Fighters Benefit Association (NPFBA) or their administrators, California Administration Insurance Services Inc. or its authorized representative, any records or knowledge of me or my health needed to evaluate my application or claim, including information regarding drug, alcohol, or psychiatric treatment or results of an HIV antibody test.

Duration: This authorization shall become effective immediately and shall remain in effect until one-year from the date of signature.

Revocation: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

Redisclosure: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify the records to be disclosed: All Records relating to my current or past health conditions

The requester may use the health information authorized on this form for the following purposes only: The review and underwriting of my application for Long Term Care (LTC) coverage. In addition, this information may be used to adjudicate any claim that is filed against the Plan.

A Photostatic copy (photocopy or other form of transmission) of this authorization is as valid as the original.

X_____	_____	_____
Signature of Applicant	Printed Name	Date

Additional Information

If you answered <u>yes</u> or checked a box to any question on this application please explain below, giving full details including: Name and <u>address</u> of Physician, Condition, Treatment dates, and any resulting limitations (Please add additional pages if necessary)

Item #	Description - Dates - Details – Narrative

National Peace Officers and Fire Fighters Benefit Association™

P O Box 31 . Martell, CA 95654 . 877.582.0003 *voice* . 209.223.2966 *fax* . ***info@npfba.com*** . ***npfba.org***

National Peace Officers and Fire Fighters Benefit Association™