

Long-Term Care Insurance Eligibility Questionnaire & Request for Quote

Eligibility Questionnaire

Do you currently have or have you ever had a diagnosis for:

- | | |
|--|--|
| <ul style="list-style-type: none"> • Alzheimer's • Cerebral Atrophy • Cystic Fibrosis • Dementia • Kidney Failure • Mental Retardation • Mixed Connective Tissue Disease • Muscular Dystrophy • Multiple Myeloma • Organic Brain Syndrome • Post Polio Paralytic Syndrome • Scleroderma • Myasthenia Gravis | <ul style="list-style-type: none"> • Amyotrophic Lateral Sclerosis • Cirrhosis • Crest • TIA (transient ischemic attack) 2 or more • Memory Loss • Metastasis Cancer • Multiple Sclerosis • Neurological conditions affecting brain or spinal cord • Parkinson's • Schizophrenia • Spinal Cord Injury • Stroke/CVA |
|--|--|

Member: Yes No

Spouse/Partner: Yes No

Do you require human assistance or supervision in any of the following activities

- | | |
|--|---|
| <ul style="list-style-type: none"> • Eating • Walking • Dressing • Bathing | <ul style="list-style-type: none"> • Maintaining continence • Toileting • Transferring from bed to chair |
|--|---|

Do you currently reside in, have you been advised to enter, are you planning to enter a nursing home, assisted care living facility or other custodial facility, or are you currently receiving home health care services or attending adult day care?

Member: Yes No

Spouse/Partner: Yes No

Do you currently use one of the following medical devices?

- | | |
|--|---|
| <ul style="list-style-type: none"> • Wheelchair • Hospital bed • Oxygen • Dialysis | <ul style="list-style-type: none"> • Walker • Quad cane • Stair lift |
|--|---|

Member: Yes No

Spouse/Partner: Yes No

Have you been diagnosed or treated by a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex?

Member: Yes No

Spouse/Partner: Yes No

Are you currently receiving Social Security disability benefits?

Member: Yes No

Spouse/Partner: Yes No

If you have answered "no" to all of the questions above you may proceed with your request for quote.

Do NOT request a quote for any individual who answers "yes" to any of the questions listed in the above eligibility questionnaire.

ALL INFORMATION PROVIDED IN YOUR REQUEST IS KEPT CONFIDENTIAL

Long-term Care Request for Quote

Member: _____ Date of Birth _____ Sex M F

Spouse/
Partner: _____ Date of Birth _____ Sex M F

Have you used tobacco during the last twelve (12) months?

Member: Yes No

Spouse/Partner: Yes No

Do you work, volunteer or socialize outside the home at least 3 times week?

Member: Yes No

Spouse/Partner: Yes No

Have you completed a routine health examination (physical and blood work) administered by a doctor within the last two years?

Member: Yes No

Spouse/Partner: Yes No

Please list all medications for health problems. (Medications do not include female hormone replacement, thyroid replacement, allergy medication, vitamins or one "preventative" medication.)

Member:

Spouse/Partner:

Medication _____ Medication _____
Purpose _____ Purpose _____
Dosage _____ Dosage _____
Frequency _____ Frequency _____

Medication _____ Medication _____
Purpose _____ Purpose _____
Dosage _____ Dosage _____
Frequency _____ Frequency _____

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Dosage _____ Dosage _____
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Purpose _____ Purpose _____
Dosage _____ Dosage _____
Frequency _____ Frequency _____

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Purpose _____ Purpose _____
Dosage _____ Dosage _____
Frequency _____ Frequency _____

Please provide your height and weight:

Member: Height _____ Weight _____

Spouse/Partner: Height _____ Weight _____

Are you covered by Medicaid? (If you are eligible for or covered by Medicaid, you may not need this policy.)

Member: Yes No

Spouse/Partner: Yes No

Are you receiving any disability benefits? If yes, please explain below:

Member: Yes No

Spouse/Partner: Yes No

Do you need assistance or supervision with your daily activities, such as bathing, dressing, toileting, bowel or bladder control, transferring, managing medications, using the telephone, or walking?

Member: Yes No

Spouse/Partner: Yes No

Have you had a diagnosis for Diabetes and require 50 units or more of insulin per day? If you answer yes, do not request a price quotation.

Member: Yes No

Spouse/Partner: Yes No

Within the last 5 years, have you received medical advice, diagnosis or treatment or consulted with a member of the medical profession for any of the following conditions? If yes, explain below.

- Circulatory disorders
- Cancers
- Gastrointestinal disorders
- Hematology disorders
- Respiratory disorders
- Substance abuse

- Endocrine & Pituitary disorders
- Genitourinary disorders
- Neurological disorders
- Musculoskeletal disorders
- Eye & Ear disorders

Member: Yes No

Spouse/Partner: Yes No

SELECT DESIRED COVERAGE BELOW:

SELECTION OF PLAN: Member & spouse/Partner must have the same coverage.

Custom Care III

Core Care

Daily and/or Monthly Benefit (Daily from \$50 to \$500 / Monthly from \$1500 to \$15000)

Daily: \$ _____

Monthly: \$ _____

Included in your quotation:

- Home Care
- Adult Day Care
- Assisted Living Facilities
- Nursing Homes
- Hospice Care

Benefit period:

2 year 3 year 4 year 5 year 6 year 10 year

Elimination period:

30 day 60 day 90 day 180 day 365 day

Automatic benefit increase:

- 5% Compound Inflation CPI Compound Inflation CPI Compound Inflation to Age 75
- GPO-guaranteed purchase option

Riders: Please refer to your material for explanation of the following riders. Some riders may not be available under some plans or benefit periods.

- Survivorship & Waiver of Premium Benefit
- Shared Care
- Non-forfeiture

- Additional Cash Benefit
- Waiver of Elimination Period (Home Care)

Please provide the following contact information:

SCHOOL DISTRICT: _____ RETIRED: YES NO

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: (____) _____ EMAIL ADDRESS: _____

**MAIL TO: MEA Financial Services, Inc., Personal & Confidential: Debra Hart, 1480 Kendale Boulevard.
East Lansing, Michigan 48823 (If questions, call: 1-800-292-1950, ext. 2278)**