



Employee (Late Applicant) and Spouse
Long Term Care Medical Questionnaire/
Enrollment Form

Instructions

Each enrollee must complete and sign a separate form.

An enrollee is a person who is not currently enrolled and is requesting coverage.

- 1. Please complete if you are an employee applying for coverage AFTER the Special Enrollment or after 45 days of hire (late applicant).
2. Please complete if you are a spouse of an employee.

An enrollee is either a person who is not currently enrolled and is requesting coverage, or an enrolled person requesting an increase in existing coverage. Please print, completing all sections as directed below. Provide complete dates and details for all "Yes" answers. Please be sure to provide complete information to avoid delays in processing. Be sure to make a copy of this enrollment form for your records and return your completed form in the envelope provided to Aetna Life Insurance Company, Long Term Care Underwriting Department, P.O. Box 14550, Lexington, KY 40512-4550.

The following definition applies to any reference on this form to Immune System disorder:

DISORDER OF THE IMMUNE SYSTEM includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia) of white blood cell production and maturation, and the immune-deficiency disorders, both congenital and acquired. Also included in disorders of the immune system are lupus erythematosus, Grave's disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

ARC (AIDS RELATED COMPLEX) is a condition with signs and symptoms which may include generalized Lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression or other psychoneurotic disorders with no known cause.

Fraud Notice

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

PART A: Prescreen - To be completed by all enrollees

Have you applied for coverage under this Long Term Care Plan previously? ... Yes No

If you check "Yes" to any of the items listed below, please do not submit this form. These conditions and circumstances will result in a denial of coverage. They are not intended to be a complete list of conditions for which we deny coverage. If you do not have any of these conditions and you do complete the form, you should not assume coverage will be approved. Aetna will review the information you provide regarding your health status and decide whether to approve your request for coverage. The same guidelines apply to requests for an increase in existing coverage.

Check "Yes" if you have ever experienced or been specifically diagnosed, treated for, or told that you have any of the following conditions. Check "No" if you have not. If you have doubt about your answer, ask your doctor.

- Alzheimer's Disease, dementia or chronic permanent memory loss? ... Yes No
Parkinson's Disease, Multiple Sclerosis (MS), Huntington's Chorea, or Amyotrophic Lateral Sclerosis (ALS)? ... Yes No
Permanent paralysis? ... Yes No
Post Polio Syndrome? ... Yes No

Do you currently and on an ongoing basis:

- Receive home health care or adult day care, reside in (or have been recommended to) a nursing home or home for the aged? ... Yes No
Use a walker, wheelchair, oxygen, catheter, or kidney dialysis? ... Yes No
Receive assistance from or the supervision of another person for dressing, toileting, walking, eating or transferring (moving from chair to chair, or bed to chair)? ... Yes No

ProtectCheck Information

If you select ProtectCheck method of payment, please note:

- 1. Withdrawals will be made on the first business day of each month.
2. In the event funds are not available any month, the following month's withdrawal will be equal to two months' premium.
3. Withdrawals will continue until Aetna has had a reasonable opportunity to act upon a written request to terminate this service.
4. Aetna Life Insurance Company retains the right to terminate coverage in the event funds are not available.

If you have any questions about a particular condition or circumstance, or if you have any questions about your enrollment process, please call Aetna's Long Term Care Hotline at 1-800-537-8521.

**PART B: Enrollment Options**

<b>Activity (check one):</b> <input type="checkbox"/> New Enrollment <input type="checkbox"/> Increasing Coverage	<b>Individual requesting coverage is:</b> <input type="checkbox"/> Active Employee (Late Applicant) <input type="checkbox"/> Spouse of Employee
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**PART C: Policyholder**

Employer Name Greek Orthodox	Policyholder Number 658408	Control Number 890006
(50-001)		Aetna Use Only: (06) (Monthly Premium Cost)

**PART D: Daily Benefit / Plan Options / or Increasing Coverage**

1.) **Would you like to include the following options: select all that apply, see rate page in the 'Outline of Coverage' for additional cost:**

a. Lifetime Maximum Benefit (Choose one):     3 Years                       5 Years                       20 Years

b.     Benefit Bank

c.     Return of Contributions Death Benefit

d. Inflation Protection (Choose One):     Voluntary Inflation Protection                       Automatic Inflation Protection

e. Informal Care Option (Choose one):     25% of your DBA for up to 50 days per year                       25% of your DBA for up to 365 days per year

2.) **Please select a Daily Benefit Amount (Choose One)**     \$100                       \$200                       \$300

If you would like to choose a Daily Benefit Amount other than the ones listed, indicate the amount here (choose between \$100 and \$350): \$ \_\_\_\_\_

3.) **If you are Increasing your Daily Benefit Amount, please indicate the additional amount only:**                      \$ \_\_\_\_\_

Total coverage including this increase amount must not exceed \$350. You may increase coverage in \$1 increments.

**PART E: Enrollee Information**

Enrollee Name (Last, First, Middle Initial)		Social Security Number _____ - _____ - _____		
Street Address		City	State	ZIP Code
Daytime Phone Number (    )	Birthdate (Month/Date/Year) /    /	Sex M    F	Height Ft.    In.	Weight lbs.
Return of Contribution Beneficiary Name (Last, First, Middle Initial) Complete <u>only</u> if you elect include the Death Benefit feature in your Long Term Care plan.		Return of Contribution Beneficiary Social Security Number _____ - _____ - _____		

**PART F: Employee Information - (Please complete if the individual REQUESTING coverage is a Spouse of an Employee)**

Relationship to Employer: Employee	Employee Name (Last, First, Middle Initial)	Social Security Number _____ - _____ - _____
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**PART G: Lapse Notification**

If, after your coverage takes effect, you stop paying premiums, you will receive notice that your coverage is about to lapse (terminate). We will be glad to send a copy of this notice to another person if you would like. That person will not be responsible for payment of the premium, and you will always receive your own copy of the notice. If you want a copy sent to another person, please give us that person's name and address:

\_\_\_\_\_  
Name (First, Last)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
ZIP Code

**Protection Against Unintended Lapse.** I understand that I have the right to designate at least one other person other than myself to receive notice of lapse or termination of this long-term care insurance coverage for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect **NOT** to designate any person to receive the notice.

\_\_\_\_\_  
Enrollee's Signature

\_\_\_\_\_  
Date Signed

**PART H: Medical Questionnaire**

If you check "yes" to any items in PART H, please provide an explanation in the space provided. Explanations should include dates, treatments, and any residual effects of the disease. Please indicate whether you have attached additional pages, and be sure to put your name and Social Security Number on any attached sheets.

**Have you ever been treated, advised to have treatment/surgery, or taken medication for:**

- 1. Chest pains, headaches, dizziness, fainting spells, blood pressure, heart attack, heart failure (CHF), or other diseases of the heart or blood vessels (circulatory system)? .....  Yes  No
- 2. Mental, emotional or nervous disorder, depression, memory impairment, confusion, anxiety, Alzheimer's Disease or other disorders of the brain? .....  Yes  No
- 3. Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the joints, or other disease or injury (fractures, amputations) of the bones, joints, or spine? .....  Yes  No
- 4. Cancer, tumor, or other malignancy or growth? .....  Yes  No
- 5. Stroke, TIA (mini-stroke), paralysis, numbness, or visual disturbances? .....  Yes  No
- 6. Emphysema, other respiratory or lung diseases, or breathing conditions? .....  Yes  No

**In the past 5 years have you:**

- 7. Received or been advised to have treatment for alcohol or drug use? .....  Yes  No
- 8. Been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), ARC, or AIDS-related disorder? .....  Yes  No

**Do you currently:**

- 9. Take any medications? If "Yes", list drugs, dosages, and conditions in the space provided on the next page. ....  Yes  No

Please list all medications currently taken. Note drug dosage and the condition for which the medication was prescribed:

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Please provide explanations of any "yes" answers to questions 1-9. Include dates, treatments and residual effects. For additional space, use next page.

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**Privacy Notice**

In evaluating your insurability, we rely primarily on the health information you furnish to us in this statement. In addition, however, we may request additional medical information about you from any of the sources specified in the authorization below or you may be contacted for a telephone interview or a home visit.

**Disclosure of Information to Others**

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

**Your Right of Access and Correction**

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding) and to request correction, amendment or deletion of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right, or if you wish to have a more detailed explanation of our information practices, please contact: Aetna Life Insurance Company, Long Term Care Underwriting Department, 151 Farmington Avenue, Hartford, CT 06156-3705.

**PART I: Certification/Authorization**

**Certification.** I certify that the answers and statements on this form are complete and true to the best of my knowledge and belief. I agree that this document is my enrollment request for group Long Term Care Insurance or for an increase in existing coverage. I understand coverage will be effective only if and when Aetna Life Insurance Company gives its written consent, and that any misstatements or omissions will make any insurance based upon this enrollment form void at the option of Aetna. **I understand I may be contacted in person or by telephone by a representative of Aetna as part of the medical review process.**

**Authorization.** To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital service and prepaid health plans, and employers: You are authorized to provide Aetna Life Insurance Company and any insurance agents acting on Aetna's behalf with information concerning health care, advice, treatment or supplies (including those relating to mental illness and/or AIDS/HIV) provided to me or any members of my family for whom coverage has been requested. This information will be used for the purpose of determining eligibility for Long Term Care Group Insurance coverage. This authorization will be valid for 30 months from the date of this enrollment request.

I acknowledge that I have read the Privacy Notice, Notice to Applicant and Fraud Notice (shown on the front page) and know that I have a right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization is as valid as the original. If I am accepted, my coverage will be effective in accordance with the group policy issued.

If approved for Long Term Care Insurance coverage/increase in existing coverage, I agree to make the required contributions in accordance with the group insurance policy issued directly to Aetna Life Insurance Company.

*CAUTION: If your answers on this application are incorrect or untrue, Aetna may have the right to deny benefits or rescind your certificate.*

Enrollee's Signature

Date

**Questions? Call Aetna's Long Term Care Hotline at 1-800-537-8521**