



## Long Term Care Insurance Personal Worksheet

This form is used for the benefit of prospective insureds. It assists Aetna Life Insurance Company (Aetna) in selling long term care insurance to people who need the coverage and who can afford it. Aetna is required to present this form to you and to offer to discuss the affordability of this insurance. Aetna is also required to fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and Aetna decide if you should buy this insurance. However, you may choose not to discuss any or all of the information elicited by this form.

People buy long term care insurance for a variety of reasons, including:

- to *avoid spending assets* for long term care;
- to make sure there are *choices* regarding the type of care received;
- to *protect family* members from having to pay for care; or
- to *decrease* the chances of going on Medicaid.

These are all very important reasons to keep in mind when considering the purchase of long term care insurance. Long term care insurance, however, can be expensive, and may not be appropriate for everyone. One way to help you decide if long term care insurance is right for you, is to review your financial status. The following list of questions is a financial guideline to help you review your financial status. Please consider *protection of assets, freedom of choice, family and financial* reasons before making your decision.

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### **Premium Information** *(Please refer to the enrollment kit for the premium rate for your age and plan selection options.)*

Policy Form Numbers: Group policy # GR-700-W

*(In certain states, the group policy form number may be: GR-700; GR-700-WFQ; or GR-700-WQF.)*

The premium for the coverage you are considering will be \$\_\_\_\_\_ per \_\_\_\_\_.

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### **Type of Policy** (noncancellable/guaranteed renewable):

Coverage under the group policy is **guaranteed renewable** to each covered person, except for non-payment of any required premium.

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### **Aetna's Right to Increase Premiums**

Aetna has a **limited** right to increase premiums after you have purchased your coverage. Any increase must apply identically to all such group policies with similar rating characteristics in the plan sponsor's state such as age, rate classification and selected benefit options. *You cannot be singled out for a premium increase for any reason, including increasing age or use of long-term care coverage.*

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## Rate Increase History

Aetna has sold long term-care insurance since 1987 and has sold this policy since 1994. Aetna has never raised its rates for long term care insurance in this state or any other state; however, rates may change at any time you elect to modify benefits for your coverage.

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### Questions Related to Your Income

(You are not required to answer these questions; they are intended to help you.)

How will you pay each year's premium?

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

Have you considered whether you could afford to keep this coverage if the premiums were raised, for example, by 20%?

What is your annual income? **(Please 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? **(Please check one)**

No change    Increase    Decrease

*If you will be paying premiums 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 if it is offered as an option under this group policy? **(Please 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 in 2002 was \$54,900<sup>1</sup>, but this figure varies across the country. In ten years, the national average annual cost would be about \$89,426 if costs increase 5% annually.*

The elimination period for the group policy you are considering is [90] days. Approximate cost \$ \_\_\_\_\_ for that period of care.

*In order to determine the approximate cost, you will need to know costs in the area of the country where you will likely receive long-term care. A good way to do this is to check nursing facility costs for that area. For example: If the elimination period were 90 days and the national average daily cost in 2002 were \$150.41<sup>1</sup>, then the approximate cost for that period of care would be \$13,536.90.*

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

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

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<sup>1</sup> GE LTC Survey, 3/02

**Questions Related to Your Savings and Investments**

(You are not required to answer these questions either.)

Not counting your home, about how much are all your assets (savings and investments) worth? **(Please 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? **(Please 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 long-term care.*

**Disclosure Statement**

**(Please check one)**

- The answers to the questions above describe my financial situation.

**OR**

- I choose not to complete this information. However, I have reviewed the information provided on the Personal Worksheet, and I wish to purchase this long term care insurance coverage. Please proceed with your review of my Enrollment Form/Medical Questionnaire.

**OR**

- I choose not to complete this information. I have decided not to buy this long term care insurance coverage at this time. I understand that you will close my file and that coverage will not be issued.

**IN ORDER FOR YOUR ENROLLMENT FORM TO BE PROCESSED, YOU MUST ACKNOWLEDGE THE PREMIUM DISCLOSURE BELOW AND RETURN THIS FORM TO AETNA IN THE SELF-ADDRESSED ENVELOPE PROVIDED.**

**(This box must be checked)**

- I acknowledge that I have reviewed this form including the sections *Premium Information, Aetna's Right to Increase Premiums, Rate Increase History* and the *Potential Rate Increase Disclosure Form* describing the potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this group policy may increase in the future.**

Signed: \_\_\_\_\_  
(Enrollee)

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_  
(Enrollee)

Plan Sponsor: \_\_\_\_\_

Enrollee's State of Residence: \_\_\_\_\_

**Please make a copy of this form for your records and send a copy to us with your enrollment form. Thank you.**