The Prudential Insurance Company of America
Prudential Long Term Care Customer Service Center
P.O. Box 8526, Philadelphia, PA 19176-8526 • 1-800-732-0416

State Notices

IMPORTANT STATE NOTICES ABOUT PRUDENTIAL LONG TERM CARE℠ INSURANCE

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties.

To residents of California:
THIS PLAN IS APPROVED LONG-TERM CARE INSURANCE UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THIS INSURANCE WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE. FOR INFORMATION ABOUT INSURANCE UNDER THE CALIFORNIA PARTNERSHIP FOR LONG TERM CARE, CALL THE HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM (HICAP) AT THIS TOLL-FREE NUMBER: 1-800-434-0222.

To residents of Illinois:
The policy is not approved for Medicaid Asset Protection under the Illinois Long Term Care Partnership Program. However, the policy is an approved long term care policy under state insurance regulations. For information about policies approved under the Illinois Long Term Care Partnership Program, call the Senior Helpline at the Illinois Department on Aging at 1-800-252-8966.

To residents of Indiana:
The policy does not qualify for Medicaid Asset Protection under the Indiana Long Term Care Program. However, the policy is an approved long term care policy under state insurance regulations. For information about policies and certificates qualifying under the Indiana Long Term Care Program, call the Senior Health Insurance Information Program of the Indiana Department of Insurance at 1-800-452-4800.

To residents of Iowa:
The policy does not qualify for Medicaid Asset Protection under the Iowa Long Term Care Asset Preservation Program. However, the policy is an approved long term care policy under state insurance regulations. For information about policies and certificates qualifying under the Iowa Long Term Care Asset Preservation Program, call the Senior Health Insurance Information Program of the Iowa Division of Insurance at 1-800-281-5705.

To residents of Massachusetts:
FEDERAL INCOME TAX EXEMPTIONS: This Coverage IS intended to be a federally qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

STATE MASSHEALTH (MEDICAID) EXEMPTIONS: This Coverage IS intended to satisfy Massachusetts' minimum long-term care insurance coverage requirements as of the Certificate's Effective Date for certain asset and liability exemptions under the Massachusetts MassHealth (Medicaid) Program if you purchase a Plan with a Nursing Home Daily Maximum greater than $125 per day. Please note that there may be other MassHealth (Medicaid) requirements to qualify for these exemptions. Although this Certificate may satisfy requirements at the time it is issued, it may not qualify at the time you enter a nursing home if you have used benefits.

To residents of Michigan:
For additional information about Long Term Care Coverage, write to the MICHIGAN INSURANCE BUREAU, P.O. BOX 30220, LANSING, MI 48909, or call the Area Agency on Aging in your community.

To residents of New Jersey: Caution: Any person who includes any false or misleading information on an application for coverage under a group policy is subject to criminal and civil penalties.

To residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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Enrollment Form

INSTRUCTIONS: Read and complete all necessary parts of this enrollment form. **Please print using blue or black ink.** Use an "X" to mark boxes where indicated. **Provide your signature in all areas required**. Return completed forms to: Prudential Long Term Care Unit, P.O. Box 8526, Philadelphia, PA 19176-8526. *If you have questions, call 1-800-732-0416.*

A APPLICANT INFORMATION

Eligibility Status
(check one)
☐ Actively-at-work benefit-eligible Employee
☐ Spouse
☐ Domestic Partner
☐ Parent
☐ Parent-in-law
☐ Grandparent
☐ Grandparent-in-law
☐ Adult Child
☐ Spouse of Adult Child

☐ Mr. ☐ Mrs. ☐ Ms. ☐ ____ **Marital Status** ☐ Married ☐ Unmarried

Full name _____

Address _____ **Apt.** _____
No P.O. Boxes please

City _____ **State** _____ **ZIP** _____

Daytime phone ( ) - **Evening phone** ( ) -
Best time to call: ☐ AM ☐ PM

Date of birth _____ **Date of hire** _____ **Social Security number** _____

If married, is your spouse applying for this insurance? **Yes** ☐ **No** ☐

If your spouse currently has Prudential Long Term Care℠ Insurance, please provide policy/certificate number: _____

If this application is for someone other than an eligible employee (e.g., a spouse, family member, domestic partner or other relation), please provide information about the eligible employee in this section.

Employee full name _____ Date of hire _____

Employee Social Security number _____

Daytime phone ( ) - Evening phone ( ) -

B BENEFIT OPTIONS SELECTION for Federally Tax Qualified Long Term Care Insurance contract

1. Coverage Amounts	Nursing Home Daily Benefit Maximum	Assisted Living/Residential Care Facility Daily Benefit Maximum	Home & Community-Based Care Daily Benefit Maximum	Lifetime Maximum
☐ Plan 1	$100	$100	$100	$109,500
☐ Plan 2	$100	$100	$100	$182,500
☐ Plan 3	$150	$150	$150	$164,250
☐ Plan 4	$150	$150	$150	$273,750
☐ Plan 5	$250	$250	$250	$273,750
☐ Plan 6	$250	$250	$250	$456,250

2. Home and Community-Based Care Daily Maximum
is 100% of the Nursing Home Care Daily Maximum

3. Optional Automatic Inflation Increase Rider — I have reviewed the Outline of Coverage and the graphs which compare the benefits and premiums of this Coverage with and without this Rider, and I want this Rider included in my Coverage. **Yes** ☐ **No** ☐

X *If you choose "NO" for the Automatic Inflation Increase Rider, please sign:* _____

C PAYMENT METHOD

Choose ONE of the following payment plans.

☐ **Payroll Deduction** If choosing this option, indicate your current payroll frequency:
☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

☐ **Electronic Funds Transfer (EFT) — Monthly Payment** If choosing this option, you must complete and return the enclosed EFT Authorization Form and a sample voided check.

☐ **Direct Billing**

Bill to:
☐ Applicant
☐ Employee, if other than applicant

How often:
☐ Quarterly
☐ Semi-Annually
☐ Annually

Billing address, if different from Section A:
_____
_____

D INSURANCE HISTORY

1. Are you covered by Medicaid or Medi-Cal (not Medicare)? **Yes** ☐ **No** ☐

2. Do you have another long term care insurance policy or certificate in force (including health care service contract or health maintenance organization contract)? **Yes** ☐ **No** ☐

3. Did you have another long term care insurance policy or certificate in force during the last 12 months? **Yes** ☐ **No** ☐

4. Do you intend to replace any of your medical or health insurance coverage with this insurance? **Yes** ☐ **No** ☐

If you answered "YES" to questions 3 or 4 of this section, please provide the following information.

Name of company _____
Address _____
_____
Policy number _____
☐ Check here if you intend to replace this policy.
☐ Check here if this policy lapsed. Give date: _____

Name of company _____
Address _____
_____
Policy number _____
☐ Check here if you intend to replace this policy.
☐ Check here if this policy lapsed. Give date: _____

E NOTIFICATION OF UNINTENTIONAL LAPSE

You can provide Prudential with the name of a friend or relative to notify if your coverage is about to lapse because the premium was not paid when due. This designation does not constitute an acceptance of liability by the person named. Prudential will notify you each year of your right to designate or change the existing designation for this purpose. **Choose ONE of the following options:**

☐ **Name a Designee**

First name M.I.

Last name

Address

City

State ZIP

☐ **Waive this Notice option**

I understand that I have the right to name at least one person other than myself to receive notice of lapse or termination of my long term care insurance coverage for non-payment of premium. I understand that notice will not be given until 30 days after the premium is due and not paid. **By my signature, I elect NOT to name any person to receive such notice.**

X Applicant's signature

Date

F APPLICANT AGREEMENTS

Caution: If your answers on this Enrollment Form are misstated or untrue, Prudential may have the right to deny benefits or rescind your coverage.

To the best of my knowledge and belief, the answers on this Enrollment Form are complete and true. I understand and agree that:

1. The Long Term Care Insurance coverage is underwritten by The Prudential Insurance Company of America (Prudential), whose corporate offices are located in Newark, New Jersey.
2. This Enrollment Form will be the basis for the Long Term Care Insurance coverage for which I am applying to Prudential under a Group Contract.
3. My coverage will NOT take effect unless Prudential has approved this Enrollment Form. If issued, my Long Term Care Insurance coverage will take effect on the Effective Date assigned by Prudential.
4. Prudential has the right to change premium rates in the future but only on a class basis.
5. If Payroll Deduction is indicated in Section C, I authorize Shoreline School District to make the payroll deductions needed for premium payment for the applicant listed in Section A. I understand all deductions for this applicant and other applicants for whom I am authorizing deductions will appear as one line item on my payroll/earnings statement.
6. I have received the Outline of Coverage and *A Shopper's Guide to Long Term Care Insurance.*
7. I have received the Privacy Notice concerning Prudential's Information Practices.
8. If I am eligible for Medicare, I have received the *Guide to Health Insurance for People with Medicare.*
9. I have read, or had read to me, the completed Enrollment Form, and I understand that any false statement or misrepresentation in my Enrollment Form may result in loss of coverage under the Group Contract.

X Applicant's signature Date

NOTE: If Payroll Deduction is selected in Section C, and if this application is for someone other than an eligible employee, please be sure that the employee authorizes payroll deduction by signing below.

X Employee's signature (if other than applicant) Date