Instructions

Each person applying for coverage must complete a separate application.

In addition to completing the application, we may obtain your medical records from your doctor. We may also have a nurse call you and conduct a telephone interview or arrange for a convenient time for a nurse to speak with you in person due to cause for proof of insurability.

**NOTE: ALL APPLICANTS MUST MEET THE ESTABLISHED UNDERWRITING CRITERIA TO BE APPROVED FOR COVERAGE UNDER THE CALPERS LONG-TERM CARE PROGRAM.**

We will inform you of the decision we make concerning your application approximately six to eight weeks after we receive it.

You must be between the ages of 18 and 79 to apply for coverage.

Make a copy of this application to retain for your records. It is a good idea to review the application again before mailing it to make certain all information is complete. **You must sign and date sections C, G and H.** You will be asked to resign and redate these sections again if your application is returned for missing information.

**Your Application Will Be Returned If All of the Required Sections Are Not Signed.**

If you attach additional information to your application be sure to include your name and social security number.

Mail your application in the postage-paid envelope provided. If you do not have the postage-paid envelope, please mail this application to:

CalPERS Long-Term Care Program  
PO Box 64902  
St. Paul, MN 55164-0902

Do not send payment at this time; we will begin deductions or bill you if your application is approved.

**A Special Note About Premiums:** Your premiums are designed to remain level over your lifetime. Any change of premiums would have to be approved by the CalPERS Board and be made for everyone with similar coverage. You cannot be singled out for a rate increase. Should a rate increase occur, all members would receive a 60-day written notice.

**Questions?**

If you have any questions about the CalPERS Long-Term Care Program, or if you would like help in completing your application, please call toll free at **1-800-908-9119** Monday through Friday from 7:00 A.M. to 7:00 P.M. Pacific time.
Applicant Information

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

- [ ] Active Employee
- [ ] Spouse of Retiree or Annuitant
- [ ] Spouse of Active Employee
- [ ] Parent of Active Employee, Retiree or Annuitant
- [ ] Retiree of Annuitant
- [ ] Parent-in-law of Active Employee, Retiree or Annuitant
- [ ] Sibling of Active Employee, Retiree or Annuitant

I am a member of: [ ] CalPERS [ ] CalSTRS [ ] Other: __________________________

Name (First) __________________________ (Middle Initial) __________________________ (Last) __________________________

Address __________________________ __________________________

City __________________________ State __________________________ ZIP Code __________________________

Date of Birth (MM/DD/YY) __________________________ Social Security Number __________________________

Home Phone Number __________________________ Best Time to Be Reached __________________________ Work Phone Number __________________________

E-mail Address __________________________

Gender: [ ] Male [ ] Female

Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced

1. How did you hear about the Program?: [ ] Mail [ ] Seminar [ ] Worksite [ ] Website

2. Describe briefly in your own handwriting your current hobbies, volunteer work and regular exercise:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

3. [ ] Yes [ ] No Are you currently employed and actively working? If “Yes,” how many hours per week? ______

4. [ ] Yes [ ] No Are you receiving disability income, workers’ compensation, SSI or any other state or federal disability benefits? If “Yes,” please give details on nature and source of benefits.

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________

CPAPPL0106
### Medical Questions

**Please answer “Yes” or “No” by checking the box.**

1. ☐ Yes ☐ No  
   **Do you currently** require the “hands-on” assistance of, or supervision by, another person in performing any of the following activities: moving in/out of the bed or chair; controlling bowel/bladder; bathing; eating; dressing; or using the toilet?

2. **Are you currently** receiving:
   - 2a ☐ Yes ☐ No  Nursing Home Care (in a nursing home or extended care unit of a hospital)?
   - 2b ☐ Yes ☐ No  Home Health Care (visiting nurse, therapist or health aide visits)?
   - 2c ☐ Yes ☐ No  Adult Day Care Services?

3. **Have you had**, do you **currently have**, or have you **been medically diagnosed** as having any of the following conditions:
   - 3a ☐ Yes ☐ No  Organic Brain Syndrome; Memory Loss; Mild Cognitive Impairment; Senility; Dementia; or Alzheimer’s Disease?
   - 3b ☐ Yes ☐ No  Metastic Cancer (cancer has spread from original site)?
   - 3c ☐ Yes ☐ No  Parkinson’s Disease; Mental Retardation; Downs Syndrome; Muscular Dystrophy; Multiple Sclerosis; Myasthenia Gravis; Amyotrophic Lateral Sclerosis (ALS); Huntington’s Chorea; Multiple Strokes; Multiple Transient Ischemic Attacks (TIAs); or Hydrocephalus?
   - 3d ☐ Yes ☐ No  AIDS or AIDS Related Complex (ARC)?

   *If you answer “Yes” to questions 1, 2 or 3 and you feel you have fully recovered or are no longer requiring services described above, please attach an explanation including conditions, services used and time frames.*

4. **Do you now use or in the past 12 months** have you used (check all that apply or **None**):
   - ☐ Oxygen
   - ☐ Quad cane
   - ☐ Walker
   - ☐ Hospital bed in your home
   - ☐ Wheelchair
   - ☐ Kidney dialysis
   - ☐ Motorized scooter
   - ☐ None

   Please describe checked item(s), and their use:

5. ☐ Yes ☐ No  **Have you taken any prescription medication** during the past six months?  
   *If you need more space to complete this section, please attach another sheet of paper.*

   **Medication** | **Dosage & Frequency** *(ex.: 20mg/2 a day)* | **Reason Prescribed**
   --- | --- | ---
   | | |
   | | |
   | | |

6. **Please provide your height** *(ft. and in.)*  
<table>
<thead>
<tr>
<th>Feet</th>
<th>Inches</th>
<th><strong>and weight</strong> <em>(lbs.)</em></th>
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</table>

7. ☐ Yes ☐ No  **Have you used any tobacco products in the past 24 months?**
   *If yes, when did you quit?____________  Describe type and amount:*  

8. **Do you currently** require any human assistance or supervision with any of the following daily activities (check all that apply or **None**):
   - ☐ Shopping
   - ☐ Doing housework
   - ☐ Managing finances
   - ☐ Doing laundry
   - ☐ None
   - ☐ Preparing meals
   - ☐ Using transportation
   - ☐ Taking medications
   - ☐ Toileting/Bowel & Bladder Control

9. **During the past three years** have you **(check and describe below all that apply or None of the above)**:
   - ☐ Been medically advised to have surgery that has not been performed?
   - ☐ Been referred to or consulted a specialist?
   - ☐ Been referred to or consulted a health care professional other than your primary care physician?
   - ☐ Been admitted to or medically advised to enter a nursing home or an extended care unit of a hospital?
   - ☐ Received home care services (visiting nurse, nurse’s aide, therapist or meals on wheels)?
   - ☐ Been a patient in a hospital, emergency room, outpatient surgery or other health care facility?
   - ☐ Used adult day care services or outpatient therapy (physical or occupational therapy or rehabilitation)?
   - ☐ None of the above

   Please describe and include dates:  
   |  
   |  
   |  
   |  
   |  
   |  
   |  

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**If you answer “Yes” to questions 1, 2 or 3 and you feel you have fully recovered or are no longer requiring services described above, please attach an explanation including conditions, services used and time frames.**
Medical Questions
(Continued)

10. Within the last three years have you consulted with a health professional, taken any medication, been medically diagnosed, been tested or evaluated for, or been confined to a convalescent facility, hospital or nursing home facility for any of the following conditions (check all that apply below or None of the above):

☐ 1. Alcohol or Drug Abuse
☐ 2. Anemia or Related Illness
☐ 3. Angina
☐ 4. Arthritis
☐ 5. Asthma
☐ 6. Back or Spine Injury
☐ 7. Blood Disorder (Do not check if only blood disorder is HIV Positive.)
☐ 8. Brain Disorder/ Difficulty Speaking
☐ 9. Cancer/Tumor
☐ 10. Chronic Infection
☐ 11. Chronic Bronchitis
☐ 12. Congestive Heart Failure (CHF)
☐ 13. Convulsions/Seizures/ Epilepsy
☐ 14. Depression/Manic
Depressive Illness
☐ 15. Diabetes
☐ 16. Emphysema/Chronic Obstructive Pulmonary Disease (COPD)
☐ 17. Fainting Spells/Blacking Out
☐ 18. Falls
☐ 19. Foot/Ankle Swelling
☐ 20. Fractures
☐ 21. Heart Attack/Myocardial/ Infarction
☐ 22. High Blood Pressure/ Hypertension
☐ 23. Hodgkin’s Disease/ Lymphoma
☐ 24. Immune System Disorder (Do not check if only immune disorder is HIV Positive.)
☐ 25. Injury Due to Falls/Imbalance
☐ 26. Joint Replacement/Amputation
☐ 27. Kidney Failure/Kidney Disease
☐ 28. Leukemia
☐ 29. Macular Degeneration
☐ 30. Memory Loss/Forgetfulness
☐ 31. Osteoporosis
☐ 32. Conditions Causing Crippling or Limited Motion
☐ 33. Paralysis
☐ 34. Peripheral Vascular Disease
☐ 35. Pressure Sores/Bed Sores/ Skin Ulcers
☐ 36. Schizophrenia/Psychoses
☐ 37. Shortness of Breath
☐ 38. Stroke
☐ 39. Transplant
☐ 40. Transient Ischemic Attack (TIA)
☐ 41. Tremor
☐ 42. Other medical conditions not mentioned above
☐ None of the above

11. Please list all physicians you have seen in the past three years, including the physicians specialty and reason for the visit. If you need more space to complete this section, please attach another sheet of paper.

<table>
<thead>
<tr>
<th>Physician’s Name</th>
<th>Specialty</th>
<th>Reason for Visit</th>
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</table>

Authorization for Release of Medical Information
THIS SECTION MUST BE COMPLETED

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, care provider, care manager or evaluator, insurance company or insurance support organization to give to the California Public Employees’ Retirement System or its authorized representative any records or knowledge of me or my health needed to evaluate my application, including information regarding drug, alcohol or psychiatric treatment or results of an HIV antibody test. I agree that this authorization will be valid for 24 months from the date signed unless I revoke it in writing. I understand that my revocation will not be effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. A photocopy of this authorization is as valid as the original.

Applicant Name (please print) ____________________________
Signature of Applicant ____________________________ Date (MM/DD/YY) ____________

This authorization is in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
**Attending Physician Information**

Please complete below for your Primary Care Doctor (physician with most of your medical records).

1. □ Yes  □ No  Do you have a primary care physician?
2. □ Yes  □ No  Have you seen this physician in the last two years?

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>Phone Number</th>
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<th>Address</th>
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<table>
<thead>
<tr>
<th>State</th>
<th>ZIP Code</th>
<th>Kaiser* or Medical Record Number (if known)</th>
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</table>

*For Kaiser patients: your application may be delayed if you do not include your medical record number.

**Replacement Coverage Information**

Please answer the following questions about existing coverage you may have and whether you plan to replace it with the CalPERS coverage. Federal law requires that we ask you these questions. Your answers to these questions will NOT affect your eligibility for this program. You should not replace any existing medical or health insurance coverage you have with the CalPERS Long-Term Care Program.

1. □ Yes  □ No  Are you covered by Medicaid (called Medi-Cal in California)?
   (Please note that this is NOT a reference to Medicare.)

2. If you already have another long-term care insurance policy or certificate, you should review that policy carefully and compare its benefits and costs with the benefits and costs of the CalPERS coverage. It may or may not make sense for you to replace that policy or certificate. If you do decide to apply for the CalPERS coverage, you should not cancel any long-term care insurance you currently have unless/until your coverage under the CalPERS Program is effective.
   □ Yes  □ No  Are you replacing another long-term care insurance policy or certificate currently in force?
   If yes, please provide the following information:

<table>
<thead>
<tr>
<th>Insurance Company Name</th>
<th>Policy Number</th>
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<tr>
<th>Insurance Company Address</th>
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<table>
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<tr>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
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**Final Billing Designee**

Please complete even if you elect not to have a designee.

It is a good idea to designate another person to receive notice if your coverage is about to lapse (terminate) because you missed a premium payment. This gives you added protection against an unintended lapse in your coverage. We will notify the person you designate only after you have first been notified and 30 days after your premium is due and remains unpaid.

Would you like to name a person in addition to yourself to receive notice if your coverage is about to lapse because of a missed premium payment? We do not recommend that you designate a member of your household as a final billing designee.

*Please check one of the following:  □ I elect NOT to name a Final Billing Designee to receive this notice.  □ I elect the Final Billing Designee listed below to receive this notice.*

**Information about your designee:**

<table>
<thead>
<tr>
<th>Name (First)</th>
<th>(Middle Initial)</th>
<th>(Last)</th>
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<tr>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
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<table>
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<tr>
<th>Home Phone Number</th>
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You may change the named designee at any time by notifying us in writing at the address on the instruction page.
Plan Options

For plan descriptions and rates, refer to Plans at a Glance and the Monthly Rates sheet. Please call 1-800-908-9119 if you need assistance with your plan choice. Fill out either SECTION G1 or SECTION G2 below. Do not fill out both sections.

### SECTION G1
Mark an “X” in only one box in each of the four lines below.

<table>
<thead>
<tr>
<th></th>
<th>Type of Plan:</th>
<th>Comprehensive</th>
<th>Facilities Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Daily Benefit Amount (DBA):</td>
<td>$130</td>
<td>$150</td>
</tr>
<tr>
<td>2.</td>
<td>Total Coverage Amount:</td>
<td>Lifetime (Unlimited)</td>
<td>Maximum Benefit: 6 years = 2190 x DBA</td>
</tr>
<tr>
<td>3.</td>
<td>Inflation Protection (IP):</td>
<td>Built-In 5% IP (Compounded Annually)</td>
<td>Benefit Increase Option (BIO) (offered every three years)*</td>
</tr>
</tbody>
</table>

If you have chosen the Comprehensive or Facilities Only Plan, Please Read and Sign Here

I certify that I have reviewed all the information, eligibility criteria and notices contained in this application kit 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 which could include recision of my coverage or benefit denial may be applied.

I understand that the plan I am applying for has been approved by the Board of Administration of the California Public Employees’ Retirement System, but does not qualify for Medi-Cal Asset Protection under the California Partnership for Long-Term Care.

*I have reviewed the application materials that compare the benefits and premiums of the above plans with Built-In Inflation Protection and Benefit Increase Option. I understand that by checking the Benefit Increase Option box, I have rejected a plan with Built-In five percent (5%) Inflation Protection compounded annually.

Signature of Applicant Date

### DO NOT COMPLETE SECTION G2 BELOW IF SECTION G1 ABOVE IS COMPLETED

### SECTION G2
Mark an “X” in only one box in each of lines 1 through 3 below.

<table>
<thead>
<tr>
<th></th>
<th>Type of Plan:</th>
<th>Partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Daily Benefit Amount (DBA):</td>
<td>$130</td>
</tr>
<tr>
<td>2.</td>
<td>Total Coverage Amount:</td>
<td>Maximum Benefit: 1 year = 365 x DBA</td>
</tr>
<tr>
<td>3.</td>
<td>Inflation Protection (IP):</td>
<td>Includes Built-In 5% IP (Compounded Annually)</td>
</tr>
</tbody>
</table>

If you have chosen the Partnership Plan, Please Read and Sign Here

I certify that I have reviewed all the information, eligibility criteria and notices contained in this application kit 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 which could include recision of my coverage or benefit denial may be applied.

I understand that this is the first step to apply for a Partnership-approved long-term care program that qualifies for Medi-Cal Asset Protection under the California Partnership for Long-Term Care. To complete the application process, I am requesting the additional Partnership materials.

The benefits payable by the Plan qualify for Medi-Cal Asset Protection under the California Partnership for Long-Term Care. Eligibility for Medi-Cal is not automatic. If and when you need Medi-Cal, you must apply and meet the asset standards in effect at the time. Upon becoming a Medi-Cal beneficiary, you will be eligible for all medically necessary benefits that Medi-Cal provides at that time, but you may need to apply a portion of your income toward the cost of care. Medi-Cal services may be different than the services received under the private coverage.

Signature of Applicant Date
Payment Options

Choose a payment or deduction option below. Please complete both Step 1 and Step 2.
We ask you to select a second option in case we are unable to provide your preferred payment option.

About Payroll or Pension Deduction: Most, but not all, public employers and retirement systems offer payroll or pension deduction. If you select either of these payment options in Step 1, please also indicate in Step 2 an alternative payment option should payroll or pension deduction not be available. Check with your Benefits Department to confirm if this billing option is available.

Note: Payroll or pension deduction is NOT available for part-time, seasonal, or permanent intermittent employees, or siblings, parents or parents-in-law of public employees, retirees and annuitants. (Pension deduction is currently available to CalPERS and CalSTRS retirees or annuitants and their spouses. Please call 1-800-908-9119 for current pension deduction information on other California public retirement systems). There may be a delay of 30–60 days in processing your first deduction due to set-up time for payroll/pension deduction. You MUST COMPLETE BOTH STEP 1 AND STEP 2. IF YOU DO NOT COMPLETE BOTH STEPS, YOUR APPLICATION WILL BE RETURNED.

S T E P  1

Please select one option:
A. ☐ Payroll Deduction  B. ☐ Pension Deduction  C. ☐ I do not want either Payroll or Pension Deduction (skip to Step 2)

Name of Employee, Retiree or Annuitant (if state employee/retiree/annuitant, provide as it appears on your payroll/pension check)

Name (First) (Middle Initial) (Last)

Social Security Number of Employee, Retiree or Annuitant

☐ Employee: Provide the name of your public employer as it appears on your payroll check.

☐ Retiree/Annuitant: Provide the name of your Retirement System such as CalPERS, CalSTRS or another California public retirement system (please specify)

“I authorize my employer/retirement system to deduct from my pay or pension benefits the required premium for my or my spouse’s CalPERS Long-Term Care Plan.”

Signature of Employee, Retiree or Annuitant Date

S T E P  2

Choose ONE of the following options. If you did not indicate a payment option in Step 1, this will be your payment option. If you indicated a payment option in Step 1, the option selected below will only be your payment option if payroll or pension deduction is not available to you.

1. ☐ Monthly Electronic Funds Transfer (also complete Section F.) I authorize CalPERS or its designated agent and the financial institution named below to initiate monthly withdrawals from my checking/savings account. This authorization will remain in effect until I provide written notification to cancel to CalPERS or its designated agent and my financial institution.

I understand that if the necessary funds are not on deposit in my account on the day designated to execute the automatic transfer, I will be billed directly. Electronic Funds Transfers draft approximately the 5th business day of each month.

Please provide the following information and then sign below. You must attach a voided check if you wish to have funds drawn from your checking account. Should you wish for funds to be drawn from your savings account, please attach a voided savings account slip.

Name of Bank or Financial Institution

Telephone Number

Checking Account # OR Savings Account #

Depositor(s) Signature Date

Depositor(s) Signature Date

(The signature must be that of the depositor(s) as shown on bank records for this account. If joint account, both depositors must sign.)

2. ☐ Bill me directly (Select one billing frequency and complete Section F—Final Billing Designee.)

☐ Annually ☐ Semi-annually ☐ Quarterly
APPLICATION

The CalPERS Long-Term Care Program 2006

“Peace of mind begins with a plan.”

Comprehensive Plan
Facilities Only Plan
Partnership Plan