



Consumer's Guide to Long-Term Care

This guide has been prepared by the Wisconsin Office of the Commissioner of Insurance (OCI) and must be given to all prospective buyers of long-term care insurance at the time an application is taken or when long-term care insurance is solicited, whether or not the solicitation results in a sale.

Wisconsin Office of the Commissioner of Insurance

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For more information on long-term care insurance call the Medigap Helpline at 1-800-242-1060. The Medigap Helpline is a statewide toll-free number set up by the Wisconsin Board on Aging and Long-Term Care to answer questions about health insurance and other health care benefits for the elderly. It has no connection with any insurance company.

A list of long-term care insurance policies currently being sold in Wisconsin is available at oci.wi.gov/Pages/Consumers/PI-046.aspx.

Disclaimer

This guide is intended as a general overview of current law in this area, but is not intended as a substitute for legal advice in any particular situation. You may want to consult your attorney about your specific rights. Publications are updated annually unless otherwise stated and, as such, the information in this publication may not be accurate or timely in all instances. Publications are available on OCI's website at oci.wi.gov/Publications. If you need a printed copy of a publication, use the online order form (oci.wi.gov/Pages/Consumers/Order-a-Publication.aspx) or call 1-800-236-8517. One copy of this publication is available free of charge to the general public. All materials may be printed or copied without permission.

File a Complaint

If you have a specific complaint about your insurance, refer it first to the insurance company or agent involved. If you do not receive satisfactory answers, contact the Office of the Commissioner of Insurance (OCI).

- Reach out to OCI (1-800-236-8517, ocicomplaints@wisconsin.gov) to speak with our staff. If sending an email, please indicate your name and phone number.
- File a complaint with OCI. You can file a complaint online at oci.wi.gov/complaints. If you would like to file your complaint by mail, visit oci.wi.gov/complaints, email ocicomplaints@wisconsin.gov, or call 1-800-236-8517 for a form.

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Frequently Asked Questions

Does Medicare cover long-term care services?

You should not rely on Medicare to pay for your long-term care needs. Medicare provides only limited [coverage](#) for long-term care primarily related to recuperating from a sickness or injury. Medicare pays only for skilled nursing care and [medically necessary](#) services.

Can my premiums be increased?

Yes, [premiums](#) for all long-term care [insurance policies](#) may be increased. However, if premiums are based on [issue age](#), they may increase only if premiums are increased for all individuals insured under the same type of policy. If premiums are based on [attained age](#), premiums will increase as you age.

Can the insurance company cancel my long-term care policy?

No, your policy is guaranteed renewable for life. The policy may terminate only when you cease paying your insurance premiums or if you use the maximum amount of benefits available under the policy.

Are preexisting conditions covered under long-term care insurance policies?

[Preexisting conditions](#) must be covered by long-term care insurance policies. However, insurance companies may have a preexisting condition [waiting period](#) of up to six months. After your policy is in effect for six months, it will pay for covered benefits. Please note, if you have preexisting medical problems at the time you apply for coverage, the insurance company is not required to accept your application or to issue coverage.

Are Alzheimer's and other dementias covered by long-term care insurance?

Alzheimer's disease and other dementias are required to be covered by long-term care policies. However, if you have Alzheimer's or other dementia at the time you apply for coverage, the insurance company is not required to accept your application or to issue coverage.

What is an elimination period?

An [elimination period](#) is similar to a [deductible](#). When you begin using long-term care services, there is a waiting period before the policy begins paying benefits. You are responsible for paying for all expenses during the elimination period.

Are benefits paid for all institutional settings, such as community based residential facilities (CBRFs), assisted living facilities, and residential care facilities?

Some policies pay for assisted living facilities, some do not. Long-term care policies pay only those benefits described or defined in the policy. **Most policies do not cover [CBRFs](#) or other placement. Read the definitions in your policy carefully.**

How much does a stay in a nursing home cost?

The costs of nursing home care vary among facilities and locations. You should contact those facilities you would consider acceptable and ask about their current daily charges. You can then determine the amount of coverage you will need.

What is Long-Term Care?

In general, the phrase "long-term care" refers to a broad range of services you may need for an extended period of time because of a chronic illness or disability. It usually does not include the type of care you receive on a short-term basis following a hospitalization or an acute illness.

Long-term care includes medical services, such as nursing care or therapies. It also includes supportive services, such as help in bathing, dressing, getting in and out of bed, taking medicines, or preparing meals.

Long-term care can be provided in a variety of settings, including nursing homes, your home, an adult day care center, or a group living arrangement with supportive services. Community-based long-term care (provided outside of nursing homes) is often given by family and friends, but may also be provided by paid individuals or agencies, some of which are licensed by the state and/or certified by public funding programs like Medicare.

Nursing Home Care

Care in a nursing home includes several different levels of care:

Skilled Nursing Care

This is care furnished on a physician's order which requires the skills of professional personnel, such as a registered nurse or a licensed practical nurse, and is provided either directly by or under the supervision of these personnel.

Intermediate Nursing Care

This is basic care including physical, emotional, social, and other restorative services given under periodic medical supervision. This nursing care requires the skill of a registered nurse in administration, including observation and recording of reactions and symptoms, and supervision of nursing care.

Personal or Custodial Care

This is care that can be performed by persons without medical training and is primarily for the purpose of meeting the personal needs of the patient, including feeding and personal hygiene.

Community-Based Long-Term Care

Community-based long-term care may be provided in many settings and by many kinds of providers. If you are receiving several services from different providers, a professional [case manager](#) may be involved in arranging for and managing the services. A few of the specific kinds of services and agencies providing community-based long-term care include:

Home Health Care

[Home health care](#) includes skilled nursing services, such as providing therapy treatments or administering medication; home health aide services, such as checking temperature and blood pressure; personal care, such as help with bathing, dressing, walking, and exercise; and physical, occupational, respiratory, or speech therapy.

Assisted Living Facility Care

[Assisted living facility](#) care is care given in a residential facility and includes supportive, personal, or nursing services. Supportive services may involve assistance with meals, housekeeping, laundry, and arranging for transportation. Personal services means direct, hands-on help with [activities of daily living](#).

Adult Day Care

[Adult day care](#) is care given in a nonresidential, community-based group program designed to meet the needs of functionally impaired adults. It is a structured, comprehensive program that may provide a variety of health, social, and related support services during any part of a day.

Respite Care

[Respite care](#) is the provision of personal care, supervision, or other services to a functionally impaired person in order to temporarily relieve a family member or other primary caregiver from caregiving duties.

Respite care services are usually provided in the impaired person's home or in another home or homelike setting but may also be provided in a nursing home.

Hospice Care

[Hospice care](#) is a specially designed package of social and medical services primarily providing pain relief, symptom management, and supportive services to terminally ill people and their families.

Who Needs Long-Term Care?

It is important to recognize at some time in your life you may require long-term care services. Therefore, you should think about how to pay for this care.

Your level of disability determines whether you require long-term care. The chances of needing long-term care usually increase as you age, but long-term care may be needed at any age.

The longer a person lives, the more likely it is he or she will need some kind of long-term care. Some people who have acute illnesses may need nursing home or home health care for only short periods of time. Others may need care for many months or years. Many people who need long-term care receive care in their own homes through services provided by home health agencies, relatives, or friends. Others receive care through nursing homes, group homes, or assisted living facilities.

Risk Factors for Needing Long-Term Care

Life expectancy: The longer you live, the more likely it is you will need long-term care.

Gender: Women are more likely to need long-term care because they live longer.

Married or single: If you are married and have adult children, you may be more likely to receive informal care at home.

Health factors: If poor health runs in your family, you could be at greater risk than another person of the same age and gender.

How Much Does Long-Term Care Cost?

The costs for long-term care vary depending on the service and the area in which services are provided. All types of long-term care services can be expensive if they are provided frequently or for a long period of time.

Information regarding the current costs of specific types of long-term services in your area and the projected costs for the future is available on the U.S. Department of Health and Human Services, Administration on Aging, website at [longtermcare.acl.gov/costs-how-to-pay/index.html](https://www.longtermcare.acl.gov/costs-how-to-pay/index.html)

Who Pays for Long-Term Care?

Private Individuals

Most long-term care is paid for by the people receiving the care or by their families. Other sources of payment include Medicare, Medicaid (Medical Assistance), veterans' payments, and private insurance. Many individuals who require extensive long-term care eventually "spend-down" their savings and other resources and become eligible for Medicaid.

Medicare

Medicare is the federal program which helps pay hospital and medical costs for those who are 65 or older and some disabled persons. **It provides very limited coverage for short periods of time for nursing home and home health care but does not cover any long-term care services for extended periods of time.**

Nursing Home Care

If a nursing home stay is approved by Medicare, then Medicare pays in full for up to 20 days of skilled nursing care in a skilled nursing facility approved by Medicare. However, Medicare will pay for your stay only if it follows a hospitalization of at least 3 days and you enter a Medicare-certified nursing home within 30 days after hospital discharge.

From the 21st to the 100th day, Medicare pays part of the cost if the stay is still approved by Medicare. Medicare pays **nothing** beyond the 100th day.

Very few nursing home stays are covered by Medicare. This is both because many nursing homes do not participate in the Medicare program and because Medicare narrowly defines "skilled care."

Home Health Care

Medicare covers only those home health care visits that **Medicare considers to be medically necessary**. Medically necessary care is narrowly defined and you must meet certain other criteria before Medicare will pay for the care. For example:

- The care must include part-time skilled nursing care, physical therapy, or speech therapy;

- You must be **confined** to home;
- Your doctor must set up a home health plan; and
- The agency providing services must participate in Medicare.

Most home health care visits do *not* meet Medicare's definition of medically necessary care. Therefore, Medicare will not pay for them.

Medicare Supplement Insurance

Medicare supplement insurance policies do not provide coverage for long- term care. They are designed to supplement Medicare and provide very limited coverage for nursing home and home health care.

For more information on the benefits included in Medicare supplement insurance policies, review the Wisconsin Guide to Health Insurance for People with Medicare publication which is available from the Office of the Commissioner of Insurance at oci.wi.gov/Pages/Consumers/PI-002.aspx.

Medicaid

Wisconsin's ForwardHealth Medicaid plans for elderly, blind or disabled are government health care programs paid for by state and federal governments. These Medicaid plans are available to those who are:

- Age 65 or over, blind, or disabled,
- With family income at or below the monthly program limit, and
- Who are United States citizens or legal immigrants.

If you are eligible, Medicaid will pay for most health care costs, including nursing home and community-based care.

Nursing Home Care

Medicaid is a major source of payment for nursing home care. About 64% of all nursing home residents in Wisconsin receive help with their nursing home costs. To qualify for Medicaid nursing home benefits, you must require medical, nursing, and/or therapeutic care on a daily basis, and be under a doctor's plan of treatment. Even if you become eligible for Medicaid, most of your income must be used to pay nursing home bills, with Medicaid paying remaining costs.*

When first admitted, many residents of nursing homes are able to pay for their care themselves. Over the course of a long nursing home stay, many people use most of their savings to pay for their care and then become eligible for Medicaid.

*Wisconsin Department of Health Services

Home Health Care

Medicaid may pay for services you receive in your home. However, you must be under a doctor's plan of care, have medical needs that can be met in your own home, and receive services from a home health care agency certified by Medicaid.

Personal Care

Medicaid also pays for personal care, such as assistance with bathing, dressing, eating, or getting in and out of bed. To be paid by Medicaid, you must be under a doctor's plan of care **and** you must receive services from a personal care agency certified by Medicaid. You may also be eligible for a limited amount of necessary household help, such as grocery shopping, meal preparation, or laundry.

Aging and Disability Resource Centers (ADRCs)

ADRCs are designed to be a single entry point where older people and people with disabilities and their families can get information and advice about a wide range of resources available to them in their local communities. ADRCs help people understand all of the long-term care options available to them, including publicly funded programs like [Family](#)

[Care, IRIS](#), and [PACE](#), as well as private service providers. Information about ADRCs available in your area is available at dhs.wisconsin.gov/adrc/index.htm.

Spousal Impoverishment Protections

If you are married and have a spouse who is receiving long-term care in a nursing home, the law permits you to keep a certain amount of monthly income and retain a certain amount of assets even if your spouse's long-term care costs are being paid by Medicaid. The amount you are allowed to retain is in addition to the family home and other non-counted assets.

More information is online at dhs.wisconsin.gov/medicaid/spousal-impoverishment.htm or by contacting your county or tribal aging office at dhs.wisconsin.gov/aging/offices/coagof.htm.

Estate Recovery Program

Wisconsin has an estate recovery program through which the state seeks repayment for the costs of certain long-term care services paid for on behalf of recipients by Medicaid, BadgerCare Plus, Community Options Program (COP), or non-Medicaid Family Care, and any services provided by the Wisconsin Chronic Disease Program (WCDP).

The recovery is made from the estate of a recipient, from the estate of the recipient's surviving spouse, from certain non-probate property, and from liens placed on their homes. Recovery is made when a recipient and the recipient's dependents no longer need those assets.

Wisconsin is required by state and federal laws to recover some of the money used to pay for services for Medicaid recipients. These laws are designed to recover from the assets of those who received benefits from the Medicaid program.

More information about the Estate Recovery Program is available from your county or tribal aging office (dhs.wisconsin.gov/aging/offices/coagof.htm). Information is also available on the Wisconsin Department of Health Services website at dhs.wisconsin.gov/medicaid/erp.htm.

Should I Buy Long-Term Care Insurance?

For some individuals, long-term care insurance is an affordable and attractive form of insurance intended to help pay for a stay in a nursing home or other long-term care services. For others, the cost is too high and the benefits are insufficient.

The purchase of long-term care insurance should not cause a financial hardship by making you neglect other more pressing financial needs. Each person must examine his or her needs and resources to decide whether long-term care insurance is appropriate.

Whether you should buy a policy will depend on:

- your age
 - financial status (including your assets and annual income)
 - health
 - marital status
 - overall retirement objectives.
-

For example, if your only source of income is a minimum Social Security benefit or Supplemental Security Income (SSI), or if your assets and income make you close to Medicaid eligibility, you should carefully consider whether you can afford a long-term care, nursing home, or home health care policy. It does not make sense to buy a policy if you cannot afford to pay the premiums year after year.

Remember, if you have existing health problems that are likely to result in the need for long-term care, such as Alzheimer's disease, you probably will not qualify for a policy.

Personal Worksheet

A Long-Term Care Personal Worksheet is available on pages 35–36 of this publication to assist you in identifying questions you may want to ask yourself. You will also be asked to complete this Personal Worksheet at the time you apply for long-term care insurance.

Types of Long-Term Care Insurance Policies

In Wisconsin, there are three types of insurance policies currently on the market to cover long-term care expenses. They are:

1. **Long-Term Care Insurance Policies**
These policies cover both institutional (nursing home or other facility) care and care in the community (home health care or other community-based services).
2. **Nursing Home Insurance Policies**
These policies cover **only** institutional care, such as in a nursing home. These policies may or may not cover care in an assisted living facility.
3. **Home Health Care Insurance Policies**
These policies cover **only** community care, such as home health care. These policies may or may not cover community-based services, such as adult day care.

Important Note

Only those policies that provide coverage for both institutional and community-based care may be advertised or sold as long-term care insurance policies.

Wisconsin Minimum Standards for Policies

The Wisconsin Office of the Commissioner of Insurance has set minimum standards for each of the three types of policies covering long-term care expenses.

All three types of policies must:

- Provide at least one year of benefits.
- Provide a minimum \$60 a day benefit.

- Provide benefits based on the level of care only if the lowest limit of daily benefits is not less than 50% of the highest limit of daily benefits. For example, benefits provided for home health care would have to be at least 50% of those provided for nursing home care.
- Provide coverage whether or not care is medically necessary. The policy may require the care be provided in accordance with a plan of care.
- Pay benefits without requiring you to be in a hospital before getting the covered service.
- Pay benefits if you are unable to perform three or more activities of daily living (ADLs) or if you have a [cognitive impairment](#). The assessment of ADLs and cognitive impairment needs to be performed by licensed or certified professionals, such as physicians, nurses, or social workers.
- Pay benefits for “irreversible dementia” (such as Alzheimer’s disease) provided you have met the waiting periods under the policy and need the type of care covered by the policy. This does not prevent an insurance company from refusing to accept an application from you if you have Alzheimer’s or a similar disease.
- Offer an inflation protection option that increases the maximum daily benefit and lifetime benefit amounts in an amount at least equal to 5% compounded annually.
- Offer a nonforfeiture benefits option that provides paid-up insurance if your policy lapses.
- Describe the [benefit appeal](#) procedure. This procedure requires the insurance company to review the appeal and make a decision within 30 days.

Policies which include home health care benefits must pay for community-based (home health) care:

- Whether or not you have an acute medical problem.
- Even if the services are not provided by a Medicare-certified agency or provider.
- Even if you were not previously in a hospital or nursing home.

Important Note

Policies which cover *only* nursing home care or *only* home health care provide limited benefits for long-term care services and may not be adequate for your needs. If you want coverage for both nursing home and home health care, you are better off buying a comprehensive long-term care insurance policy. Even a comprehensive policy may not cover all the types of services you may need or want.

Federally Tax-Qualified Long-Term Care Insurance Policies

The federal Health Insurance Portability and Accountability Act (HIPAA) allows for certain federal income tax advantages for long-term care insurance policies that are designated as “tax-qualified” or “qualified.” If you have a tax-qualified policy, you may be able to deduct part or all of the premium you pay for the policy. You can include the premiums with other annual uncompensated medical expenses in excess of 7.5% of your adjusted gross income. The amount of the premium you can claim as a deduction depends upon your age.

Long-term care insurance policies sold on or after January 1, 1997, as tax-qualified policies must meet certain standards. These policies must contain a caption on the face page of the policy similar to this sentence:

This policy is intended to be a tax-qualified long-term care insurance contract under Section 7702B (b) of the Internal Revenue Code.

At the time you apply for long-term care insurance, you must receive an [Outline of Coverage](#) containing a notice on the face page indicating the policy is intended to be a tax-qualified policy.

Tax-qualified long-term care insurance policies are required to cover services for a chronically ill individual. These services are given according to a plan of care prescribed by a [licensed health care practitioner](#). You are considered chronically ill if you are unable to perform a certain number of activities of daily living without substantial help from another person for at least 90 days. You also may be considered chronically ill if you need substantial supervision to protect your health and safety because you have a cognitive impairment.

The benefits paid by a tax-qualified long-term care insurance policy are generally not taxable as income. Benefits you receive from a non-tax-qualified long-term care insurance policy may or may not be taxable as income.

State Income Tax Deduction

You can subtract the amount paid for long-term care insurance from your Wisconsin income tax. This subtraction applies to both policies designated for federal income tax purposes as tax-qualified and policies that are non-tax-qualified. The instruction booklet you receive with your Wisconsin income tax forms includes information on the subtraction for long-term care insurance.

Long-Term Care Insurance Partnership Program

Long-term care insurance policies that qualify for Long-Term Care Partnership Program status are intended to allow you to protect some or all of your assets and still qualify for Medicaid if your long-term care needs extend beyond the period covered by your qualified long-term care partnership insurance policy.

Long-term care partnership policies must include inflation protection coverage that meets specific minimum standards based on your age at the time you apply for a qualified long-term care partnership policy.

If you are under age 61	the policy must provide compound annual inflation protection
If you are age 61 but less than age 76	the policy must provide 3% annual simple inflation protection or provide compound annual inflation protection
If you are at least age 76	the policy may provide the inflation protection identified above but is not required to do so

All long-term care partnership policies are intended to be federally tax-qualified long-term care insurance policies as defined by federal Internal Revenue Code.

Purchasing a qualified long-term care partnership policy does not guarantee you benefits, coverage eligibility, or asset protection under the Medicaid program. For example:

- States may withdraw from the partnership program.
- If you exhaust your long-term care insurance benefits under a policy qualified for partnership program status, you may find the long-term care services you are receiving are not covered services under Wisconsin’s Medicaid program, i.e., assisted living coverage.
- If you exhaust your long-term care insurance benefits under a policy qualified for partnership program status, you may find the facility in which you are receiving care does not accept Medicaid.
- If you move to another state, you may find your new state does not participate in the long-term care partnership program and it does not recognize your long-term care policy’s partnership program status in reference to qualifying for Medicaid.

Interstate Insurance Product Regulation Commission (IIPRC)

Wisconsin is a member of the Interstate Insurance Product Regulation Commission (IIPRC). IIPRC was created through a multi-state agreement to streamline the process of filing and reviewing insurance products using uniform national standards IIPRC members develop and adopt.

IIPRC has developed national standards for long-term care insurance products, rate filings, and advertisements. Wisconsin allows long-term care products filed with and approved by IIPRC to be sold in Wisconsin. IIPRC long-term care policies meet IIPRC uniform product standards rather than the Wisconsin standards. More information about IIPRC is available at insurancecompact.org.

Life/Annuity Insurance—Long-Term Care Riders

Another way to cover long-term care expenses is through a rider attached to a life insurance policy. Long-term care riders attached to life insurance policies are different from long-term care policies in several respects. For example, monthly benefits for a stay in a covered nursing home are typically based on a percentage of the life insurance amount. A \$100,000 policy with a 2% benefit would give you \$2,000 a month. A monthly benefit for home health care, when covered under the rider, is usually half of the nursing home benefit.

Long-term care benefits under these riders are tied directly to the amount of life insurance in force. These benefits will be reduced by any loans or withdrawals against the policy. Using the long-term care benefits will also reduce life insurance coverage under the policy.

A long-term care rider has a separate insurance charge that usually increases each year in a manner similar to the cost of the life insurance under the basic policy. The annual charge for the rider will not exceed the guaranteed cost and will normally be less.

Some life insurance companies offer **annuity** contracts with a rider that covers long-term care expenses. An annuity contract with a long-term care rider allows you to use the funds accumulated in your annuity to pay for long-term care expenses without applying any surrender charges. Companies charge an additional premium for this rider.

What Should I Look for in Comparing Policies?

Type of Coverage

You should compare similar policies. For instance, compare nursing home only policies to nursing home only policies.

Benefit Payments

You should review how the policy pays benefits as policies pay benefits in different ways. For example, some policies pay a fixed amount for each day you are confined in a nursing home or each day you receive community-based care, regardless of the actual cost of the care. Other policies pay according

to the provider's actual charges up to a fixed daily amount or a percent of the charges. Policies paying benefits based on a [usual and customary charge](#) basis or prevailing charge basis contain a notice to this effect on the face page of the policy.

Duration of Benefits

You should also examine the period of time benefits are paid. Depending on the policy, benefits may last for only one year or for the rest of your life. In general, plans that provide payments for longer periods of time are more expensive. You may select from several options when you first buy the policy. However, you may not be able to increase the benefit amounts at a later date without proving insurability.

Policy Limits

Policies frequently limit benefits to specific types of services provided by specific types of facilities or agencies. For example, services provided in the home may be limited to those provided by a licensed home health agency. Other types of personal care, help with household chores, or other services may not be covered. One policy may cover ambulance service to and from the hospital, but the same type of policy offered by another company may not. It is important to check each policy to be sure you know exactly what services are covered. The kind of long-term care services you may need or want may not be covered under the policy.

Policy Definitions

You should review the policy's definitions regarding the types of facilities covered. The state of Wisconsin has licensed, certified, and registered facilities that provide differing levels of supportive care, personal care, and nursing services.

Policies providing coverage for nursing care in a licensed facility will cover care in a nursing home. However, the policies providing coverage for nursing care in a licensed facility will not cover care in an assisted living facility. Assisted living facilities are certified or registered to provide assisted living services. They are not licensed to provide nursing care. Long-term care policies usually do not cover any care in a community-based residential facility.

Premiums

You should determine whether premium payments are based on **issue age** or **attained age**. Issue age premiums will increase only if premiums are increased for everyone insured under the policy form. Attained age premiums automatically increase as one ages.

You should also compare prices when you compare policies. Ask questions. Check to see if the policy you are considering is a lot less or a lot more expensive than other policies with similar benefits.

Standards for Benefit Triggers

Policies are required to pay benefits based upon [benefit triggers](#) called "activities of daily living" (ADLs). Policies must base benefits on at least six ADLs. Some policies pay benefits based on seven ADLs.

ADLs are:

- Bathing—Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence—The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag.
- Dressing—Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Eating—Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- Toileting—Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring—Moving into or out of a bed, chair, or wheelchair.

Policies must pay benefits when you require assistance to perform three of the six activities of daily living or have a cognitive impairment. A cognitive impairment is a deficiency in short-term or long-term memory, orientation as to person, place, and time, deductive or abstract reasoning, or judgment as it relates to safety awareness. Many policies pay benefits when you are unable to perform two of the ADLs.

Assessment of ADLs and cognitive impairment can be performed by a certified or licensed health care practitioner, such as a physician, a nurse, or a social worker.

You would be considered unable to perform an activity of daily living if you need hands-on assistance to perform the activity or, in the case of a cognitive impairment, must have supervision or verbal cueing to protect yourself and others.

Preexisting Condition Waiting Period

If you are sick or under a doctor's care for a particular condition when you purchase the policy, you may **not** be eligible for benefits for that condition until a certain period of time has passed. This is called a **preexisting condition waiting period**.

Preexisting condition waiting periods vary from company to company. The longest waiting period permitted in Wisconsin is six months. This waiting period can be applied only to conditions that you have **not** been asked about on the application and for which you have seen or been treated by a doctor in the six months before you take out the policy. However, if you have preexisting medical problems at the time you apply for coverage, the insurance company is not required to accept your application or to issue coverage.

Elimination Period

Policies frequently have elimination periods. This is the number of days you must be in a nursing home or other facility receiving the care covered by the policy, or the number of home care visits that must be received before benefits are paid.

You will pay all of the cost of care during the elimination period. Usually, the longer the elimination period, the lower the premium. The longer the elimination period, the less chance there is you will collect benefits.

Elimination periods do not begin until the preexisting condition waiting period has been satisfied. Wisconsin law allows insurance companies to offer elimination periods up to 365 days, but the company must also sell the same type of policy that offers elimination periods for 180 days or less.

Inflation Protection

If your long-term care policy does not include a way for benefits to increase as long-term care costs increase, **you may have a benefit that is too low by the time you need care.**

All policies must offer the option to purchase inflation protection at 5% compounded annually. Some policies may allow you to purchase additional coverage at a later date. Policies that have an inflation protection rider and have dollar amounts listed for the maximum benefits must increase both the maximum benefits and the daily benefits each year at the rate of 5% compounded annually. Adding an inflation protection rider to a policy will increase the cost of the policy.

Waiver of Premium

Many policies provide for a [waiver of premium](#). This means after a specified period of time of **receiving** benefits under the policy you may apply to have your premiums waived until you are no longer receiving covered care or the lifetime maximum benefit has been paid.

Nonforfeiture Benefits

All policies must offer the option to purchase a shortened [benefit period](#) nonforfeiture benefit option. The nonforfeiture benefit provides paid-up long-term care, nursing home only, or home care only insurance coverage after you have paid premiums for three years but no longer continue to do so.

The maximum benefit under the paid-up policy is the greater of 100% of the sum of all premiums paid for the policy, including premiums paid prior to any change in benefits, or 30 times the daily benefit amount in effect on the lapse date. As with the inflation protection option, a nonforfeiture benefit rider adds to the cost of the policy.

Long-Term Care Rate Increase Standards

If you have a policy issued between **August 1, 1996, and December 31, 2001**, your policy is subject to certain standards which restrict the number and amount of premium increases. Your initial premium may not increase for the first three years the policy is in force. After the first three years, the rate is guaranteed for at least two years.

It is important to know if the company raises premiums on its long-term care policy forms by more than 50% in any three-year period, it will be restricted from selling policies in Wisconsin. If you are over the age of 75 and purchased your policy during the time period noted above, you can only receive a 10% rate increase every two years.

Although rate increases are applied to everyone having the same policy form, it is possible categories of individuals covered under the policy form will see different amounts of increase based on the riders they purchased and the amount of risk associated with their age category.

If you have a policy **issued on or after January 1, 2002**, your policy is subject to Wisconsin insurance laws that were amended to provide added protections, including rating practice and consumer protection provisions. Insurance companies are required to establish initial premium rates that are sufficient and are expected to remain the same over the life of the policy. Furthermore, the insurance company is required to disclose to you your policy's past premium rate increases.

Long-term care insurance premium rates are increasing and will continue to do so. You should consider whether you can afford the premiums for long-term care insurance now and in the future. A general guideline says you should not spend more than 7% of your annual income for long-term care insurance. You should determine whether you can afford to pay the premiums for the next 15, 20, or 25 years. Will you be able to afford the premiums if they increase 30%, 40%, 50% or more?

You may find that your income decreases when you lose your spouse. This may make it difficult for you to continue paying long-term care insurance premiums. However, women also tend to outlive their spouse. You may find you have less family support and caregiving available as you age, which may require that you pay [out-of-pocket](#) for home health care or nursing home services.

Personal Worksheet

You will be asked to complete a Personal Worksheet at the time you apply for long-term care insurance. A copy of the Personal Worksheet is included on [page 24](#) of this publication.

Other Ways to Pay For Long-Term Care

Long-term care insurance is only one way of paying for potential home health or nursing home care. You may be able to rely on family support and caregiving.

There may also be organizations in your community that have volunteers who provide support and caregiving services, or you may be eligible for veteran benefits and services.

You may consider, as part of your personal financial plan, relying on personal savings, such as savings accounts, certificates of deposit, money market accounts, IRAs, a 401K, a Keough plan, life insurance accumulation options, or pension benefits. Another consideration is a reverse mortgage or a continuing care contract. Additional information showing different ways to pay for long-term care is available at longtermcare.gov/costs-how-to-pay.

Policy Exclusions

Long-term care policies may have certain [exclusions](#). The most common are for mental and nervous disorders, preexisting conditions, care received outside the USA, and care needed as a result of self-inflicted injury.

Important Note

Under Wisconsin law *once you are insured and have satisfied any waiting periods, including any elimination period, policies may not refuse benefits for irreversible dementia, such as Alzheimer's disease, provided you need the services covered by the policy. Policies may exclude coverage for other conditions or situations. You should carefully review the Outline of Coverage that you receive when you are solicited for the policy. The Outline of Coverage will list the exclusions and summarize the type of coverage offered by the policy.*

Renewability

All policies currently on the market are "[guaranteed renewable](#)" for life. This means your coverage will continue as long as you pay the premium. The renewal provision of a policy is on the first page of the policy and in the Outline of

Coverage. The insurance company may raise premiums, but only if it raises them for all individuals who have the same policy. This does not mean your coverage will continue if you have exhausted the benefits in the policy. If you buy a policy with a one-year benefit period, your benefits will end after one year of the insurance company paying benefits. You will not be able to renew these benefits.

Reinstatement

Policies also include reinstatement provisions. If you fail to pay premiums, the insurance company is required to give notice to you and your designee that the policy will lapse in 30 days. If your policy lapses and you provide proof of cognitive impairment or inability to perform activities of daily living, your policy can be reinstated if you request reinstatement within at least five months after lapse and pay the past due premiums.

Cost of Policy

The premium may vary according to many factors, including the policy benefits, your age, sex, and place of residence. The conditions under which the premium can be raised and the actual premium charged are discussed in the Outline of Coverage. Policies purchased at younger ages are generally less expensive than those bought at older ages.

Compare prices when you compare policies. Ask questions if the policy you are considering is a lot less or a lot more expensive than other policies with similar benefits.

Cancellation

You have the right to request cancellation of the policy at any time and the insurance company must issue a prorated premium refund. If you die while the policy is in force, the insurance company will issue a refund of premiums to your estate.

Health Questions

When you apply for long-term care insurance, you may be asked questions relating to your health status, including any prior hospitalization and nursing home confinements. Each insurance company has its own standards for deciding who is eligible for a policy. If the questions are not answered accurately, the insurance company may refuse to pay benefits, terminate the contract, and return your premium at the time you make a claim. Since the application is part of the policy, check it again when you receive the policy to make sure all questions have been answered accurately.

Checklist

Using the Long-Term Care Insurance Checklist included on [pages 22-23](#) in this publication will give you a more accurate idea of the actual policy premium.

Should I Change to Another Long-Term Care Policy?

It may make sense to change to another long-term care policy if your current policy no longer provides the benefits or the amount of coverage you want. For example, if your current policy provides a \$100 daily benefit amount for nursing home care, but nursing homes in your area charge significantly more, you may want to increase your coverage.

Before you decide to change policies, you should contact your existing insurance company and see if you can upgrade your current policy and what the cost

of the upgraded coverage will be. You will not automatically be eligible for upgraded coverage but will be required to submit an application and answer medical questions. If you are in good health, you should qualify for the upgraded coverage if available.

If upgrading your coverage is not an option, you can keep your existing coverage and purchase an additional policy or replace your current policy with one that has the benefits you want. **However, before you cancel your current policy, make sure the new insurance company has accepted your application and issued a new policy to you.**

You should not replace your policy merely because your insurance agent is working for another insurance company. The new policy will most likely be more expensive because insurance companies charge higher premiums for new coverage based on the applicant's current age.

Consumer Protections

Wisconsin law requires insurance companies selling long-term care insurance policies provide you with specific information at the time you are considering the purchase of long-term care insurance. This information includes:

- **An outline of coverage.** This is a summary of the policy explaining what it will cover and what it will not cover.
- **Company history of rate increases.** The insurance company must disclose its past premium increases.
- **Personal Worksheet.** You will be asked to complete a Personal Worksheet that can help determine your ability to pay premiums at the time of application and over time and your reasons for buying the insurance. Completing the Personal Worksheet will help you determine if long-term care is suitable for you. A copy of this worksheet is on [page 24](#).
- **Ability to designate a person (in addition to yourself) to receive notice of lapse or termination of the policy for nonpayment of premiums.** As a protection against unintentional lapse, you have the right to designate another person, in addition to yourself, to receive a letter when your policy is about to lapse or terminate for nonpayment of premium.

After you apply for long-term care insurance, the policy you receive is required to provide the following consumer protections:

- **30-day free-look period.** Once you receive your insurance policy, you have 30 days to review it and, if you change your mind and want to return the policy, you will receive a full refund of the premiums you paid.
- **Contingent nonforfeiture benefit.** Policies issued after January 1, 2002, must include a contingent benefit upon lapse requirement. The benefit will be triggered if your policy is subject to a substantial premium increase and you did not buy a shortened benefit nonforfeiture option.

A contingent benefit upon lapse requirement will provide added protection to you in the event of lapse. For example, if you are 70 years old and you had rejected the insurance company's offer of a nonforfeiture benefit and the premium rises to 40% more than the original premium you paid when you first bought the policy, you will be offered two options.

The options are offered so you do not have to lapse the policy and lose your coverage. You will have the choice to:

- reduce your benefit amount and keep paying the original premium, or
 - convert the policy to paid-up status with a shorter benefit period and pay no more premiums. Of course, you may also choose to keep your policy and continue to pay the higher premium.
- **Benefit appeal procedure.** You have the right under your long-term care insurance or life insurance long-term care policy to appeal a benefit denial. The benefit appeals internal procedure must be described in your policy.

Buying Tips

- **Check on the agent selling the policy.** You can check with the Office of the Commissioner of Insurance (OCI) to see if an agent is licensed. It is a good idea to work with a local agent who will be available to help file [claims](#) and answer questions. Feel free to ask the agent how long he or she has been an agent, as well as the names of other companies the agent represents. Check with friends and neighbors for the name of a good agent and try to schedule an appointment in the agent's office.
- **Try to compare several policies.** Contact several companies and agents before you buy a long-term care policy. A list of insurers selling long-term care insurance policies in Wisconsin is available on OCI's website.
- **Call the Medigap Helpline** at 1-800-242-1060. This is a nationwide toll-free number that has been set up by the state to answer questions for the elderly concerning health insurance.
- **Check with OCI** to find out whether there have been any administrative actions taken against the company or the agent.
- **Take your time.** This is not the type of purchase you should make without considering all your options and making sure you need and can afford the insurance. Do not let anyone pressure you into making a quick decision. Use this publication to assist you in making your decision. You can also obtain a list of insurers that offer long-term care policies in Wisconsin on OCI's website or contacting OCI.
- **Do not be misled into thinking your medical history is not important.** You should answer all the questions on the application completely and accurately. If an agent fills out the application for you, you should read it and make sure the application is accurate before you sign it. If you sign an application that includes incorrect or incomplete information, the insurance company may refuse to pay your claims and can cancel your insurance policy.
- **Policies must include a "free-look" period.** You will have at least 30 days from the time you receive the policy to look it over and decide if you want to keep it. If you decide to return the policy to the company within the "free-look" period, you will receive a full refund of your premiums.

However, if you decide to keep the policy, be sure your application is correct and complete. The application is a part of the policy.

- **Do not be misled by advertising.** Do not be misled by the endorsements of celebrities. Most of these people are professional actors who are paid to advertise insurance policies. They are not insurance experts.
- **Be wary of cards received in the mail that look as if they were sent by the federal government.** They may actually have been sent by insurance companies trying to find potential buyers. Be skeptical if you are asked questions over the phone about Medicare or your insurance. Any information you give may be sold to insurance agents who will call you or come to your home.
- **Do not over-insure.** It is not necessary to buy several policies. One good long-term care insurance policy, which covers both institutional and community-based care, is enough.
- **Be careful about dropping one policy to buy another.** Before you buy a new policy, be absolutely sure it is better than the one you already have. If you switch policies, you may be subject to new preexisting condition waiting periods or have other restrictions placed on your benefits. However, if you replace your policy and there is no lapse in coverage, the time you were covered under one policy counts toward meeting the preexisting condition waiting period under the new policy.
- **Never pay an agent in cash.** Pay by a check made payable to the insurance company.
- **Be sure to get the name, address, and telephone number of the agent and the company.** Obtain a local or toll-free number (if the company has one) so you can contact the company.

- **If you do not receive your policy within 45 to 60 days, contact the company or agent.**
- **Review your policy carefully.** If you have questions about your insurance policy, contact your insurance agent for clarification. If you still have questions, contact the Office of the Commissioner of Insurance or the Board on Aging and Long-Term Care.

Questions to Ask the Selling Agent:

- What type of policy is it and what coverage does it provide? Is the policy considered a long-term care, nursing home only, or home health care only policy?
- What types of facilities or providers are eligible to provide the care covered by the policy. Are these facilities and providers available in my community?
- How long will the benefits last?
- How much will the policy pay each day?
- Does the policy have elimination periods before benefits begin? How long are they?
- Are there any preexisting condition limitations?
- What is the cost of nonforfeiture benefits. Inflation protection. Waiver of premium?
- What happens if you do not pay your premium?
- What conditions are not covered by the policy?
- What number of ADLs must be deficient?
- Is the policy considered a "tax-qualified" policy?
- Whom do you contact if you have questions about coverage or if you need help filing a claim?

What if I Have Questions or Complaints?

If you have questions or complaints about:

Medicare

Contact your local Social Security office or your county or tribal aging office dhs.wisconsin.gov/aging/offices/coagof.htm, or you may contact the Social Security Administration by calling toll-free 1-800-772-1213.

Medicaid

Contact your county Social Service Agency or the hotline for recipients, advocates and people interested in applying for Medicaid. The toll-free number is 1-800-362-3002.

Insurance

Contact the agent or company involved. If you do not get satisfactory answers, contact the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, Wisconsin, 53707-7873. Phone: 1-800-236-8517. Deaf, hearing, or speech impaired callers may reach OCI through WI TRS.

OCI's website

oci.wi.gov

Board on Aging and Long-Term Care (BOALTC)

1402 Pankratz Street, Suite 111
 Madison, WI 53704-4001
 1-800-242-1060
longtermcare.wi.gov

Glossary

Activities of Daily Living (ADLs): Activities that are a normal part of everyday life, such as bathing, continence, dressing, eating, toileting, and transferring.

Adult Day Care: Care given in a nonresidential, community-based group program designed to meet the needs of functionally impaired adults. It is a structured, comprehensive program that may provide a variety of health, social, and related support services during any part of a day.

Alternative Plan of Care: If you otherwise qualify for benefits, this provision allows you to qualify for benefits not specifically listed in the policy upon the agreement of you, your physician, and the company.

Annuity: An insurance contract where an insurance company promises to make payments to an annuitant over a specified period of time or for life.

Annuitant: A person who receives benefit payments from an annuity.

Assisted Living Facility: A facility certified or registered by the Department of Health Services (DHS). These facilities exist to bridge the gap between independent living and nursing homes and provide a variety of services depending on the needs of the residents. Assisted Living Facilities are covered only if your policy identifies these facilities as a covered benefit and the facility has been certified or registered by DHS.

Bed Reservation: This benefit is payable if you are receiving nursing home care and need to spend time in a hospital. The company will cover any charge made by the nursing home for reserving your bed during your hospitalization.

Benefit Triggers: A term used to describe when to pay benefits. One type of benefit trigger is an activity of daily living (ADL). Insurance companies may use different events or types of benefit triggers to determine when benefits will begin to be paid. The triggers are described in the eligibility criteria of the policy.

Care Coordination: Services provided by a licensed or certified health care professional designated by the insurance company to perform an assessment and develop a plan to meet your long-term care needs.

Caregiver Training: Training provided in order to assist an informal and unpaid caregiver to care for you at home.

Case Management: Services provided by a licensed or certified health care professional to assist in arranging, monitoring, or coordinating long-term care services.

Cognitive Impairment: A deficiency in your short-term or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Community-Based Residential Facility (CBRF): These facilities are licensed, registered, or certified by the Department of Health Services (DHS). CBRFs are covered only if your policy identifies these facilities as a covered benefit and the facility has been licensed as a CBRF by DHS. (page 5)

Contingent Nonforfeiture or Contingent Benefit upon Lapse: If you reject the mandatory offer of a nonforfeiture benefit, the insurance company must provide a "contingent benefit upon lapse." This means when the premiums increase to a certain level (based on a table of increase provided to you in the policy information), the benefit will take effect. You will then be offered, within 120 days of the due date of the new premium, the opportunity to accept **one** of the following options:

1) reduce your benefits provided by the current policy so your premium will stay the same, or 2) convert your policy to a paid-up status with a shorter benefit period.

Elimination Period: The number of days you must wait after receiving long-term care before receiving insurance benefits.

Exclusion: Any condition or expense that the policy will not pay.

Family Care: A Medicaid program that serves Wisconsin residents with physical disabilities, or intellectual/developmental disabilities and the frail elderly that is designed to provide them with choice about and access to long-term care that will increase their ability to live in the community.

Guaranteed Purchase: A rider to a policy that allows you to increase the benefits during specific periods of time without proof of insurability.

Home Health Care: Care including skilled nursing services, such as providing therapy treatments or administering medication; home health aide services, such as checking temperature and blood pressure; personal care, such as help with bathing, dressing, walking, and exercise; and physical, occupational, respiratory, or speech therapy.

Hospice Care: A specially designed package of social and medical services that primarily provides pain relief, symptom management, and supportive services to terminally ill people and their families.

Instrumental Activities of Daily Living: Basic functional activities necessary for you to remain in your home, such as meal preparation, shopping, light housekeeping, laundry, telephoning, and handling money and paying bills.

IRIS (Include, Respect, I Self- Direct): A Medicaid program available to Wisconsin residents determined financially eligible for Medicaid, functionally in need of nursing home or intermediate care facility level of care, and living in a county where managed long-term care and IRIS are available.

Licensed Health Care Practitioner: Any physician, registered nurse, licensed or certified social worker, or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

Outline of Coverage: A summary of a policy's benefits and limitations that makes it easier to understand a policy and compare it to others.

Insurance companies must provide you with this summary before you purchase a long-term care policy.

PACE (Program of All-inclusive Care for the Elderly): A Medicare and Medicaid program that helps eligible Wisconsin residents meet their health care needs in the community instead of going to a nursing home or other care facility.

Paid-up Survivor: A rider that, in the event of the death of your spouse, waives the premiums for life if both you and your spouse had coverage for a specified time with the same company.

Plan of Care: A plan outlining the care you need and the length of time the care will be needed.

Residential Care Apartment Complexes (RCAC): These facilities are certified by the Department of Health Services (DHS). RCACs are covered only if your policy identifies these facilities as a covered benefit and the facility has been certified as an RCAC by DHS.

Respite Care: The provision of personal care, supervision, or other services to a functionally impaired person to relieve a family member or other primary caregiver from caregiving duties. Respite care services are usually provided in the impaired person's home or in another home or homelike setting, but may also be provided in a nursing home.

Restoration of Benefits: If you collect benefits from a policy and then recover to the point where you are not receiving care qualifying you for benefits for a certain period of time, you can have those benefits restored back to the original level.

Look to see if this is a provision in the policy or if it is available as a rider for an additional premium.

Return of Premium: A rider providing that if you die after being insured for a specified period or if you have paid premiums for a specified period, the insurance company will return premiums paid minus any benefits paid.

Waiver of Premium: The suspension of premium payments after you have been receiving benefits from the policy for the period of time specified in the policy.

Long-Term Care Insurance Checklist

Name and Address of Company: _____

Telephone Number: _____

Name and Address of Agent: _____

Telephone Number: _____

<u>Type of Care Covered</u>	Daily Benefit	Length of Benefit	Limitations
1. Institutional Care			
Nursing Home:			
Assisted Living Facility:			
Hospice Facility:			
Bed Reservation Guarantee:			
2. Community-Based Care			
Home Health Care:			
Adult Day Care:			
Respite Care:			
Hospice:			
Other:			

OTHER ITEMS

Elimination Period:

Per occurrence: _____

Per lifetime: _____

Waiting Period for Preexisting Conditions: _____

Long-Term Care Insurance Checklist (Continued)

Premium Payment Period:

Attained Age (premiums increase as [insured](#) ages): _____

Issue Age (premiums will not increase merely due to increase in insured's age): _____

Lifetime or Period-Specific: _____

Policy Exclusions and Limitations: _____

Waiver of Premium: _____

Inflation Protection: _____

Nonforfeiture Benefits: _____

COST OF POLICY:

Basic Policy: _____

Inflation Protection: _____

Nonforfeiture Benefits: _____

Additional Benefits: _____

Long-Term Care Insurance Personal Worksheet

People buy long-term care insurance for a variety of reasons. These reasons include avoiding 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. However, long-term care insurance can be expensive and is not appropriate for everyone. State law requires the insurance company to ask you to complete this worksheet to help you and the insurance company determine whether you should buy this policy.

Premium

Policy Form Number(s) _____

The premium for the coverage you are considering will be [\$_____per month, or \$_____per year,] [a one-time single premium of \$_____.]

Type of Policy (noncancellable/guaranteed renewable): _____

[The company cannot raise your rates on this policy. [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.] Note. The insurer shall use the bracketed sentence or sentence applicable to the product offered. If a company includes a statement regarding not having raised rates, it must disclose the company's rate increases under prior policies providing essentially similar coverage.

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state. [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years. [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).]

Questions Related to Your Income

How will you pay each year's premium?

Income Savings Family members

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

Note: The insurer shall use the bracketed sentence unless the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one)

Under \$10,000 \$[10,000-20,000] \$[20,000-30,000] \$[30,000-50,000] Over \$[50,000]

Note: The insurer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

No change Increase Decrease

If you will be paying premiums with money received only 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? (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 of care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.

What elimination period are you considering? Number of days _____ Approximate cost \$ _____ for that period of care.

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

- From my Income From my Savings \ Investments My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, what is the approximate value of all of your assets (savings and investments)? (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? (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

(Check one.)

The answers to the questions above describe my financial situation.

or

I choose not to complete this information.

(This box must be checked)

I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand the rates for this policy may increase in the future.**

Signed: _____
(Applicant)

(Date)

[I explained to the applicant the importance of completing this information.

Signed: _____
(Agent)

(Date)

Agent's Printed Name: _____]

Note: In order for us to process your application, please return this signed statement to [name of company], along with your application.

[My agent has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.

Signed: _____
(Applicant)

(Date)