# SeniorClass

## Long-Term Care

***Non-Tax Qualified Outline Of Coverage***

Loyal American
Life Insurance Company[sm]

# NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

*LOYAL AMERICAN LIFE INSURANCE COMPANY*

P.O. Box 559004 • Austin, Texas 78755-9004 • (800) 633-6752

## SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your Application, you intend to lapse or otherwise terminate existing accident and sickness or Long Term Care insurance and replace it with the Long Term Care Policy to be issued by Loyal American Life Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or Long Term Care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this Long Term Care coverage is a wise decision.

**STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE):**

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy may not contain new pre-existing conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions or probationary periods in the new policy for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the Application concerning your medical health history. Failure to include all material medical information on an Application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the Application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Jerry Hill / Beneflex Financial Group ______________________________

Typed Name of Agent or Broker — Signature of Agent, Broker, or Other Representative

11811 East Freeway, STE 545, Houston, Texas 77029

Typed Address of Agent or Broker

The above "Notice to Applicant" was delivered to me on: ______________________________

Date — Applicant's Signature

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**NOTICE TO AGENT**

One copy of this form must be left with the Applicant. One copy is to be sent to the Company with the Application for insurance. Record the name of the company and the policy number being replaced.

Policy being replaced is policy number ______________________________

Issued by: ______________________________

(Company name and address)

# *LOYAL AMERICAN LIFE INSURANCE COMPANY*

**P.O. Box 559004 • Austin, TX 78755-9004**
**800-880-8824**

## APPROPRIATE LONG TERM CARE INSURANCE
## OUTLINE OF COVERAGE
## Policy Form L-6000-NQ-TX

**THIS POLICY IS NOT INTENDED TO BE A QUALIFIED LONG TERM CARE INSURANCE CONTRACT UNDER SECTION 7702B (b) OF THE INTERNAL REVENUE CODE OF 1986, AS AMENDED. YOU SHOULD CONSULT WITH YOUR ATTORNEY, ACCOUNTANT, OR TAX ADVISOR REGARDING THE TAX IMPLICATIONS OF PURCHASING LONG TERM CARE INSURANCE.**

**Caution: The issuance of the long term care insurance policy is based upon your responses to the questions on your application. A copy of your application will be attached to your policy. If your answers are incorrect or untrue, we may have the right to deny benefits or rescind your policy as described in the Time Limit on Certain Defenses provision. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, contact us at this address: Loyal American Life Insurance Company, P.O. Box 559004, Austin, Texas 78755-9004.**

**Notice to Buyer: This policy may not cover all of the costs associated with long-term care incurred by the policyholder during the period of coverage. The policyholder is advised to review carefully all policy limitations. In addition, the policyholder is advised that based on current health care cost trends, the benefits provided by this policy may be significantly diminished in terms of real value to the policyholder, depending on the amount of time which elapses between the date of purchase and the date upon which the policyholder first becomes eligible for those benefits.**

1. The policy is an individual policy of insurance.
2. **PURPOSE OF OUTLINE OF COVERAGE.** This Outline of Coverage provides a very brief description of the important features of the policy. You should compare this Outline of Coverage to outlines of coverage for other insurance available to you. This is not an insurance contract, but only a summary of coverage. Only the individual policy contains the governing contractual provisions of your insurance. This means that the policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY CAREFULLY!**
3. **TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED.**
   (a) **THIRTY DAY FREE LOOK.** If you feel the policy does not meet your insurance needs, return it to us or your agent within 30 days after you have received it. We will refund your premium within 30 days of our receipt of the policy and will consider the policy never to have been issued.
   (b) **RETURN OF UNEARNED PREMIUMS.** The policy contains a provision providing for return of unearned premium upon notice of your death or your spouse's death, subject to the optional Survivorship Benefit Rider. It also provides for a return of unearned premium for surrender of the policy.

4. **MEDICARE SUPPLEMENT INSURANCE DISCLAIMER. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide (Guide to Health Insurance for People with Medicare) available from us. Neither Loyal American Life Insurance Company nor its agents represent Medicare, the federal government, or any state government.

5. **LONG TERM CARE COVERAGE.** Long term care insurance is designed to provide coverage for necessary or medically necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home. Coverage is provided for the benefits outlined in the paragraph 6 "Benefits Provided By This Policy". Those benefits may be limited by the exclusions and limitations outlined in the paragraph 7 "Exclusions and Limitations".

   The policy reimburses you for expenses you incur for covered long term care, subject to the policy limitations and elimination periods.

6. **BENEFITS PROVIDED BY THIS POLICY.**

   (a) **BENEFIT LIMITS.**

   Maximum Daily Home and Community Care Benefit $ ________________

   Maximum Daily Facility Benefit $ ________________

   Maximum Lifetime Benefit $ ________________

   The Maximum Lifetime Benefit is the total amount we will pay in your lifetime for all benefits provided by the policy.

   Elimination Period ______________ Days

   The Elimination Period is the total number of days that Appropriate Long Term Care services covered under the policy must be received after you are eligible for the payment of and before benefits are payable. The Elimination Period must be satisfied within 365 days of the day you first receive an Appropriate Long Term Care service and meet the conditions for receiving benefits. The Appropriate Long Term Care services need not be provided on consecutive days in order to satisfy the Elimination Period. The Elimination Period may be met before the filing of a claim if we can establish you were eligible for the payment of benefits before filing a claim. This Elimination Period has to be met only once while your policy is in force. Any day on which covered services are reimbursed by insurance or Medicare may be counted toward meeting the Elimination Period.

   The Elimination Period does not apply to the Care Advisory Services Benefit or the Informal Caregiver Support Benefits (including both the Respite Care Benefit and Informal Caregiver Training Benefit), however days on which you receive only those benefits do not count toward satisfying the Elimination Period.

   (b) **FACILITY BENEFITS.**

   For each day of your stay in a Long Term Care Facility or Alternate Care Facility, after the satisfaction of the Elimination Period, we will pay the lesser of:

   (1) The Maximum Daily Facility Benefit; or
   (2) The amount of money remaining in the Maximum Lifetime Benefit; or
   (3) The expenses incurred for such care , including room and board, but excluding convenience

and comfort items, beauty and salon expenses, prescription medications, and other charges that are not directly related to the provision of care in the facility.

All Facility Benefits received by You must be provided for in a Plan of Care and will count toward the Maximum Lifetime Benefit.

"Alternate Care Facility" means a facility that is licensed or accredited by the appropriate agency to give ongoing care and related services to inpatients in one place.

If the facility is not licensed or accredited by the state in which the care is received, it must a) provide 24 hour-a-day care and services sufficient to support needs due to inability to perform Activities of Daily Living or Impairment of Cognitive Ability; and b) have a trained and ready to respond employee on duty at all times to give that care; and c) provides 3 meals-a-day and accommodate special dietary needs; and d) have formal arrangements for the services of a physician or nurse to give medical care in case of emergency; and e) care for a minimum of 6 resident inpatients in one (1) location; and f) have appropriate methods and procedures for handling and administering drugs and biologicals. These requirements are typically met by hospice care facilities or assisted living facilities. They may also be met by some personal care and adult congregate care facilities. They are NOT met by individual homes or independent living units. An Alternate Care Facility does not mean a Long Term Care Facility, hospital or clinic, boarding home, or a place which operates primarily for the treatment of alcoholics or drug addicts.

"Long Term Care Facility" means a facility that is licensed by the appropriate Federal or state licensing agency to engage primarily in providing nursing care to resident inpatients. If the facility is not located in Texas and is not licensed by the state in which the care is received, it must meet all of the following criteria: a) provide nursing care on an inpatient basis under the supervision of a physician; b) have 24 hour-a-day nursing services provided by or under the supervision of a registered nurse (R.N.), licensed vocational nurse (L.V.N.), or licensed practical nurse (L.P.N.), and c) keep a daily medical record of each patient; and d) may be either a freestanding facility or a distinct part of a facility such as a ward, wing, unit, or swing-bed of a hospital or other institution.

BED RESERVATION BENEFIT

When provided in a Plan of Care, we will continue to pay up to the Maximum Daily Facility Benefit when you are charged for your room in a Facility while you are temporarily absent during the course of your stay. This Bed Reservation Benefit will be limited to 21 times the Maximum Daily Facility Benefit per calendar year. Unused benefits cannot be carried over into the next calendar year. All Bed Reservation Benefits received by you will count against the Maximum Lifetime Benefit.

(c) **ALTERNATE PLAN OF CARE BENEFIT**

We reserve the right to pay for alternate services, devices or types of care under a written Alternate Plan of Care, if such plan is medically acceptable. This Alternate Plan of Care must be agreed to by you, your Licensed Health Care Practitioner, when applicable, and us; and will be developed by or with Licensed Health Care Practitioners; and must be for Appropriate Long Term Care. Any plan, including the benefit levels to be payable, may be adopted, as long as it is mutually agreeable to you, your Licensed Health Care Practitioner, when applicable, and us. We are not obligated to provide benefits for services received prior to such agreement. Agreement to participate in an Alternate Plan of Care will not waive any of your or our rights under the policy.

This plan may specify special treatments or different sites or levels of care. Some of the services you may receive may differ from those otherwise covered by your policy. In this case, benefits will be paid at the levels specified and agreed to in the Alternate Plan of Care.

Any benefits payable under this provision will count toward the Maximum Lifetime Benefit and will be subject to the Elimination Period. We reserve the right to decline to authorize alternate benefits and services. You have the right at any time to discontinue the alternate benefits and resume receiving the benefits specifically defined in the policy.

(d) **HOME AND COMMUNITY CARE BENEFITS.**

HOME AND COMMUNITY CARE BENEFIT

We will pay benefits when you require Home and Community Care or Hospice Services and as provided in a Plan of Care. Home and Community Care and Hospice Services will count toward the Maximum Lifetime Benefit. Care Management Costs will count toward the Maximum Lifetime Benefit.

For Home and Community Care or Hospice Services received during the first 30 consecutive calendar days after the satisfaction of the Elimination Period, for care received during a day, we will pay the lesser of:

(1) Two times the Maximum Daily Home and Community Care Benefit, or
(2) The amount of money remaining in the Maximum Lifetime Benefit; or
(3) The total of:
  a. the expenses incurred for occupational, physical, respiratory, or speech therapy; or nursing care services provided by a registered nurse (R.N.) or a licensed practical or vocational nurse (L.P.N. or L.V.N.); and
  b. the expenses incurred for Maintenance and Personal Care Services provided by a Home Health Care Provider or Independent Caregiver; and
  c. the expenses incurred for home delivered or special meals, nutrition services; and
  d. the expenses incurred from an Adult Day Care Center and transportation between the home and the Adult Day Care Center.

For Home and Community Care or Hospice Services received beginning with the thirty-first (31st) calendar day after the satisfaction of the Elimination Period, for care received during a day, we will pay the lesser of:

(1) The Maximum Daily Home and Community Care Benefit, or
(2) The amount of money remaining in the Maximum Lifetime Benefit; or
(3) The total of:
  a. the expenses incurred for occupational, physical, respiratory, or speech therapy; or nursing care services provided by a registered nurse (R.N.) or a licensed practical or vocational nurse (L.P.N. or L.V.N.); and
  b. the expenses incurred for Maintenance and Personal Care Services provided by a Home Health Care Provider or Independent Caregiver; and
  c. the expenses incurred for home delivered meals, special meals, nutrition services; and
  d. the expenses incurred from an Adult Day Care Center and transportation between the home and the Adult Day Care Center.

“Adult Day Care” means A social and health-related services program provided during the day in a community group setting, for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home.

"Adult Day Care Center" means an organization which provides a program of adult day care that is state licensed, if the state in which it is located licenses adult day care facilities; or meets all of these tests:

(1) it operates at least 5 Days a week for a minimum of 6 hours a Day and is not an overnight facility; and
(2) it maintains a written record for each client which includes a Plan of Care and a record of all services provided; and
(3) it has established procedures for obtaining appropriate aid in the event of a medical emergency; and
(4) it has formal arrangements for providing services of: a dietician; a licensed physical therapist; a licensed speech therapist; and a licensed occupational therapist; and
(5) its staff includes all of the following: a full-time director; 1 or more Nurses in attendance during operating hours for at least 4 hours a Day; enough full-time staff members to maintain a client-to-staff ratio of 8 or less to 1.

"Home Health Care Agency" means a business which provides home health service and is licensed by the Texas Department of Health.

"Home Health Care Provider" means a person who provides Home Health Care or Hospice Services pursuant to an agreement with a Home Health Care Agency. A Home Health Care Provider cannot be a member of Your Immediate Family or anyone living with You.

"Independent Caregiver" is an individual who provides Home Health Care or Hospice Services and:

(1) Who holds an active State license or certificate appropriate to the level of care being provided and works independent of a licensed home health care agency. The licensure or certification must be in the State where care will be provided; or
(2) If the state does not require licensure or certification, is an individual who has been chosen by you and has been qualified under the Independent Caregiver Certification Benefit and has been approved by us.

The policy will not pay benefits for any care or services that are provided without charge in the absence of insurance. The Independent Caregiver must be approved by a Care Advisor and approved by us, regardless of the type of care or services being provided. Benefits will not be considered for any care or services rendered by an Independent Caregiver prior to our approval. An Independent Caregiver cannot be a member of your immediate family. The Independent Caregiver will be required to provide:

(1) Proof of certification or licensure, if applicable; and
(2) Daily records of the care or service provided including the daily charges.

INDEPENDENT CAREGIVER CERTIFICATION BENEFIT

When provided in a Plan of care, this benefit provides you with the freedom to choose the individual who will provide your long term care. This individual can be anyone you choose other than a member of your immediate family or anyone living with you.

If the individual you choose is already licensed or certified in the state where the care will be given, this individual may be considered an Independent Caregiver under the policy subject to our approval.

If the individual you choose is not licensed or certified in the state where the care will be given or if the state where the care will be given does not require such license or certificate, we will pay for the training of this individual if the training plan is:

(1) Approved by a Licensed Health Care Practitioner; and
(2) Agreed to by you, us and your Licensed Health Care Practitioner, when applicable.

We are not obligated to provide benefits for services received prior to such agreement.

After the satisfactory completion of this training, this newly trained individual will be considered an Independent Caregiver. Any benefits payable under this provision, including the expense incurred for the services of the Licensed Health Care Practitioner, count against the Maximum Lifetime Benefit.

(e) **CARE ADVISORY SERVICES.**

You may use Care Advisory Services when You are eligible for other covered benefits and You use a Care Advisory Services Agency designated by Us. Care Advisory Services help You identify Your specific care needs. A Care Advisor will identify the long term care services and programs in Your area that can best meet those needs.

You may choose to use Your own Licensed Health Care Practitioner to perform an assessment and develop a plan of care instead of a care advisory services agency designated by Us. If You choose to use Your own Licensed Health Care Practitioner, We will not pay for the care advisory services. However, We will pay for the covered expenses You incur for Your own Licensed Health Care Practitioner to perform an assessment and develop a plan of care. Payment of these charges will not reduce Your Maximum Lifetime Benefit or Your daily, annual, or lifetime benefit maximums.

You are not required to complete the Elimination Period before using this benefit and days when you receive Care Advisory Services do not count toward the satisfaction of the Elimination Period. However, the Elimination Period must be completed, where required, in order to receive other policy benefits.

(f) **INFORMAL CAREGIVER SUPPORT BENEFITS.**

RESPITE CARE BENEFIT

In addition to the Home and Community Care Benefit and when provided in a Plan of Care, we will pay up to the Respite Care Benefit Limit, defined below, per calendar year to relieve your Informal Caregiver as follows:

(1) For each day Respite Care is received in a Facility, we will pay the lesser of:
   a. The Maximum Daily Facility Benefit, or
   b. The amount of money remaining in the Maximum Lifetime Benefit; or
   c. The expenses incurred for such care.

(2) For each day Respite Care is received in your home or in an Adult Day Care Center, we will pay the lesser of:
   a. The Maximum Daily Home and Community Care Benefit; or
   b. The amount of money remaining in the Maximum Lifetime Benefit; or
   c. The expenses incurred for such care.

The Respite Care Benefit Limit will be equal to 30 times the Maximum Daily Facility Benefit. Unused benefits cannot be carried over into the next calendar year. The Elimination Period does not apply to this benefit, however days on which you receive Respite Care cannot count toward satisfying your Elimination Period. Benefits received under the Respite Care Benefit will count against the Maximum Lifetime Benefit.

“Respite Care” is care provided by or through a Long Term Care Facility; Alternate Care Facility, Independent Caregiver, Adult Day Care Center, or Home Health Care Provider to temporarily relieve the Informal Caregiver.

Agent Name Jerry Hill
Agent # 736990

# *LOYAL AMERICAN LIFE INSURANCE COMPANY*

5508 Parkcrest Drive • P.O. Box 559004 • Austin, Texas 78755-9004

## LONG TERM CARE POLICY APPLICATION

☐ New Business
☐ Reinstatement
☐ Benefit Change

### PROPOSED INSURED

First: ______ Middle Initial: ______ Last: ______ Height: ______ Weight: ______

DOB: ____/_____/_______ Age: _____

Tobacco Use in Last 2 Years: ☐ Yes ☐ No

Social Security #: ____________________

Home Address: ______________________________________________

Home Telephone: (_______) _________________

**Long Term Care Plan:** ☐ Qualified ☐ Non-Qualified

Daily Benefit Amount: $______________________

Elimination Period (days): ☐ 0 ☐ 7 ☐ 30 ☐ 60 ☐ 90 ☐ 180

Benefit Period (years): ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Life

**Home Health Care Option**: ☐ Yes ☐ No

Daily Benefit (% of LTC Daily Benefit):
☐ 50% ☐ 80% ☐ 100% ☐ 125% ☐ 150%

**Rider Options:**

Restoration of Benefits Rider.......................................... ☐ Yes ☐ No
Shared Extended Expense Rider....................................... ☐ Yes ☐ No
Dual Waiver of Premium Rider......................................... ☐ Yes ☐ No
Survivorship Rider.......................................................... ☐ Yes ☐ No
Shortened Benefit Period Non-Forfeiture Rider............. ☐ Yes ☐ No
☐ Compound or ☐ Simple Inflation or ☐ Guaranteed Purchase

Premium Payment:
☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly PAC

Premium Class Applied For: ☐ Preferred ☐ Select ☐ Standard

Total Premium Less Policy Fee: $_________________

Billing Address: ________________________________________

### PROPOSED INSURED SPOUSE

First: ______ Middle Initial: ______ Last: ______ Height: ______ Weight: ______

DOB: ____/_____/_______ Age: _____

Tobacco Use in Last 2 Years: ☐ Yes ☐ No

Social Security #: ____________________

Home Address: ______________________________________________

Home Telephone: (________) ____________________

**Long Term Care Plan:** ☐ Qualified ☐ Non-Qualified

Daily Benefit Amount: $______________________

Elimination Period (days): ☐ 0 ☐ 7 ☐ 30 ☐ 60 ☐ 90 ☐ 180

Benefit Period (years): ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Life

**Home Health Care Option**: ☐ Yes ☐ No

Daily Benefit (% of LTC Daily Benefit):
☐ 50% ☐ 80% ☐ 100% ☐ 125% ☐ 150%

**Rider Options:**

Restoration of Benefits Rider.......................................... ☐ Yes ☐ No
Shared Extended Expense Rider....................................... ☐ Yes ☐ No
Dual Waiver of Premium Rider......................................... ☐ Yes ☐ No
Survivorship Rider.......................................................... ☐ Yes ☐ No
Shortened Benefit Period Non-Forfeiture Rider............. ☐ Yes ☐ No
☐ Compound or ☐ Simple Inflation or ☐ Guaranteed Purchase

Premium Payment:
☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly PAC

Premium Class Applied For: ☐ Preferred ☐ Select ☐ Standard

Total Premium Less Policy Fee: $_________________

Billing Address: ________________________________________

### MEDICAL QUESTIONS PART I

| Answer every question for each proposed insured. If the answer to any of the questions in this section is "YES" for either person, that person is not eligible for coverage. Circle the applicable condition. | **Insured** | **Insured Spouse** |
|---|---|---|
| 1. Are you currently being covered or have you been covered within the last 12 months by a state assistance program (Medicaid) or are you currently receiving or have you received within the last 12 months any type of disability benefit, including Social Security Disability? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Have you been medically treated for or diagnosed with any type of the following conditions: Alzheimer's Disease; dementia or senility; Parkinson's Disease; or organic brain syndrome? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. Have you been medically treated or diagnosed with kidney disease requiring dialysis or Cirrhosis of the liver? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4. Have you tested positive on a Human Immunodeficiency Virus (HIV) related test or been diagnosed as having HIV, AIDS Related Complex (ARC), or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV Infection or other sickness or condition derived from such infection? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 5. Have you been medically treated for or diagnosed with Multiple Sclerosis, Muscular Dystrophy, Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), any degenerative neuromuscular disease, Paget's Disease of the bone, any degenerative bone disease, paralysis, paraplegia, quadriplegia, or any amputation(s) due to a medical condition? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 6. Within the past 12 months, have you received or been advised to receive Home Health Care; use or been advised to use an Adult Day Care Facility; been confined to or advised to enter a Nursing Home, Assisted Living Facility, or any other similar facility? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 7. Do you currently or within the last 12 months have you required assistance or supervision in any way in performing any of the following activities: eating, dressing, bathing, toileting, transferring to or from a bed or chair, or walking? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 8. Do you use or have you been advised to use a wheelchair, walker, quad cane, or motorized scooter; or are you currently bedridden? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 9. Do you currently use or within the last 12 months have you used or been advised to use any medical appliance such as a catheter, oxygen equipment, respirator, insulin pump, or dialysis machine? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 10. Due to any present or past mental or physical disability, is any person or institution currently authorized to act on your behalf? | ☐ Yes ☐ No | ☐ Yes ☐ No |

## MEDICAL QUESTIONS PART 2

| **Individual consideration will be given to applicant who answer "YES" to the following questions (circle the applicable conditions):** | **Insured** | **Insured Spouse** |
|---|---|---|
| 1. Have you ever had an application for life, health, or long term care insurance declined, rated, modified, postponed, or had a reinstatement request refused? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Have you ever received disability benefits of any type? If yes, from ____________to ____________ Reason:______________________________ | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. Do you currently require or receive assistance with or in the past 12 months have you required or received assistance with shopping, cleaning, cooking, laundry, or transportation? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4. Are you currently or within the last five years have you been: | | |
| a. Confined or been advised to be confined to a hospital or health care facility? | | |
| b. Confined or been advised to be confined to a nursing home? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c. Received home health care or been advised to receive home health care? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 5. Within the past five years, have you received, been advised to receive, or sought any medical advice, examination, or treatment for: | ☐ Yes ☐ No | ☐ Yes ☐ No |
| a. Internal cancer, melanoma, leukemia, or Hodgkin's Disease? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b. Stroke, TIA, Epilepsy, seizures, encephalitis, or meningitis? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c. Depression, Psychosis, or any other mental, nervous, emotional, or brain disease or disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d. Nephritis, renal insufficiency, incontinence, or Diabetes? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| e. Osteoporosis, Osteomyelitis, Arthritis, Rheumatoid Arthritis, Polio, or any back, spine, bone, joint, or muscle disease or disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| f. Heart attack, heart disorder, pacemaker, hypertension, Cystic Fibrosis, Tuberculosis, Emphysema, Chronic Obstructive Pulmonary Disorder (COPD), cerebrovascular insufficiency, or other lung disease or disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| g. Drug or Alcohol abuse, addiction, or dependency? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| h. Skin cancer, Scleroderma, any connective tissue disease, or any other skin condition? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| i. Anemia, Sickle Cell Anemia, or any other blood disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 6. Do you currently or within the last 12 months have you used a straight cane? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 7. Within the past 5 years, have you received any medical or surgical advice, follow-up care, examination, or treatment for any health condition not included in the previously listed medical/health questions? | ☐ Yes ☐ No | ☐ Yes ☐ No |

**If any question is answered "YES", please list complete details. Include insured's name, dates, names and addresses for doctors consulted and hospitalization. If more space is needed, attach a separate sheet with the proposed insured(s)' name and signature.**

| Insured Name | Question Number | Nature of Disease or Condition | Dates From | Dates To | Name & Address of Physician and Hospital Name if Hospitalized | Surgery Yes or No | Date & Degree of Recovery |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

### PROPOSED INSURED

8. Are you currently taking any medications? ☐ Yes ☐ No
If "Yes" then list below. Attach additional sheet if necessary.

| Medication | Condition | Dosage |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

### Physician Information

9. List all physicians who have medical records for you: Use additional sheet if necessary. Include your name and signature.

Primary Doctor's Name: ______________________
Dr. Address: ______________________
Date Last Seen: ______________ Phone # (____) ____________
Other Doctor's Name: ______________________
Dr. Address: ______________________
Specialty:______________________
Date Last Seen: ______________ Phone # (____) ____________

### PROPOSED INSURED SPOUSE

8. Are you currently taking any medications? ☐ Yes ☐ No
If "Yes" then list below. Attach additional sheet if necessary.

| Medication | Condition | Dosage |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

### Physician Information

9. List all physicians who have medical records for you: Use additional sheet if necessary. Include your name and signature.

Primary Doctor's Name: ______________________
Dr. Address: ______________________
Date Last Seen: ______________ Phone # (____) ____________
Other Doctor's Name: ______________________
Dr. Address: ______________________
Specialty:______________________
Date Last Seen: ______________ Phone # (____) ____________

## ADDITIONAL INFORMATION

| | Insured | Insured Spouse |
|---|---|---|
| 1. Do you have any other long term care insurance policy, certificate, or rider in force (including health care service contracts or health maintenance organization contracts)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Have you ever been insured by Loyal American Life Insurance Company? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. a. Did you have another long term care insurance policy, certificate, or rider in force during the last 12 months? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b. If so, with which company? ______________________ | | |
| c. If that policy lapsed, when did it lapse? ______________________ | | |
| 4. List all other health insurance currently in force below: ______________________ | | |
| 5. Do you intend to replace any of your medical, health, or long term care insurance with this insurance? If so, please indicate below: | ☐ Yes ☐ No | ☐ Yes ☐ No |

| Insured Name | Policy Number | Name of Company | Type of Coverage | Coverage Amount | To be Replaced |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**PROTECTION AGAINST UNINTENDED LAPSE:** I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this Long Term Care Insurance policy for nonpayment of premium. I understand that this notice will not be given until 30 days after a premium is due and unpaid. I also understand that I can change this designation at any time and will be notified at least once every 2 years of this right.

**PROPOSED INSURED**

☐ I elect NOT to designate any person to receive such notice.
☐ I elect the following person to receive such notice:
Name: ______________________
Address: ______________________

**PROPOSED INSURED SPOUSE**

☐ I elect NOT to designate any person to receive such notice.
☐ I elect the following person to receive such notice:
Name: ______________________
Address: ______________________

**PROPOSED INSURED**

Beneficiary: ______________________
Relationship: ____________ SS # ______-_____-_______

**TELEPHONE INTERVIEW AUTHORIZATION**
I understand that I may be contacted by a representative of Loyal American Life Insurance Company to verify my health history and condition(s).

The best time to call would be: __________ AM / PM.
Alternate Daytime Phone Number: (______) ____________

Signature: ______________________

**PROPOSED INSURED SPOUSE**

Beneficiary: ______________________
Relationship: ____________ SS # ______-_____-_______

**TELEPHONE INTERVIEW AUTHORIZATION**
I understand that I may be contacted by a representative of Loyal American Life Insurance Company to verify my health history and condition(s).

The best time to call would be: __________ AM / PM.
Alternate Daytime Phone Number: (______) ____________

Signature: ______________________

HOME OFFICE ENDORSEMENTS:

## NOTICE TO APPLICANTS FOR INSURANCE

Information regarding your insurability will be treated as confidential. Loyal American Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon a receipt from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedure set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. The Bureau's telephone number is (617) 426-3660. Loyal American Life Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may also apply for life or health insurance or to whom a claim for benefits may be submitted.

## NOTICE OF INFORMATION PRACTICES

Thank you for giving Loyal American Life Insurance Company the opportunity to consider your insurance needs. As part of our normal underwriting procedure for processing applications, we may obtain an investigative consumer report where information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of such information which may include information as to your character, general reputation, personal characteristics, and mode of living. The information obtained in such investigative consumer report will not be used to make a determination of your sexual preference. You have the right to make a written request for additional, detailed information about the nature and scope of this investigation.

We may telephone you to confirm information given in your application or to obtain additional information needed to process your application.

All information requested in your application or obtained from other sources, such as your physicians or hospitals, where you have been treated is for the sole purpose of determining your acceptability for the insurance coverage for which you have applied. All information obtained will be kept confidential. Upon your written request, we will furnish you or your physician with the nature and/or source of the information.

## AGREEMENT AND AUTHORIZATION TO OBTAIN INFORMATION

I hereby represent that the foregoing answers are recorded as given by me and that the same are full, complete and true. I represent that all questions on this application were asked and that the answers were properly recorded. I further agree that this insurance applied for shall be subject to the conditions and provisions of the certificate and shall not be in force until the application is accepted and the certificate issued by the Company. I represent that I am not covered by a State Medical program. I acknowledge receipt of the Outline of Coverage. No agent has the right to waive the answer to any question in this application, to pass on insurability, to waive any of Company's rights or requirements, or to make or alter any contract. I agree that this application shall form a part of any certificate issued.

I acknowledge that I have read and understand the Notice to Applicants for Insurance and the Notice of Information Practices above.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, the U.S. Veterans Administration and Selective Service System, insurance company, The Medical Information Bureau, or any other organization, institution, or person that has any records or knowledge of me or my health to give to Loyal American Life Insurance Company and its reinsurer(s) any such information. This authorization will be valid for 24 months from the date the authorization is signed.

The undersigned applicant(s) and agent represent that the applicant has read or had read to him the completed application and he realizes any false statement or misrepresentation therein which is material to the risk or hazard assumed may result in a loss of coverage under the certificate subject to the Time Limit on Certain Defenses and legal proceedings. A photographic copy of this authorization shall be as valid as the original.

**CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, LOYAL AMERICAN LIFE INSURANCE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR POLICY.**

**I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF INSURANCE FRAUD.**

Note to Agent: Is replacement of insurance involved? ☐ Yes ☐ No

Signed at ______________________ Date: ______________________
(city and state)

Proposed Insured Read and Signed: ______________________

Proposed Insured Spouse Read and Signed: ______________________

Agent's Signature ______________________ Writing Number 3B00120000 License Number: 736990

Agent's Printed Name Jerry Hill / Beneflex Financial Group Check Block if Agent Family Business ☐

## AUTHORIZATION TO HONOR CHECKS DRAWN BY LOYAL AMERICAN LIFE INSURANCE COMPANY

Name of Bank: ______________________ Routing Number: ______________________

As a convenience to me, I hereby request and authorize you to initiate debit entries, whether by electronic or paper means, with said debits drawn on my account by and payable to the order of the LOYAL AMERICAN LIFE INSURANCE COMPANY, Austin, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check drawn on my account and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring such debit. I further agree that if any such debit is not paid by me for any reason, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such non-payment results in the forfeiture of insurance.

______________________ ✓) ______________________

Date (Your signature EXACTLY as it appears on Bank Records) (Account Number )

**IMPORTANT: FOR BANK ACCOUNT IDENTIFICATION, ENCLOSE A VOIDED BLANK PERSONAL CHECK.**

## QUESTIONS WHICH MUST BE ANSWERED BY THE AGENT

1. List any other health insurance policies and certificates you have sold to the applicant.
______________________
2. List policies and certificates sold which are still in force.
______________________
3. List policies and certificates sold in the past 5 years which are no longer in force.
______________________
4. List any other health insurance policies or certificates the applicant has in force.
______________________
5. List all Long Term Care or Home Health Care insurance policies you sold to the proposed insured(s) which are no longer in force. ______________________
Have any policies been replaced by you? ☐ Yes ☐ No
If yes, give details. ______________________
6. Did you personally interview the proposed insured(s) and witness his/her signature(s)? ☐ Yes ☐ No
7. Was anyone else present? If yes, who? ______________________ ☐ Yes ☐ No
8. Did you observe any physical or mental impairments with regard to memory, walking or speaking, or any tremor? ☐ Yes ☐ No
If yes, explain: Who? ______________ What? ______________
9. Does the applicant live alone? If no, with whom does the proposed insured reside? ______________ ☐ Yes ☐ No
10. Type of dwelling: ☐ Private Home ☐ Apartment ☐ Retirement or Adult Living Facility ☐ Nursing Facility
☐ Other, please specify ______________________
11. Have you any other information regarding the health, habits, or home surroundings of the person(s) proposed for insurance in this application? If yes, explain ______________________ ☐ Yes ☐ No
12. If the application cannot be issued as applied for, do you want us to increase the premium or reduce the benefits?
______________________

I hereby certify that I have truly and accurately recorded on this application the information supplied by the Proposed Insured(s) and did personally witness the signing of this application by the Proposed Insured(s). I also certify that I have given the Proposed Insured(s) a copy of the Replacement Notice, if replacement was indicated.

______________________ ______________________

Licensed Agent's Signature Date

Jerry Hill / Beneflex Financial Group 736990

Licensed Agent's Printed Name Agent License #

# *LOYAL AMERICAN LIFE INSURANCE COMPANY*

**P.O. Box 559004 • Austin, Texas 78755-9004 • (800) 633-6752**

## SUPPLEMENTARY APPLICATION

### Inflation Protection

I have reviewed the Outline of Coverage and the graphs that compare the benefits of this policy with and without inflation protection. I realize that based on current health care cost trends, the benefits provided by a long term care plan which does not have meaningful inflation protection may be significantly diminished in terms of real value to me, depending on the amount of time which elapses between the date I purchase the policy and the date on which I first become eligible to use them. Specifically, I have reviewed the Long Term Care Policy and the Inflation Benefit Rider, and:

☐ Yes, I **do** reject the inflation protection. ☐ No, I **do not** reject the inflation protection.

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

### Non-Forfeiture Protection

I have reviewed the Outline of Coverage and the Non-Forfeiture benefits as described herein. Specifically, I have reviewed the Long Term Care Policy and the Shortened Benefit Period Non-Forfeiture Rider, and:

☐ Yes, I **do** reject the non-forfeiture protection. ☐ No, I **do not** reject the non-forfeiture protection.

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

______________________________ ____________________

Signature of Applicant Date

______________________________ ____________________

Signature of Agent Date

**This Supplement shall be attached to and considered a part of the Application for Long Term Care Policy.**

# NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

*LOYAL AMERICAN LIFE INSURANCE COMPANY*

P.O. Box 559004 • Austin, Texas 78755-9004 • (800) 633-6752

## SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your Application, you intend to lapse or otherwise terminate existing accident and sickness or Long Term Care insurance and replace it with the Long Term Care Policy to be issued by Loyal American Life Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or Long Term Care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this Long Term Care coverage is a wise decision.

**STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE):**

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy may not contain new pre-existing conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions or probationary periods in the new policy for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the Application concerning your medical health history. Failure to include all material medical information on an Application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the Application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Jerry Hill / Beneflex Financial Group
Typed Name of Agent or Broker

_______________________________
Signature of Agent, Broker, or Other Representative

11811 East Freeway, STE 545, Houston, Texas 77029
Typed Address of Agent or Broker

The above "Notice to Applicant" was delivered to me on: _______________________________
Date Applicant's Signature

---

**NOTICE TO AGENT**

One copy of this form must be left with the Applicant. One copy is to be sent to the Company with the Application for insurance. Record the name of the company and the policy number being replaced.

Policy being replaced is policy number _______________________________

Issued by: _______________________________
(Company name and address)

# LONG TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM

*LOYAL AMERICAN LIFE INSURANCE COMPANY*
P.O. Box 559004
Austin, Texas 78755-9004
800-633-6752

1. This long-term care coverage is Guaranteed Renewable. This means that the rates for this coverage may be increased in the future. Your rates CANNOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all insureds with a policy similar to yours.
2. If you receive a premium rate increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:
   (a) Pay the increased premium and continue your coverage in force as is.
   (b) Reduce your coverage benefits to a level such that your premiums will not increase.
   (c) Exercise your long-term care non-forfeiture option, if purchased. This option is available for purchase for an additional premium.
   (d) Exercise your contingent non-forfeiture rights, See No. 3. This option is available if you do not purchase a long-term care non-forfeiture option mentioned in (c) above.
3. Contingent Non-forfeiture Rights

   If the premium rate for your policy goes up in the future and you do not buy a long-term care non-forfeiture option, you may be eligible for contingent non-forfeiture.

   (a) You will keep some long-term care insurance coverage, if:
      (1) Your premium after the increase exceeds your original premium by the percentage shown, or more, in the table provided on the next page; and
      (2) You do not pay your premium within one hundred and twenty (120) days of the increase causing your policy to lapse.
   (b) The amount of coverage, new lifetime maximum benefit amount, etc., you will keep will equal to the total amount of premiums you have paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you have paid, the amount of coverage will be that remaining amount.
   (c) Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

      Should you choose this Contingent Non-forfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

      Example:

      - You bought the policy at age sixty-five (65) and paid the one thousand dollar ($1,000) annual premium for ten (10) years, so you have paid a total of ten thousand dollars ($10,000) in premium.
      - In the eleventh year, you receive a rate increase of fifty percent (50%), or five hundred dollars ($500) for a new annual premium of one thousand five hundred dollars ($1,500), and you decide to not pay any more premiums causing your policy to lapse.
      - Your "paid-up" policy benefits are ten thousand dollars ($10,000), provided you have at least ten thousand dollars ($10,000) of benefits remaining under your policy.

## Contingent Non-forfeiture Cumulative Premium Increase over Initial Premium That Qualifies for Contingent Non-forfeiture Table

**Percentage increase is cumulative from the date of original issue. It does NOT represent a one-time increase.**

| ISSUE AGE | PERCENT INCREASE OVER INITIAL PREMIUM | ISSUE AGE | PERCENT INCREASE OVER INITIAL PREMIUM |
|---|---|---|---|
| 29 and under | 200% | 72 | 36% |
| 30-34 | 190% | 73 | 34% |
| 35-39 | 170% | 74 | 32% |
| 40-44 | 150% | 75 | 30% |
| 45-49 | 130% | 76 | 28% |
| 50-54 | 110% | 77 | 26% |
| 55-59 | 90% | 78 | 24% |
| 60 | 70% | 79 | 22% |
| 61 | 66% | 80 | 20% |
| 62 | 62% | 81 | 19% |
| 63 | 58% | 82 | 18% |
| 64 | 54% | 83 | 17% |
| 65 | 50% | 84 | 16% |
| 66 | 48% | 85 | 15% |
| 67 | 46% | 86 | 14% |
| 68 | 44% | 87 | 13% |
| 69 | 42% | 88 | 12% |
| 70 | 40% | 89 | 11% |
| 71 | 38% | 90 and over | 10% |

4. Premium rate that is applicable to you and that will be in effect until a request is made and filed with the Texas Department of Insurance for an increase is shown on the application. The premium for this coverage will be shown on the schedule page of your policy.

5. If your rates are changed, the new rates will become effective on the next billing date. The new rates will remain in effect until another request is made and filed with the Texas Department of Insurance. You have the right to receive a revised premium rate if the premium rate is changed.

6. Rate Increase History
   We have sold long-term care insurance since 2002 and have sold this policy series Form number L-6000-NQ-TX and Form number L-6000-TQ-TX since 2002. We have never raised rates for any long-term care policy sold in this state or any other state.

*LOYAL AMERICAN LIFE INSURANCE COMPANY*
P.O. Box 559004
Austin, Texas 78755-9004
800-633-6752

# Acknowledgement of Receipt

I hereby acknowledge receipt of the Long Term Care Potential Rate Increase Disclosure Form.

______________________________ ______________________
Applicant's Signature Date

______________________________ ______________________
Agent's Signature Date

INFORMAL CAREGIVER TRAINING BENEFIT

If you are determined by us to be Functionally Disabled and you require Appropriate Long Term Care and when provided in a Plan of Care, we will pay the expenses incurred for Informal Caregiver Training, not to exceed 5 times the Maximum Daily Home and Community Care Benefit during a Plan of Care. This benefit will be paid in addition to the Home and Community Care Benefit. The Elimination Period does not apply to this benefit, and days on which you receive the Informal Caregiver Training Benefit do not count toward satisfying the Elimination Period. Benefits received under the Informal Caregiver Training Benefit do not count against the Maximum Lifetime Benefit.

If you require a stay in a Facility or are hospitalized, the Informal Caregiver Training Benefit will only be payable if the training will make it possible for you to return to or remain in your home where you can be cared for by the Informal Caregiver.

(g) **HOME MEDICAL TECHNOLOGY BENEFIT.**
When provided in a Plan of Care, this benefit pays the actual expense you incur each month, up to a monthly maximum equal to the Maximum Daily Home and Community Care Benefit, for the rental or lease of Home Medical Technology specified in your Plan of Care. This Home Medical Technology must be agreed upon by you and us, prior to its rental or lease. We will only pay the Home Medical Technology Benefit for equipment installed in your home while your policy is in effect. We will not pay for any charges for normal telephone service while the equipment is installed or for a home security system.

(h) **OPTIONAL SHARED EXTENDED EXPENSE BENEFIT.** (This benefit is included only if you elect rider form L-6013 Series.)

☐ **Selected** ☐ **Not Selected**

Shared Benefit Amount $ _______________ (Amount must be less than or equal to the Maximum Lifetime Benefit.)

This benefit provides for an additional benefit amount that can be used when either or both spouses have exhausted their Maximum Lifetime Benefit. We will pay benefits for expenses incurred that exceed the Maximum Lifetime Benefit up to an additional amount equal to the Shared Benefit Amount. If both spouses are incurring expenses that exceed their individual Maximum Lifetime Benefit at the same time, we will pay the total combined expenses each month until the Shared Benefit Amount is exceeded.

(i) **RESTORATION OF BENEFITS RIDER.** (This benefit is included only if you elect rider form L-6010 Series.)

☐ **Selected** ☐ **Not Selected**

We will restore the Maximum Lifetime Benefit to the amounts that would have applied if no benefits had been paid under the policy. The Maximum Lifetime will be restored if we verify that all of the following conditions have been met:

(1) The Maximum Lifetime Benefit has not been exhausted; and
(2) You have not required assistance to perform 2 or more Activities of Daily Living or Substantial Supervision due to Impairment of Cognitive Ability for a period of 180 consecutive days; and
(3) Our Licensed Health Care Practitioner confirms that you have had neither Impairment of Cognitive Ability nor Functional Incapacity for a period of 180 consecutive days.

If you have already satisfied your Elimination Period, you do not have to meet a new Elimination Period after your Maximum Lifetime Benefit is restored.

(j) **SURVIVORSHIP BENEFIT RIDER.** (This benefit is included only if you elect rider form L-6011 Series.)

☐ **Selected** ☐ **Not Selected**

If your spouse dies after your policy has been in force for at least 10 consecutive years, we will permanently waive any premium that becomes due for your policy if:
(1) Both You and Your Spouse have had long term care insurance in force with Us for at least 10 consecutive years, other than under a Nonforfeiture Benefit, on the date of the death of Your Spouse; and
(2) Both you and your spouse have a Survivorship Benefit that has been in force for at least 10 consecutive years on the date of the death of your spouse.

No further premium payments will be required. We will also return the pro-rata portion of any premium you have paid for the period after your spouse has died. This benefit will remain in effect even if benefits are paid or payable under your policy or your spouse's policy.

(k) **ELIGIBILITY FOR BENEFITS.**
We will pay benefits when we verify that:
(1) You are unable to perform, without assistance, at least two (2) Activities of Daily Living; or
(2) You suffer from Impairment of Cognitive Ability; and
(3) A licensed health care practitioner has certified, within 12 months, that you meet the Activity of Daily Living or the Impairment of Cognitive Ability requirements above; and has developed a written plan of care which details the appropriate long term care you need.

Except where otherwise stated, no benefits under your policy will be paid:
(1) For care received when your policy was not in force; or
(2) For a service not covered under your policy; or
(3) Unless you satisfy the Elimination Period, where required; or
(4) In excess of the Maximum Daily Benefit; or
(5) In excess of the Maximum Lifetime Benefit; or
(6) If any of the exclusions of the policy apply.

Home and Community Care Benefits and Facility Benefits cannot be paid for the same day. In the case where both types of benefits are received on the same day, the benefit with the highest amount payable will be paid



Leave with Applicant

"Functionally Disabled" means certified by a Licensed Health Care Practitioner as:

(1) Being unable to perform (without assistance from another individual) at least two (2) Activities of Daily Living, or
(2) Requiring Substantial Supervision to protect Yourself from threats to health and safety due to Impairment of Cognitive Ability.

With respect to care in a Long Term Care Facility it also may that such care is certified by a physician to be medically necessary.

To be eligible for benefits under this policy, You must be certified as Functionally Disabled by a Licensed Health Care Practitioner at least once every twelve (12) months beginning with the first (1st) day of eligibility for benefits.

"Activities of Daily Living" are (1) Eating: Feeding yourself by getting food into your body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously; (2) Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs; (3) Bathing: Washing yourself by sponge bath; or in either a tub or shower, including the task of getting in or out of the tub or shower; (4) Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene; (5) Transferring: Sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair or other means; (6) 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.

"Impairment of Cognitive Ability" means a deterioration or loss in intellectual capacity requiring substantial supervision for protection of self or others, as established by the clinical diagnosis of any licensed practitioner in this state authorized to make such a diagnosis. Such diagnosis shall include the patient's history and physical, neurological, psychological and/or psychiatric evaluations, and laboratory findings.

7. **LIMITATIONS AND EXCLUSIONS.**

(a) **PRE-EXISTING CONDITIONS.** This policy does not have a pre-existing condition limitation.
(b) **NON-ELIGIBLE FACILITIES/PROVIDERS.** Long Term Care Facility benefits are not provided for confinement in a facility, or its sections, which is primarily a hospital or clinic, boarding home, or a place which operates primarily for the treatment of alcoholics or drug addicts.
(c) **NON-ELIGIBLE LEVELS OF CARE.** The policy will not provide benefits for care or services by unlicensed or uncertified providers to the extent that such licensing or certification is required in the state in which the care is given.
(d) **EXCLUSIONS AND EXCEPTIONS.** We will not pay benefits for any care services that are:
    (1) Provided without charge in the absence of insurance; or
    (2) Provided outside of the United States of America or its territories or possessions; or
    (3) Provided by or in a Veteran's Administration or federal government facility, unless a valid charge is made to you or to your estate; or
    (4) Resulting, directly or indirectly, from attempted suicide or an intentionally self-inflicted injury while sane or insane, occurring after you become insured under the policy;
    (5) For care which results from participation in a felony, riot, or insurrection;
    (6) Resulting, directly or indirectly, from your alcoholism or addiction to drugs or narcotics. This does not include addiction which results from drugs or narcotics taken as prescribed by a physician;
    (7) Resulting from war or act of war (declared or undeclared); or

(8) Due to a condition for which you can receive benefits under Workers' Compensation, Employer's Liability or the Occupational Disease Act or Law; or
(9) Not included in a Plan of Care; or
(10) Provided in a governmental facility (unless otherwise required by law); benefits provided under Medicare or other governmental program (except Medicaid); any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

**THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.**

8. **RELATIONSHIP OF COST OF CARE AND BENEFITS.** Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted.

(a) Except as described in number 14 – Offer of Inflation below, your benefit levels will not increase over time.
(b) You are allowed to select the **Elimination Period** and the **Benefit Period** for the benefits of Your coverage.
(c) No additional underwriting or health screening will be required for the purchase of any optional benefits beyond what is required by the policy, if application for optional benefits is made at the time of application for the policy.
(d) There will be an additional premium charge imposed for purchasing the optional benefit riders for this plan. See the attachment to this Outline of Coverage for an illustration of the optional inflation benefit.

9. **TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

(a) **RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. Loyal American Life Insurance Company cannot change any of the terms of your policy on its own, except that, in the future, **IT MAY INCREASE THE PREMIUM YOU PAY.**

We may change your premium rates. Any change will apply to all policies in the same class as yours in the state where the policy was issued. We must give you at least 60 days written notice before we change your premium.

(b) **WAIVER OF PREMIUM BENEFIT.** We will waive any premium that becomes due after 90 days of covered Appropriate Long Term Care services are provided in accordance with a written plan of care. The 90 days of covered Appropriate Long Term Care services must be received within 365 days of the 1st date Appropriate Long Term Care services are received. Days when covered services are received which are used to satisfy the Elimination Period can be used to satisfy the qualifications for this benefit. Days when covered services are received which do not satisfy the Elimination period cannot be used to satisfy the qualifications for this benefit. Also, after the waiver of premium starts, we will return the pro-rata portion of any premium you paid for that period during which you qualified for the waiver of premium.

You must pay any premium that becomes due after you are no longer eligible to receive benefits under this Waiver of Premium Benefit provision, including the pro-rata premium for the period from the end of your eligibility to the next premium due date.

(c) **OPTIONAL DUAL WAIVER OF PREMIUM BENEFIT.** (This benefit is included only if you and

your spouse elect rider form L-6012 Series.)

☐ **Selected** ☐ **Not Selected**

When the premium under your spouse's policy with us is waived due to receiving appropriate long term care during a plan of care, we will also waive any premium that becomes due for your policy if:

(1) Both you and your spouse have long term care insurance in force with us, other than under a Nonforfeiture Benefit, on the date your spouse's premium is waived.

(2) Both you and your spouse have a Dual Waiver of Premium Benefit in force with us on the date your spouse's premium is waived.

We will also return the pro-rata portion of any premium you have paid for the period after your spouse's premium is waived.

You must pay any premium that becomes due after your spouse's premium is no longer waived.

10. **ALZHEIMER'S DISEASE ,OTHER ORGANIC BRAIN DISORDERS, AND BIOLOGICALLY BASED BRAIN DISEASES/SERIOUS MENTAL ILLNESS.** If You meet the eligibility requirements described in the "Eligibility for Benefits" found in the paragraph 6 of this Outline, this policy will provide benefits because of a clinical diagnosis of Alzheimer's Disease or related degenerative illnesses and illnesses involving dementia, or due to biologically based brain diseases/serious mental illnesses, including schizophrenia, paranoid and other psychotic disorders, bipolar disorders (mixed, manic, and depressive); major depressive disorders (single episode or recurrent); and schizo-affective disorders (bipolar or depressive).

11. **PREMIUM.**

(a) The total annual premium for the policy is $ ______________

(b) The premium factors for the following optional benefits, if selected, is:

| | |
|---|---|
| Automatic or Guaranteed Purchase Option Benefit | $ ______________ |
| Dual Waiver of Premium Benefit | $ ______________ |
| Shortened Benefit Period Nonforfeiture Benefit | $ ______________ |
| Shared Extended Expense Benefit | $ ______________ |
| Restoration of Benefits | $ ______________ |
| Survivorship Benefit | $ ______________ |

GRACE PERIOD

You are allowed a 65-day grace period for late payment of each premium due after the first premium. Your policy will remain in force during this period.

If You do not pay Your premium by the end of the grace period, the policy will terminate

12. **TEXAS DEPARTMENT OF INSURANCE'S CONSUMER HELP LINE.**

You may call the Texas Department of Insurance's Consumer Help Line at 1-800-252-3439 for agent, company, and any other insurance information, and 1-800-599-SHOP to order publications related to long term care coverage, and the Texas Department of Aging at 1-800-252-9240 to receive counseling regarding the purchases of long term care or other health care coverage.

13. **DENIAL OF APPLICATION**

If We deny Your application for long term care insurance, We will refund any premiums paid within 30 days of such denial.

14. **OFFER OF INFLATION PROTECTION**

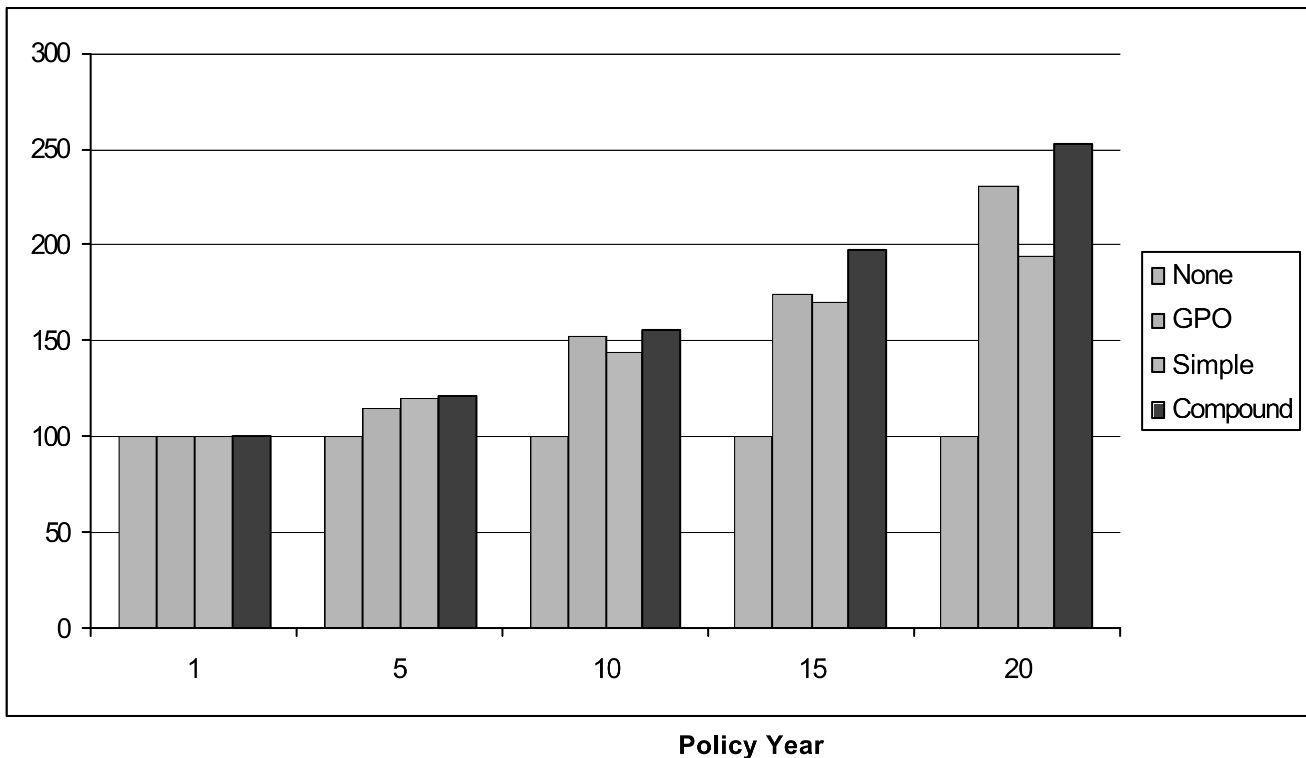
On each Policy anniversary, We will increase Your Maximum Daily Benefit Levels of any of the benefits, if selected, by the percentage stated in the rider. If the Compound Inflation Rider is selected, the increase will be compounded annually through compound inflation. If the Simple Inflation Rider is selected, the increase will be determined through simple inflation. A graphical demonstration of the benefit increases over a 20 year period associated with these inflation riders below.

If you do not select a Compound Automatic Increase Benefit Rider or a Simple Automatic Increase Benefit Rider, you may purchase Guaranteed Purchase Option Rider. This Guaranteed Purchase Option is not designed to be long term inflation protection but only provides the option to buy additional coverage every 3 years without additional underwriting or health screening.

See the following chart which illustrates Long Term Care Facility benefits over time without any increase benefit rider, with the automatic increase benefit riders and with the guaranteed purchase option rider.

**Facility Benefits Over Time**

**Maximum Daily Facility Benefit**




There will be an additional premium charged for the amount of the increase in the Maximum Daily Facility Benefit, the Maximum Lifetime Benefit and any Maximum Daily Home and Community Care Benefit. The premium for the increase will be based on your age as of the date your acceptance of this offer is received in our Administrative Office and the premium rates then in effect.

15. **OFFER OF NONFORFEITURE BENEFIT**

**OPTIONAL SHORTENED BENEFIT PERIOD NONFORFEITURE BENEFIT.** (This benefit is included only if you elect rider form L-6006 Series.)

☐ **Selected** ☐ **Not Selected**

The Nonforfeiture Benefit provides for continuation of coverage during your lifetime if you stop paying premiums after the policy has been in force at least 3 consecutive years. The benefits payable for any Appropriate Long Term Care that begins after the Nonforfeiture Date, as defined below, will be subject to the following limits:

(1) The daily and lifetime benefit maximums will be the amounts in effect on the Nonforfeiture Date.

(2) The maximum benefit we will pay for all Appropriate Long Term Care received after the Nonforfeiture Date is the greater of:
   a. 100% of the sum of all premiums paid for the policy, excluding any waived premiums; or
   b. 30 times the Maximum Daily Facility Benefit in effect on the Nonforfeiture Date.

However the total benefits payable under the policy, including the Nonforfeiture Benefit, will not exceed the amount that would have been payable if you had continued to pay the premium. Benefits will be payable in accordance with all the other terms and conditions of the policy.

The Nonforfeiture Date is the date that coverage under the policy would otherwise end in the absence of this Nonforfeiture Benefit. The Nonforfeiture Date cannot be less than 3 years after the rider effective date.

The premium for the Nonforfeiture Benefit is shown in paragraph 11 “Premium”. Electing the Nonforfeiture Benefits will increase your premium 15% if you purchase the coverage at age 40.

NUMERICAL EXAMPLE OF NONFORFEITURE OPTION

$1,000 Annual Premium, issue age 40

| For Lapse at Age | Total Premium Paid (No Claims) | Total Rider Premium | Non-Forfeiture Benefit Allowance |
|---|---|---|---|
| 40 | $1,000 | $ 150 | none |
| 50 | $10,000 | $1,500 | $10,000 |
| 60 | $20,000 | $3,000 | $20,000 |
| 70 | $30,000 | $4,500 | $30,000 |
| 80 | $40,000 | $6,000 | $40,000 |

**CONTINGENT BENEFIT UPON LAPSE.** The following benefit is added to your policy if you reject the Shortened Benefit Period Nonforfeiture Benefit Rider.

If a change in your premium rate results in a substantial premium increase, we will provide you with the following options on or before the effective date of the substantial premium increase:

(1) Offer to reduce the policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) Offer to convert the coverage to a paid-up status with a shortened benefit period. This option may be elected at any time during the 120-day period following your premium due date; and

(3) Notify you that a default or lapse at any time during the 120-day period shall be deemed to be the election of the offer to convert referred to in point 2. above.

16. **DISCLOSURE REGARDING FEDERAL TAX TREATMENT OF LONG TERM CARE INSURANCE POLICY.**

This Policy Is Not Intended To Be A Qualified Long Term Care Insurance Contract Under Section 7702b (B) Of The Internal Revenue Code Of 1986, As Amended. You Should Consult With Your Attorney, Accountant, Or Tax Advisor Regarding The Tax Implications Of Purchasing Long Term Care Insurance.

17. **ADDITIONAL FEATURES.**

(a) Medical underwriting is used for the policy. Your eligibility for coverage is based on the answers to the medical questions in the application.

(b) **OTHER IMPORTANT FEATURES.**

**UNINTENTIONAL LAPSE PROTECTION.** You have the right to name an individual (friend or relative) to receive notice when your policy will lapse because the premium has not been paid. This notice will be sent no earlier than 30 days after the date the premium is due. The policy will not terminate until 30 days after such notice is given. We will consider you and the person(s) you named notified as of 5 calendar days after the mailing date. If Your premium remains unpaid at the end of the Grace Period, You will receive written notice that the policy has lapsed and is no longer in force.

If the policy should terminate for non-payment of premium because you were Functionally Disabled under the policy, we will reinstate the policy without requiring evidence of insurability if you or your authorized representative request it within 6 months following the termination.

**PUTTING THE POLICY BACK IN FORCE AFTER NONPAYMENT OF PREMIUM WHEN YOU ARE FUNCTIONALLY DISABLED.** Within 6 months following termination of Your policy for non-payment of premium, You, or any person authorized to act on Your behalf, may request reinstatement of Your policy on the basis that You suffered from Impairment of Cognitive Ability or functional incapacity, or if You would otherwise qualify for benefits under the policy, at the time of policy termination or at the end of the grace period.

We will require evidence of clinical diagnosis or tests demonstrating that You suffered from Impairment of Cognitive Ability or functional incapacity at the time of policy termination. If such demonstration substantiates, to Our satisfaction, the existence of Impairment of Cognitive Ability or functional incapacity at the time of policy termination, We will reinstate Your policy. The clinical diagnosis and tests will be at Your expense. Functional incapacity means the inability to perform at least 2 Activities of Daily Living.

# Notes

# SeniorClass
## Long-Term Care

# Improving Your Quality of Life

### FREEDOM OF CHOICE

With SeniorClass, you always have the freedom to choose your own doctors and facility for care.

### LOYAL AMERICAN LIFE INSURANCE COMPANY SM

Loyal American Life Insurance Company SM is a subsidiary of Great American Life Insurance Company, part of Great American Financial Resources. Loyal American Life Insurance Company SM has emphasized financial strength for the protection of its policyholders. The Company is rated "A (Excellent)" by A.M. Best Company.

On behalf of your professional representatives, Loyal American Life Insurance Company SM welcomes you to become part of our family of financial services.

*Ask your Agent for information on any of our Quality Products.*
*We are here to serve you…*

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