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New Business and Underwriting – Short Term Care

Scenario 1

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- An application is submitted for Fred Smith. There are no medications listed on the application and all health questions are marked no
- Upon reviewing the prescription history, the underwriter notices that within the last 2 years the following medications have been filled:
  - Antibiotics
  - Anti-fungal cream
  - Vaccinations
  - Tramadol/ Refills
- There is nothing alarming here
- The applicant is not taking any on-going medications
- The medications Mr. Smith has taken do not indicate he has a condition that we underwrite for
- No phone interview needed
- OK to proceed to approve

Scenario 2

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- The underwriter receives an application for Michelle Jackson. All health questions are marked NO
- The medication history listed within the last 3 years shows the following:
  - Metformin (oral diabetes medication)
  - Actos (oral diabetes medication)
  - Novolin Injection (20 units daily)
  - Tresiba (Injection) is noted with numerous fills, the most recent was within the last **3 months.**
- Since the prescription history shows a new medication that is not on the application and for a condition we underwrite for, we would conduct phone interview to get clarification for the Tresiba.
- Health Questions Part 2 1B:
  - Within the past 24 months, have you been diagnosed with, received treatment for, or been prescribed medication for any of the following conditions by a medical professional:
  - Diabetes that requires more than 50 units of insulin daily or more than 2 oral and 1 injectable medication.
- Outcome: Approve with a maximum of $100 a day benefits and no inflation rider. Within the last two years, Michelle HAS taken above the threshold of 2 oral and 1 injectable medication.

Scenario 3

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- Upon receiving an application for George Glass, the underwriter notices that the health questions for PART II are not filled out.
- Mr. Glass is applying for Simple Inflation and $200 a day of coverage for both the HHC and HI riders.
- The underwriter would run the prescription history and make note of any medications (if any).
- A phone interview would be necessary to ask the health questions in section 2 and question any medications noted in the prescription history.

Scenario 4

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- The underwriter has the application for Mandy Hattan. The health questions are all marked no, and the prescriptions are listed.
- The reason given for Digoxin and Carvedilol use is listed on the application as “heart”.
- Heart is not a definitive diagnosis:
  - the underwriter would request a phone interview to rule out heart failure.
- Health Questions Part 2 1A:
  - Within the past 24 months, have you been diagnosed with, received treatment for, or been prescribed medication for any of the following conditions by a medical professional:
    - Stroke, transient ischemic attack (TIA), **congestive heart failure (CHF**), or organ transplant (other than corneal transplant).
    - Med Recs may need to be requested to determine the reason for the medications.
- Ok to proceed to approve if there is no CHF.

Health App Questions Part 1 (Declines)

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HEALTH QUESTIONS – PART I (If any answer to questions 1-5 below is "YES", you are not eligible for coverage)	APPLICANT A	APPLICANT B
1. Have you been treated or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or tested positive for human immunodeficiency virus (HIV) infection?	❑ Yes ❑ No	❑ Yes ❑ No
2. Is any applicant currently eligible for Medicaid or on early Medicare due to disability (prior to age 65) or disabled?	❑ Yes ❑ No	❑ Yes ❑ No
3. Are you currently:		
a. Receiving assistance or supervision to perform activities of daily living such as bathing, dressing, eating, toileting, getting in or out of bed, or have an inability to control bowel or bladder function?	❑ Yes ❑ No	❑ Yes ❑ No
b. Receiving home health care services, or confined in a rehabilitation facility, nursing facility, or assisted living facility?	❑ Yes ❑ No	❑ Yes ❑ No
c. Being treated, or have you been diagnosed, by a medical professional for Alzheimer's Disease, dementia, Parkinson's Disease (stage 4 or 5), Huntington's Chorea, or cognitive impairment?	❑ Yes ❑ No	❑ Yes ❑ No
d. Receiving treatment by a medical professional for diabetic complications resulting in neuropathy, proliferative retinopathy, kidney disease or failure, renal insufficiency, or kidney dialysis?	❑ Yes ❑ No	❑ Yes ❑ No
e. Receiving treatment by a medical professional for insulin dependent diabetes in conjunction with heart failure?	❑ Yes ❑ No	❑ Yes ❑ No
4. Within the past 12 months, have you been advised to have tests, treatment, or surgery that has not yet been performed or have pending test results?	❑ Yes ❑ No	❑ Yes ❑ No
5. Within the last 24 months, have you been diagnosed with, received treatment for, or been prescribed medication for any of the following conditions by a medical professional: Cancer (other than skin cancer in situ), leukemia, lymphoma, malignant melanoma, or cancer that has spread from its original site?	❑ Yes ❑ No	❑ Yes ❑ No

Health App Questions Part 2 (Reduction of Benefits)

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[HEALTH QUESTIONS – PART II (If any answer to question 1 below is "YES", any simple inflation benefit is not available, and the applicant will be limited to a maximum of $100 of daily benefit on the base Policy, Home Health Care Rider, and Hospital Indemnity Rider).	APPLICANT A	APPLICANT B
1. Within the past 24 months, have you been diagnosed with, received treatment for, or been prescribed medication for any of the following conditions by a medical professional:		
a. Stroke, transient ischemic attack (TIA), congestive heart failure (CHF), or organ transplant (other than corneal transplant)?	❑ Yes ❑ No	❑ Yes ❑ No
b. Diabetes that requires more than 50 units of insulin daily or more than 2 oral and 1 injectable medications?	❑ Yes ❑ No	❑ Yes ❑ No
c. Systemic lupus, multiple sclerosis, muscular dystrophy, cerebral palsy, motor neuron disease, Lou Gehrig's disease (ALS), psychotic disorders, alcohol, or substance abuse or any other neurological or neuromuscular disease?	❑ Yes ❑ No	❑ Yes ❑ No
d. Amputation caused by disease?	❑ Yes ❑ No	❑ Yes ❑ No
e. Chronic obstructive lung or pulmonary disease (COPD), chronic bronchitis or emphysema, respiratory disease requiring the use of oxygen, or chronic liver disease?	❑ Yes ❑ No	❑ Yes ❑ No]

Short Term Care App

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Application Page 1

Applicants A and B
Beneficiary
Special Requests

Standard Life
AND CASUALTY INSURANCE COMPANY
A ManhattanLife Company

Standard Life and Casualty Insurance Company
Home Office: Salt Lake City, UT
Administrative Office: [P.O. Box 510690, Salt Lake City, UT 84151-0690]
[(800)327-0695]

APPLICATION FOR SHORT-TERM CARE INSURANCE

❑ New Application ❑ Reinstatement Policy No._____ Group No. _____

APPLICANT A – PROPOSED INSURED'S INFORMATION		
Proposed Insured's Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)	Gender (M/F)
Address (Street, City, State, ZIP Code)		
Telephone Numbers (Home, Work, and Cell)		Social Security No.
Beneficiary Name	Requested Future Effective Date **Effective Date will be the date the application is approved by the Company or a future date, whichever is later.*	
Beneficiary Relationship	Mail Policy to: ❑ Agent ❑ Policyowner ❑ Email (Email is available for the Policyowner if the email consent authorization is signed.)	
Special Requests Section		

APPLICANT B – PROPOSED INSURED'S INFORMATION		
Proposed Insured's Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)	Gender (M/F)
Address (Street, City, State, ZIP Code)		
Telephone Numbers (Home, Work, and Cell)		Social Security No.
Beneficiary Name	Requested Future Effective Date **Effective Date will be the date the application is approved by the Company or a future date, whichever is later.*	
Beneficiary Relationship	Mail Policy to: ❑ Agent ❑ Policyowner ❑ Email (Email is available for the Policyowner if the email consent authorization is signed.)	
Special Requests Section		

Existing Coverage and Spousal Discount

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EXISTING COVERAGE(S)/REPLACEMENT(S)/ELIGIBILITY	APPLICANT A	APPLICANT B
1. Do you have any similar insurance coverage for which you are applying for currently in force?	❑ Yes ❑ No	❑ Yes ❑ No
a. If "**YES**," provide type of contract or policy number, and the name of company: _____		
b. If replacement is involved, have you received a replacement form (in states required by law)?	❑ Yes ❑ No	❑Yes ❑ No

SPOUSAL DISCOUNT INFORMATION

To qualify for a spousal discount, you and your spouse who resides with you in the same household must have short-term facility care coverage with Standard Life and Casualty Insurance Company or any of this Company's affiliates. Please indicate the following:

1. Is your spouse applying for coverage? ❑ Yes ❑ No

2. Does your spouse have a short-term care policy with Standard Life and Casualty Insurance Company or any of this Company's affiliates? If "**YES,**" provide the following information about your spouse: ❑ Yes ❑ No

Spouse's Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)	Social Security No.	Policy No.

Page 2- Benefit Selection

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APPLICANT A - INSURANCE APPLIED FOR

Short-Term Facility Care Insurance Policy

❑ Maximum Daily Base Benefit Amount $[50-600 in $10 increments] $_____

Elimination Period
[❑ 0 ❑ 20 ❑ 30 ❑ 60 ❑ 90 ❑ 100]

Benefit Period
[❑ 90 ❑ 180 ❑ 270 ❑ 360]

[Prescription Drug
[❑ $300 ❑ $500 ❑ $700]]

[Home Health Care Benefit Rider

❑ Maximum Daily Base Benefit Amount $[50-600 in $10 increments] $_____

Elimination Period
[❑ 0 ❑ 20 ❑ 30 ❑ 60 ❑ 90 ❑ 100]

Benefit Period
[❑ 90 ❑ 180 ❑ 270 ❑ 360]]

[Simple Inflation Protection

❑ Yes ❑ No
(If "**Yes**," the simple inflation protection applies to Short-Term Facility Care [and Home Health Care, if You choose the Home Health Care Rider])]

[Hospital Indemnity Benefit Rider

❑ Maximum Daily Base Benefit Amount $[50-300 in $10 increments] $_____

Benefit Period
[❑ 3 ❑ 6 ❑ 10 ❑ 20]]

In the last 24 months, have you used any tobacco products? ❑ Yes ❑ No

APPLICANT A - TOTAL PREMIUM: $_____
Total Premium does not include Your one-time, $25 policy fee

Page 2- Benefits for Applicant B

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APPLICANT B - INSURANCE APPLIED FOR

Short-Term Facility Care Insurance Policy

❑ Maximum Daily Base Benefit Amount $[50-600 in $10 increments] $_____

Elimination Period
[❑ 0 ❑ 20 ❑ 30 ❑ 60 ❑ 90 ❑ 100]

Benefit Period
[❑ 90 ❑ 180 ❑ 270 ❑ 360]

[Prescription Drug
[❑ $300 ❑ $500 ❑ $700]]

[Home Health Care Benefit Rider

❑ Maximum Daily Base Benefit Amount $[50-600 in $10 increments] $_____

Elimination Period
[❑ 0 ❑ 20 ❑ 30 ❑ 60 ❑ 90 ❑ 100]

Benefit Period
[❑ 90 ❑ 180 ❑ 270 ❑ 360]]

[Simple Inflation Protection

❑ Yes ❑ No

(If "**Yes**," the simple inflation protection applies to Short-Term Facility Care [and Home Health Care, if You choose the Home Health Care Rider])]

[Hospital Indemnity Benefit Rider

❑ Maximum Daily Base Benefit Amount $[50-300 in $10 increments] $_____

Benefit Period
[❑ 3 ❑ 6 ❑ 10 ❑ 20]]

In the last 24 months, have you used any tobacco products? ❑ Yes ❑ No

APPLICANT B - TOTAL PREMIUM: $_____

Total Premium does not include Your one-time, $25 policy fee

Page 3- After the Health Questions

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[PRESCRIPTION DRUG QUESTIONS – PART III (You must answer this question)				APPLICANT A	APPLICANT B
Has any applicant taken or been prescribed drugs by a medical professional in the last 24 months? If "**Yes**" complete the chart below.				❑ Yes ❑ No	❑ Yes ❑ No
APPLICANT A	**APPLICANT B**	**Prescribed Medication**	**Date Prescribed**	**Frequency and Dosage**	**Diagnosis/onset Date**
❑	❑				
❑	❑				
❑	❑				
❑	❑				
❑	❑				
❑	❑				
❑	❑				
❑	❑				]

Page 4- Authorization to obtain prescription history

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AUTHORIZATION AND SIGNATURE

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, MIB, LLC (MIB), Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health or having any non-medical information concerning me to give to the Standard Life and Casualty Insurance Company (the Company) or its reinsurers, any such information. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal law governing privacy and confidentiality. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

I authorize Standard Life and Casualty Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB, LLC.

I understand that I am authorizing the Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by the Company will remain protected by federal and/or state regulations.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with the Company.

Page 4- Agent Certification

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THE EFFECTIVE DATE OF THE POLICY WILL BE THE DATE RECORDED BY THE ADMINISTRATIVE OFFICE. IT IS NOT THE DATE THIS APPLICATION IS SIGNED.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at _____, on _____ X _____
(City and State) (Month/Day/Year) Applicant A's signature (or their authorized representative)

Signed at _____, on _____ X _____
(City and State) (Month/Day/Year) Applicant B's signature (or their authorized representative)

AGENT(S) STATEMENT: I, the undersigned agent, also certify that to the best of my knowledge, replacement ❑ is ❑ is not involved at this time.

X _____	_____	_____	_____ %	_____
Signature of Agent	Printed Agent's Name	Agent No.	% Credit	State ID No.
X _____	_____	_____	_____ %	_____
Signature of Agent	Printed Agent's Name	Agent No.	% Credit	State ID No.

NOTICE: All premium checks must be made payable to Standard Life and Casualty Insurance Company. Do not make the check payable to the agent or leave the payee blank.

Page 5- Email Consent

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APPLICANT A - EMAIL CONSENT AUTHORIZATION

- ❑ I give my written consent to allow Standard Life and Casualty Insurance Company (the Company) to communicate with me by email to the address(es) listed below. I confirm that I have authorization to provide consent for email to the email address(es) that I provide below and further agree to indemnify and hold harmless the Company for any action or loss arising from any incorrect or false email address(s) provided below. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation.
- ❑ I decline to give consent to the Company to communicate with me by email. (Do not provide email addresses below)

Primary email address:_____

Secondary email address: _____

Signature:_____ Date: _____

Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided by the policyholder should be aware that the insurer rightfully considers this election to be consent by the applicant that all notices may be sent electronically, including notice of non-renewal and notice of cancellation. Therefore, the applicant should be diligent in updating the electronic mail address provided to the insurer in the event that the address should change.

APPLICANT B - EMAIL CONSENT AUTHORIZATION

- ❑ I give my written consent to allow Standard Life and Casualty Insurance Company (the Company) to communicate with me by email to the address(es) listed below. I confirm that I have authorization to provide consent for email to the email address(es) that I provide below and further agree to indemnify and hold harmless the Company for any action or loss arising from any incorrect or false email address(s) provided below. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation.
- ❑ I decline to give consent to the Company to communicate with me by email. (Do not provide email addresses below)

Primary email address:_____

Secondary email address: _____

Signature:_____ Date: _____

Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided by the policyholder should be aware that the insurer rightfully considers this election to be consent by the applicant that all notices may be sent electronically, including notice of non-renewal and notice of cancellation. Therefore, the applicant should be diligent in updating the electronic mail address provided to the insurer in the event that the address should change.

Page 5- Payment and Banking Information

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PAYMENT OPTIONS AUTHORIZATION

❑ **Payroll Deduction (Listbill)**

Assigned list bill number, if known:_____

I hereby authorize my employer to deduct from my salary and pay to Standard Life and Casualty Insurance Company the premium.

❑ **Automatic Bank Draft (Electronic Funds Transfer)**

❑ Monthly ❑ Quarterly ❑ Semi-Annually ❑ Annually

Type of Account: ❑ Checking ❑ Savings

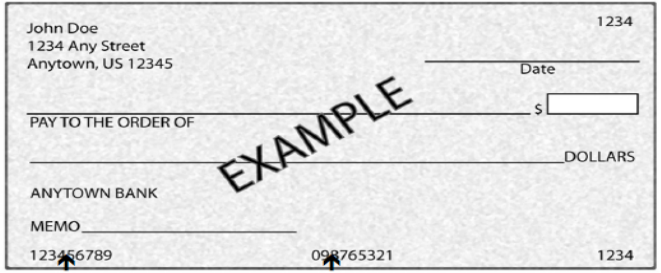
Desired withdrawal date (Between the 1st and the 28th)_____

Bank name:_____

City:_____ State:_____

Routing number (9 Digits):_____

Account number:_____



Routing Number Account Number

Authorization for Electronic Funds Transfer (EFT)

I (we) hereby authorize Standard Life and Casualty Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Accountholder's Signature_____ Date_____

❑ **Direct Billing** ❑ Quarterly ❑ Semi-Annually ❑ Annually

If your billing address is different than your home address, please enter it below:

Billing Address: _____

(Street) (City) (State) (Zip)

Name of person paying, if different: _____

Page 6- Fair Credit Reporting

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Notice of Information Practices
Including Fair Credit Reporting Act Notice and MIB, LLC Notice

To obtain further information, contact
Standard Life and Casualty Insurance Company
[P.O. Box 510690 Salt Lake City, UT 84151-0690]

Thank you for your application. It is the major source of information about you which we use in evaluating your application and reviewing your policy. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Administrative Office at the above address. You may receive a copy of such report by contacting the reporting agency.

Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency. We will not disclose information about you without your prior written authorization except as permitted by law. In certain situations we may disclose, as allowed by law, all types of nonpublic personal information as is necessary in order to conduct our business.

This could include disclosures to persons or organizations that will use the information for sales purposes, unless you indicate to us that you do not want the information disclosed for this purpose. You have the right to obtain access to certain items of information we have collected about you, andyou have the further right to request correction of information if you feel it is inaccurate. If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our Administrative Office at the address on the front of this Notice.

MIB, LLC Pre-Notice

Information regarding your insurability will be treated as confidential. Standard Life and Casualty Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, LLC (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of insurance companies that are members *of MIB Group, Inc.* If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 *or go to its website* www.mib.com. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184- 8734.

Standard Life and Casualty Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.