

# APPLICATION



## The CalPERS Long-Term Care Program 2 0 0 5

*"Peace of mind begins with a plan."*



**Comprehensive Plan  
Facilities Only Plan  
Partnership Plan**



## Instructions

### **Each person applying for coverage must complete a separate application.**

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

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

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

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

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

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

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

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

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

## Questions?

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

# **A** Applicant Information

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

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

I am a member of:  CalPERS  CalSTRS  Other: \_\_\_\_\_

\_\_\_\_\_  
Name (First) (Middle Initial) (Last)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State ZIP Code

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

\_\_\_\_\_  
Home Phone Number Best Time to Be Reached  A.M.  P.M. Work Phone Number

\_\_\_\_\_  
E-mail Address

Gender:  Male  Female Marital Status:  Married  Single  Widowed  Divorced

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

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

3.  Yes  No Are you currently employed and actively working? If "Yes," how many hours per week? \_\_\_\_\_

4.  Yes  No Are you receiving disability income, workers' compensation, SSI or any other state or federal disability benefits? If "Yes," please give details on nature and source of benefits.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# B Medical Questions

TO BE COMPLETED BY THE APPLICANT

Please answer "Yes" or "No" by checking the box.

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

2. Are you **currently** receiving:

2a  Yes  No Nursing Home Care (in a nursing home or extended care unit of a hospital)?

2b  Yes  No Home Health Care (visiting nurse, therapist or health aide visits)?

2c  Yes  No Adult Day Care Services?

3. Have you **had**, do you **currently have**, or have you **been medically diagnosed** as having any of the following conditions:

3a  Yes  No Organic Brain Syndrome; Memory Loss; Mild Cognitive Impairment; Senility; Dementia; or Alzheimer's Disease?

3b  Yes  No Metastatic Cancer (cancer has spread from original site)?

3c  Yes  No Parkinson's Disease; Mental Retardation; Downs Syndrome; Muscular Dystrophy; Multiple Sclerosis; Myasthenia Gravis; Amyotrophic Lateral Sclerosis (ALS); Huntington's Chorea; Multiple Strokes; Multiple Transient Ischemic Attacks (TIAs); or Hydrocephalus?

3d  Yes  No AIDS or AIDS Related Complex (ARC)?

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

4. Do you **now** use or in the **past 12 months** have you used (check all that apply or **None**):

Oxygen  Quad cane  Walker  Hospital bed in your home  
 Wheelchair  Kidney dialysis  Motorized scooter  **None**

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

5.  Yes  No Have you taken any **prescription medication** during the past six months?

*If you need more space to complete this section, please attach another sheet of paper.*

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

6. Please provide your **height** (ft. and in.)  feet  inches and **weight** (lbs.)

7.  Yes  No Have you used any tobacco products *in the past 24 months*?

If yes, when did you quit? \_\_\_\_\_ Describe type and amount: \_\_\_\_\_

8. Do you **currently** require any human assistance or supervision with any of the following daily activities (check all that apply or **None**):

Shopping  Doing housework  Managing finances  Doing laundry  
 Preparing meals  Using transportation  Taking medications  **None**

9. During the **past three years** have you (check and describe below all that apply or **None of the above**):

- Been medically advised to have surgery that has not been performed?
- Been referred to or consulted a specialist?
- Been referred to or consulted a health care professional other than your primary care physician?
- Been admitted to or medically advised to enter a nursing home or an extended care unit of a hospital?
- Received home care services (visiting nurse, nurse's aide, therapist or meals on wheels)?
- Been a patient in a hospital, emergency room, outpatient surgery or other health care facility?
- Used adult day care services or outpatient therapy (physical or occupational therapy or rehabilitation)?

**None of the above**

Please describe and include dates: \_\_\_\_\_

# B Medical Questions

(Continued)

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

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

11. Please give details below to all boxes checked in **Question #10**.

*If you need more space to complete this section, please attach another sheet of paper.*

Condition Number	Physician’s Name Address and Phone Number	Describe
_____	_____	_____
_____	_____	_____
_____	_____	_____

## C Authorization for Release of Medical Information

THIS SECTION MUST BE COMPLETED

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

Applicant Name (please print) \_\_\_\_\_



Signature of Applicant \_\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date (MM/DD/YY)

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

## D Attending Physician Information

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

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

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____										_____ _____		-		_____ _____		-		_____ _____	
Physician Name										Phone Number									
_____ _____ _____ _____ _____ _____ _____ _____ _____ _____										_____ _____ _____ _____ _____ _____									
Address										City									
_____ _____		_____ _____		_____ _____ _____ _____ _____ _____						_____ _____ _____ _____ _____ _____									
State		ZIP Code		Kaiser* or Medical Record Number (if known)															

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

## E Replacement Coverage Information

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

1.  Yes  No Are you covered by Medicaid (called Medi-Cal in California)?  
(Please note that this is NOT a reference to Medicare.)
2. If you already have another long-term care insurance policy or certificate, you should review that policy carefully and compare its benefits and costs with the benefits and costs of the CalPERS coverage. It may or may not make sense for you to replace that policy or certificate. If you do decide to apply for the CalPERS coverage, you should not cancel any long-term care insurance you currently have unless/until your coverage under the CalPERS Program is effective.  
 Yes  No Are you replacing another long-term care insurance policy or certificate currently in force?  
If yes, please provide the following information:

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____										_____ _____		_____ _____		_____ _____		_____ _____	
Insurance Company Name										Policy Number							
_____ _____ _____ _____ _____ _____ _____ _____ _____ _____										_____ _____ _____ _____ _____ _____							
Insurance Company Address										_____ _____ _____ _____ _____ _____							
_____ _____ _____ _____ _____ _____ _____ _____ _____ _____										_____ _____		_____ _____		_____ _____		_____ _____	
City										State		ZIP Code					

## F Final Billing Designee

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

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

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

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

### Information about your designee:

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____										_____		_____ _____ _____ _____ _____ _____ _____ _____ _____ _____											
Name (First)										(Middle Initial)		(Last)											
_____ _____ _____ _____ _____ _____ _____ _____ _____ _____										_____ _____ _____ _____ _____ _____ _____ _____ _____ _____													
Address										_____ _____ _____ _____ _____ _____													
_____ _____ _____ _____ _____ _____ _____ _____ _____ _____										_____ _____		_____ _____		_____ _____		_____ _____							
City										State		ZIP Code											
_____ _____										-		_____ _____		-		_____ _____							
Home Phone Number																							

You may change the named designee at any time by notifying us in writing at the address on the instruction page.

# G Plan Options

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

## SECTION G 1

Mark an "X" in only one box in each of the four lines below.

1. Type of Plan:  Comprehensive  Facilities Only
2. Daily Benefit Amount (DBA):  \$130  \$150  \$170  \$200  \$250
3. Total Coverage Amount:  Lifetime (Unlimited)  
 Maximum Benefit: 6 years = 2190 x DBA  
 Maximum Benefit: 3 years = 1095 x DBA
4. Inflation Protection (IP):  Built-In 5% IP (Compounded Annually)  
 Benefit Increase Option (BIO)\*

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

I certify that I have reviewed all the information, eligibility criteria and notices contained in this application kit and that all information supplied on this form is true to the best of my knowledge. I also understand and agree that the coverage for which I am applying, if issued, shall be subject to these statements and will take effect on the effective date stated on the Schedule of Benefits. If statements in this application are fraudulent or materially untrue, sanctions which could include rescission of my coverage or benefit denial may be applied.

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

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



Signature of Applicant

		/			/		
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Date

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

## SECTION G 2

Mark an "X" in only one box in each of lines 1 through 3 below.

1. Type of Plan:  Partnership
2. Daily Benefit Amount (DBA):  \$130  \$150  \$170  \$200  \$250
3. Total Coverage Amount:  Maximum Benefit: 1 year = 365 x DBA  
 Maximum Benefit: 2 years = 730 x DBA
4. Inflation Protection (IP): Includes Built-In 5% IP (Compounded Annually)

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

I certify that I have reviewed all the information, eligibility criteria and notices contained in this application kit and that all information supplied on this form is true to the best of my knowledge. I also understand and agree that the coverage for which I am applying, if issued, shall be subject to these statements and will take effect on the effective date stated on the Schedule of Benefits. If statements in this application are fraudulent or materially untrue, sanctions which could include rescission of my coverage or benefit denial may be applied.

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

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



Signature of Applicant

		/			/		
--	--	---	--	--	---	--	--

Date

