The Order of United Commercial Travelers of America • A Fraternal Benefit Society
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, OH 43215
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 800.948.1039 • www.uct.org

APPLICATION FOR SHORT TERM CARE INSURANCE POLICY

Requested Effective Date of Policy

APPLICANT

Last *First* *MI*

AGE	DATE OF BIRTH			SEX
	Month	*Day*	*Year*	☐ Male ☐ Female

SOCIAL SECURITY NUMBER

APPLICANT'S ADDRESS

Street: _____

_____

City: _____

State: _____ *Zip Code:* _____

Telephone: (_____) _____- _____

Underwriting Risk Classification Question

Have you used any form of tobacco in the past two years? ☐ Yes ☐ No

Are you a member of The Order of United Commercial Travelers of America? ☐ Yes ☐ No

Council Name: _____ **Council Location (City & State):** _____

Is your spouse also applying for the Short Term Care Insurance Policy? ☐ Yes ☐ No
If yes, please complete:

Last Name: _____ *First Name:* _____

HEALTH QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS, YOU ARE NOT ELIGIBLE FOR COVERAGE.

1. Do you require assistance or supervision of any kind to perform activities of daily living such as walking, eating, bathing, dressing, transferring or toileting? ☐ Yes ☐ No
2. Do you require assistance with shopping, housekeeping or cooking? ☐ Yes ☐ No
3. During the past two (2) years have you:
   (a) Been a resident of an assisted living facility or personal care home or been confined to a nursing home, home for the aged, or any facility providing assistance with activities of daily living? ☐ Yes ☐ No
   (b) required any assistance with mobility including the use of a walker, multi-pronged cane, walking aids, wheelchair, or scooter? ☐ Yes ☐ No
4. Are you currently bedridden, hospitalized or have you been hospitalized two or more times within the past year? ☐ Yes ☐ No
5. Within the past two years, have you been advised to have kidney dialysis, had a heart attack, stroke or heart valve surgery, been recommended to have surgery but not had such surgery, had or been treated for internal cancer, leukemia or malignant melanoma, Hodgkin's Disease, Parkinson's Disease, disabling arthritis, degenerative bone disease, cirrhosis of the liver, Alzheimer's Disease or alcohol or drug abuse? ☐ Yes ☐ No
6. Have you had or been told by your physician you needed amputation due to disease, you have emphysema, chronic bronchitis, other chronic lung disease, Myasthenia Gravis, Lupus, Multiple or Amyotrophic Lateral Sclerosis, paralysis, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
7. Do you receive Federal, state or local government financial assistance in any form, such as Supplemental Security Income or Medicaid? ☐ Yes ☐ No
8. Are you an insulin dependent diabetic? ☐ Yes ☐ No

BENEFIT OPTIONS

☐ **Short Term Care Insurance Policy** **Maximum Daily Benefit Amount: $** _____ **Elimination Period** ☐ **0 Days** ☐ **20 Days**

Maximum Benefit Period ☐ **100 Days** ☐ **200 Days** ☐ **360 Days**

Optional Riders ☐ **Home Health Care** ☐ **Compound Inflation Protection**

REPLACEMENT INFORMATION (MUST BE COMPLETED)

1. Do you have another insurance policy in force (including health care service contract or health maintenance organization contract)? ..... ☐ Yes ☐ No
2. Did you have another limited benefit policy in force during the last six (6) months? ..... ☐ Yes ☐ No

If yes, with which company: (Name and address): _____

_____

Policy Number: _____ If that policy lapsed, when did it lapse? _____

Daily Benefit Amount: $ _____ Benefit Period _____

Do you intend to replace any of your medical or health insurance coverage with this policy? ..... ☐ Yes ☐ No
If yes, please read and sign the replacement notice provided by the agent.

AUTHORIZATIONS AND SIGNATURES

I hereby apply to The Order of United Commercial Travelers of America (UCT) for a policy to be issued in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. The Order of United Commercial Travelers of America has the right to deny benefits or rescind my Policy. I understand that any change in my health prior to delivery of this policy may be used in the underwriting evaluation process. I have received an outline of coverage for the policy applied for.

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Signed At: _____ **Applicant's Signature:** _____

Dated (Month/Day/Year): _____

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. Is the insurance applied for intended to replace or change any insurance in this or any other Company? ☐ Yes ☐ No
   If "Yes," give details:

   _____

   _____
2. List any other health insurance policy you have sold to the Applicant that is still in force.

   _____

   _____
3. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

   _____

   _____

I certify that: 1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for to the Applicant.

_____ _____

Agent's Signature **Date**

_____ _____

Agent's Printed Name **Agent No.**

AUTHORIZATION & ACKNOWLEDGEMENT
THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or other medical or medically-related facility, insurance company, MIB, Inc., consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or prescription drug usage or having any non-medical information concerning me to give The Order of United Commercial Travelers of America, or its reinsurers, any such information. I understand that I am authorizing The Order of United Commercial Travelers of America to receive my health information or prescription drug usage history and my non-medical information. I understand that when my health information is disclosed pursuant to this Authorization, my medical records and the Information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I authorize The Order of United Commercial Travelers of America, or its reinsurers, to make a brief report of my protected health information to MIB, Inc.

I understand that the information requested is necessary for evaluation of my application and underwriting of my application for the Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issuance 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 Order of United Commercial Travelers of America . I understand that failure to provide the authorization to The Order of United Commercial Travelers of America *will* result in the rejection of the Insurance Policy coverage.

I understand that I may revoke this authorization at any time by notifying The Order of United Commercial Travelers of America in writing at their Home Office: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619. I understand that such revocation will not have any effect on actions The Order of United Commercial Travelers of America took prior to their receiving the revocation notice.

I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under the policy. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative may request to receive a copy of this authorization.

Applicant's Name: _____

Social Security Number: _____ **Date of Birth:** _____

Applicant's Signature: _____ **Date:** _____

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly EFT

Short Term Care Only Premium	**$** _____
Home Health Care Rider Premium	**$** _____
Compound Inflation Protection Rider Premium	**$** _____
SUBTOTAL	**$** _____
Less Spousal Discount (If Applicable)	**$** _____
Less Non-Tobacco Discount (If Applicable)	**$** _____
TOTAL MODAL PREMIUM	**$** _____
Modal Fraternal Dues (If Applicable)	**$** _____
TOTAL MODAL AMOUNT DUE	**$** _____
TOTAL AMOUNT PAID WITH APPLICATION	**$** _____

AUTHORITY TO HONOR PREMIUM CHECKS

AUTHORIZATION

IN FAVOR OF: **The Order of United Commercial Travelers of America**
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619

Name of Bank Customer: _____

Insured's Name: _____

Routing Number: _____ **Account Number:** _____

To (Name of Bank): _____

Address of Bank: _____

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you 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 any such check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Date:	**Signature of Bank Customer:**

AUTHORIZATION

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.
To: Bank above: In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

ATTACH VOIDED CHECK HERE – Deposit Slips NOT Accepted

Application for Membership

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Canadian Office: 901 Centre Street North, Room 300, Calgary, AB T2E 2P6
Tel: 403.277.0745 • Toll-free: 800.267-2371 • Fax: 403.277.6662

Proposed Member Information

Name of council applicant will belong to: _____ Council No.:_____

Council City: _____ State/Prov.: _____

Applicant Name, First: _____ MI: ____ Last: _____

Address: _____City: _____State/Prov.: _____Postal Code: _____

Home Tel.: (_____) _____ Bus. Tel.: (_____) _____

Birthday: _____ - _____ - _____ Social Security No./Social Insurance No.: _____
Month *Day* *Year*

Email Address: _____ Sex: ☐ Male ☐ Female

Is applicant currently insured with UCT? ☐ Yes ☐ No

Has applicant ever been a member of UCT? ☐ Yes ☐ No If "Yes," list member No.: _____

Is applicant's spouse a member of UCT? ☐ Yes ☐ No If "Yes," list member No.: _____

Member Dues Collected (check one)

☐ **Member Dues** – when purchasing insurance .....$30 minimum
☐ **Fraternal Membership** – no insurance purchased ($12 + $18 minimum Member Dues).....$30 minimum

Please enroll me for membership in UCT. I understand UCT is a fraternal benefit society and agree to abide by the Society's Constitution and Bylaws.

Applicant's Signature: **X** _____ Date: _____

For Completion by Sponsoring Member/Agent

This is to certify that I am acquainted with the applicant and hereby recommend the applicant for membership.

Sponsoring Member/Agent's Name *(Please Print)*: _____

Address: _____City: _____State/Prov.: _____Postal Code: _____

Sponsoring Member/Agent No.: _____

Sponsoring Member/Agent's Signature: **X** _____Date: _____

For Completion by Council Secretary if Necessary

Council Action: ☐ Approved ☐ Disapproved

Secretary's Signature: _____Date: _____

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NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by The Order of United Commercial Travelers of America. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

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 interests to make sure you understand all the relevant factors involved in replacing your present coverage.

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.

_____

(Signature of Agent, Broker or Other Representative)

Print Name and Address of Agent: _____

_____

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

_____ _____

(Applicant's Signature) **(Date)**

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SHORT TERM CARE INSURANCE POLICY

OUTLINE OF COVERAGE
POLICY FORM STC 1/09

THE POLICY PROVIDES LIMITED BENEFITS

THE POLICY IS NOT A LONG TERM CARE INSURANCE POLICY ACCORDING TO STATE INSURANCE LAWS AND REGULATIONS

READ YOUR POLICY CAREFULLY - This outline of coverage provides a very brief description of some of the important features of the policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

LIMITED BENEFIT INSURANCE COVERAGE - The policy is designed to provide benefits for convalescent care in a facility that provides nursing care or other benefits specified in the policy.

BENEFITS

Facility Confinement Benefit

Once the Elimination Period is satisfied under the policy, we will pay the actual charges incurred up to the Maximum Daily Benefit Amount for each day you are confined in a Facility.

Bed Reservation Benefit

Once the Elimination Period is satisfied, we will pay the actual charges incurred up to the Maximum Daily Benefit Amount for fees charged to reserve a bed by a Facility when You are absent for any reason during the course of an eligible confinement. This benefit is limited to twenty-one (21) days per Period of Care. Benefits payments will count toward the Maximum Benefit Period.

Qualifying For Benefits

To receive benefits under the policy, the following requirements must be met:

1. The policy must be in force on the date Covered Services are received; and
2. A Physician must certify that:
   a) You are unable to perform at least two (2) Activities of Daily Living without Hands On Assistance or Standby Assistance; or
   b) You have a Cognitive Impairment and require Substantial Supervision.

Limitations On Benefits

Benefits under the policy will not be paid during the Elimination Period and are subject to the Lifetime Maximum Benefit Period.

Important Definitions

Activities of Daily Living means the basic human functions required for you to remain independent. For the purposes of the policy, Activities of Daily Living are as follows: bathing, continence, dressing, eating, toileting and transferring.

Cognitive Impairment means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning or judgment as it relates to safety awareness. Cognitive Impairment is measured by clinical evidence and standardized tests and is based on your impairment as indicated by loss in the following areas:

1. short or long term memory; or
2. recognition of who or where You are; or time of day, month or year; or your deductive or abstract reasoning.

Covered Services means confinement in a Facility (as defined in the policy). Covered Services will be modified to include in Home Health Care, if the optional Home Health Care Rider is listed on the policy schedule page and the premium for the rider is paid.

Elimination Period means the number of Facility Confinement days (or any combination of Facility Confinement care days and Home Health Care days, if the Home Health Care Rider is elected), for which benefits are not payable under the policy. Days counted toward the Elimination Period need not be consecutive. The Elimination Period is shown on the Policy Schedule Page. The Elimination Period must be satisfied only once during the Insured's lifetime and can only be satisfied by days on which you incur charges for which payment would be made under the policy if there were no Elimination Period.

Facility means a facility that provides ongoing care and related services to at least five (5) inpatients in one (1) location and meets all of the following standards:

1. it is licensed by the appropriate licensing agency, if the state in which it operates licenses such facilities; and
2. it is operated pursuant to law; and
3. it is primarily engaged in providing, in addition to room and board accommodations, nursing care (skilled, intermediate or custodial) by or under the supervision of a duly licensed Physician; and
4. it provides twenty-four (24) hour a day care and services sufficient to support needs of persons who require nursing care; and
5. it has appropriate methods and procedures for handling and administering drugs and biologicals; and
6. it maintains a daily medical record of each patient.

A Facility includes a long term care facility, a nursing home facility or an assisted living facility.

A Facility IS NOT: a hospital, Your Home, an adult foster care facility, a facility or part thereof used primarily for rest; or a home or facility for the aged or for the care and treatment of drug and alcohol abuse; or a home or facility used for the care and treatment of Mental or Nervous Disorders or educational care.

Hands On Assistance means the physical assistance of another person without which you would be unable to perform an Activity of Daily Living.

Home means your private residence, home for the retired or aged, or a place providing residential care, including an adult congregate living facility or a personal care facility.

Lifetime Maximum Benefit Period means the maximum number of Facility confinement days (or any combination of Facility confinement days and Home Health Care days, if the Home Health Care Rider is elected) for which benefits are payable under the policy. The Lifetime Maximum Benefit Period is shown on the Policy Schedule Page and is equal to three (3) times the Maximum Benefit Period.

Maximum Benefit Period means the maximum number of Facility confinement days (or any combination of Facility confinement days and Home Health Care days, if the Home Health Care Rider is elected) for which benefits are payable under the policy per Period of Care. The Maximum Benefit Period is shown on the Policy Schedule Page.

Maximum Daily Benefit Amount means the maximum amount payable for any one day of benefits provided under the policy. The Maximum Daily Benefit Amount is shown on the Policy Schedule Page.

Important Definitions

Period of Care means the first day benefits are paid for a Facility confinement (or the first day benefits are paid for either, a Facility confinement or Home Health Care, if the optional Home Health Care Rider is elected). A Period of Care ends, if for a period of 180 consecutive days:

1. You have not met the requirements for benefit eligibility; and
2. Your Physician certifies that You did not require and have not been advised to be confined in a Facility or to receive Home Health Care for the 180 day period; and
3. You have not been confined in a Facility or received Home Health Care for the 180 day period.

Physician means a licensed practitioner of the healing arts operating within the scope of his or her license who is other than a member of your immediate family.

Standby Assistance means the presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, injury to you while you are performing an Activity of Daily Living.

Substantial Supervision means continual supervision, which may include cueing by verbal prompting, gestures, or other demonstrations by another person that is necessary to protect You from threats to your health or safety.

Exclusions: We will not pay benefits for that portion of any expense which is:

1. caused by Mental or Nervous Disorder, without demonstrable organic disease **(NOTE: ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN SYNDROMES ARE COVERED BY THIS POLICY AS ANY OTHER SICKNESS);** or
2. caused by alcoholism or drug addiction; or
3. caused by illness, treatment or medical conditions arising out of:
   a) war or act of war (whether declared or undeclared); or
   b) participation in a felony, riot or insurrection; or
   c) service in the armed forces or units auxiliary thereto; or
   d) suicide (while sane or insane), attempted suicide or intentionally self-inflicted injury; or
4. for treatment provided in a government facility (unless otherwise required by law), services for which benefits are available 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; or
5. for services provided by a member of Your Immediate Family ; or
6. for services for which no charge is normally made in the absence of insurance; or
7. for care received outside the United States or its territories.

Guaranteed Renewable For Life - Premium Subject To Change. The policy is renewable as long as you live, provided you continue to pay premiums when due. At no time while you continue your policy in force, may we place any restrictive riders on your coverage. We cannot cancel or refuse to renew the policy. Your premiums will not increase due to a change in your age or health. We can, however, change your premiums but only if we change premiums for all policies in the same premium class with the same policy form number in your state. We must give you at least thirty (30) days written notice before we change your premiums.

Premium.

You have selected the following benefits for the Base Policy:

Maximum Daily Benefit Amount **$_____**

Elimination Period **_____Days**

Maximum Benefit Period **_____Days**

Lifetime Maximum Benefit Period **_____Days**

Check **[X]** for one of the following **Base Policy Option and Optional Riders** applied for:

☐ The annual premium for the **Base Policy Form** **$ _____**

☐ The annual premium for the **Base Policy Form With the Compound Inflation Protection Rider** **$ _____**

☐ The annual premium for the **Base Policy Form With the Guaranteed Purchase Option Rider** **$ _____**

☐ **Home Health Care Rider** **$ _____**

TOTAL ANNUAL PREMIUM **$ _____**

FOR AGENT USE ONLY

Short-Term Care Application Submission Checklist:

☐ Complete Application

☐ Collect premium amount (Please remember to include membership dues – a minimum of $30 annually, $15 semi-annually, $7.50 quarterly, or $2.50 monthly)

☐ Complete Application for Membership (M-81 Rev. 0813)

☐ Provide client with Outline of Coverage

☐ Provide client with Receipt

☐ Complete Replacement Notice and leave copy with the applicant if necessary

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PREMIUM RECEIPT

Make check payable to UCT.

Received from _____ the sum of $_____.

If, for any reason, the policy is not issued, payment will be refunded in full in a timely manner. Insurance is not effective until the application is approved, the premium has been paid and the policy is issued.

Date: _____ Licensed Resident Agent: _____

NOTICE TO APPLICANT

In making this application for insurance to The Order of United Commercial Travelers of America, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

Information regarding your insurability will be treated as confidential. The Order of United Commercial Travelers of America, or its reinsurer, may; however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information about you 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. If you question the accuracy of the 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, Braintree, Massachusetts 02184-8734.

The Order of United Commercial Travelers of America, or its reinsurer, may also release information from its file to other insurance companies to whom you 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.

Leave with Applicant

Where Community and Compassion Unite

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