National Peace Officers and Fire Fighters Benefit Association

Long Term Care Application

Protecting Those Who Protect the Public

A Jointly Sponsored Long Term Care Trust of The California Law Enforcement Association® and The California Association of Professional Firefighters®

Instructions for Completing This Application

This Application must be completed by the Applicant.

When the Applicant signs this application he/she is making a certification under penalty of perjury that all answers are true and correct to the best of his/her knowledge.

NOTE: Employee and Spouse must complete separate applications.
All Incomplete Applications will be returned.

An application will be considered incomplete for any of the following reasons:

- The signature blocks are not signed.
- The medical questions are not thoroughly explained.
- Any question or field is left blank.

All applications will be individually underwritten. If necessary, we will obtain your medical records and/or request a short paramedical exam to assist us in the underwriting process.

All spouses applying for coverage are required to complete a paramedical exam at the expense of NPFBA as part of the underwriting process.

Please mail your completed application in the postage-paid envelope provided.

If this envelope was not provided to you, please mail to:

NPFBA
Long Term Care Plan
PO Box 31
Martell, CA 95654-0031

Once your application is approved you may be required to sign the "Statement of Continuing Good Health" before coverage will be issued.

If you have any questions about this Plan or if you need assistance in completing your application, please call toll free 877-582-0003, option #2.

OFFICE USE ONLY

Field Service Manager: _____

Employees and their eligible spouses may apply for coverage through this Association.

All Applicants must complete all questions and sign and date where indicated.

Applicant must be age 60 or less and must fall into one of the following categories:

1. Member of police department or fire department of municipal or public corporation or district including volunteers or reserves.
2. Peace or law enforcement officer who is a regular and salaried officer or employee of the state or of a single county or other political subdivision or public or municipal corporation.
3. Person who is an emergency medical services personnel and employed by a fire department of a city, county or district.
4. Person who at the time of becoming a member of such associations was qualified pursuant to paragraphs 1, 2, or 3 above.
5. Spouse of qualified employee pursuant to paragraphs 1, 2, or 3 above.
6. Retirees may not apply unless they are otherwise qualified in one of the above sections.

The above list of qualified applicants would generally include County DA Investigators, County Probation Officers with peace officer status, State of California Investigators with peace officer status, Correctional Officers with the Department of Corrections of the State of California, California Highway Patrol Officers, County Correctional Officers, Firefighters, and CalFire Firefighters. Others who believe they qualify and are not listed above must contact the Plan Administrator to determine eligibility.

I certify under penalty of perjury that I have read the above statement and agree that I qualify under the requirements stated above.

_____ _____

Applicant **Date**

Have you met or discussed this coverage with a representative of NPFBA? ❑ Yes ❑ No

Name of representative: _____

If no, how did you hear about NPFBA Long Term Care Plan?

❑ Referral ❑ Mailer ❑ Poster ❑ Website

Plan Options

Check Applicable Box

❑ **Plan 130/70/50**
$130/Day Nursing Home
70% Residential Care
50% Home Health Care
Respite Care Provision

❑ **Plan 150/70/50**
$150/Day Nursing Home
70% Residential Care
50% Home Health Care
Respite Care Provision

❑ **Group Plan/Negotiated Benefits Plan/Modified Payment Plan, may be available.**

Department/Plan: _____

Payment Term

Check Applicable Box

❑ **25 Years** ❑ **30 Years** ❑ **35 Years** ❑ **40 Years** ❑ **45 Years**

The maximum payment term is based on your age at time of application. Please see the published cost (rate) schedule to determine the length of time that you are allowed to make payments.
Payments must be fully paid by age 85.

Applicant Information

Please Print
I am qualified to apply as a: *(Please choose the column that pertains to you, the applicant.)*

Employee Applicant

❑ Active Full Time Firefighter
❑ Active Full Time Law Enforcement Officer
❑ Volunteer / Paid Call Firefighter
❑ Volunteer Law Enforcement Member
❑ Reserve Law Enforcement Officer
❑ Non-Safety Fire Dept. Employee
❑ Non-Safety Law Enforcement Dept. Employee

Department, Agency, or Association:

_____

Job Title: _____

Date of Hire: _____

OR

Spouse Applicant

❑ Spouse of Active Full Time Firefighter
❑ Spouse of Active Full Time Law Enforcement Officer
❑ Spouse of a Volunteer / Paid Call Firefighter
❑ Spouse of a Volunteer Law Enforcement Member
❑ Spouse of a Reserve Law Enforcement Officer
❑ Spouse of a Non-Safety Fire Dept. Employee
❑ Spouse of a Non-Safety Law Enforcement Dept. Employee

My Employer: _____

My Spouse's Employer: _____

My Spouse's Name: _____

My Spouse's SS#: _____

Last Name	First Name	M.I.

Mailing Address	City	State	Zip

Physical Address	City	State	Zip

Home Phone Number	Best Time to Call	Social Security #	Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Alternate Phone Number	Best Time to Call	Email

Height	Weight	Sex ❑ Male ❑ Female	Date of Birth	Age Last Birthday

Waist Circumference: *Using a tape measure, start at the top of your hip bone and measure around your waist level with your belly button. Please make sure that the tape is straight and snug.*	in.

Beneficiary

Please do not designate beneficiaries under the age of 18.

Primary

Full Name: _____

Relationship: _____

Phone Number: _____

Address: _____

_____

Email: _____

Alternate (Contingent)

Full Name: _____

Relationship: _____

Phone Number: _____

Address: _____

_____

Email: _____

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 coverage for nonpayment of dues. I understand that notice will not be given until thirty (30) days after payment is due and unpaid.

❑ **I designate the following person(s) to receive notice prior to cancellation of my coverage for nonpayment:**

Full Name: _____

Address: _____

Phone Number: _____ Email: _____

❑ **I elect not to designate any person to receive such notice.**

Payment Options

Note: Each Applicant will be billed on an individual basis (surcharges are per Applicant). Combined billing is not available.

Please select one of the following methods of payment:

❑ Monthly Bank Draft

Please deduct my monthly payment from (choose one):

❑ **Checking** ❑ **Savings**

_____ _____

Account Number Routing Number

_____ _____

Financial Institution Name Telephone

_____

Financial Institution Address including City, State & Zip

Attach VOIDED check here. We are unable to process your application without this information.

I hereby authorize NPFBA or its designated agent and the financial institution named below to initiate monthly withdrawals from my checking/savings account. This authority will remain in effect until I provide written notification to cancel this Plan or my affiliation with NPFBA, its designated agent or my financial institution.

I understand that if the required funds are not on deposit in my account on the day designated to execute the automatic deduction, I will be subject to the payment collection provision shown in the Evidence of Coverage and that any charges for overdraft or insufficient funds may be charged to me along with any service charges applied by NPFBA.

_____ _____

Signature Date

❑ Credit Card

❑ **Annual** ❑ **Semi-Annual** *($1.00 surcharge per transaction)* ❑ **Quarterly** *($2.00 surcharge per transaction)*

Type of Credit Card: ❑ **Master Card** ❑ **Visa** ❑ **Discover** ❑ **American Express**

_____ _____

Card Number Expiration Date

_____

Signature

❑ Group Plan/Negotiated Benefits Plan/Modified Payment Plan.

Medical Information & History

Please answer all of the following questions. If answering "Yes" to any question, please provide details in the space provided on page 11.

1. Are you employed or do you engage in hobbies, social activities, or volunteer work? ❑ Yes ❑ No

2. Have you gained or lost more than 5 pounds in the past twelve (12) months? ❑ Yes ❑ No

3. a. Are you receiving or have you applied for any type of Disability Benefits? ❑ Yes ❑ No
   b. Are you now, or have you ever received benefits from Medi-Cal or Medicare? ❑ Yes ❑ No
   c. Due to any present or past mental or physical disability, is any person or institution currently authorized to act on your behalf? ❑ Yes ❑ No
   d. Are you dependent on the use of a walker or wheelchair? ❑ Yes ❑ No
   e. Are you confined to your bed, home, hospital, or nursing home? ❑ Yes ❑ No
   f. Do you use any medical appliance such as a catheter, oxygen equipment, respirator, or a dialysis machine? ❑ Yes ❑ No

4. Do you require assistance, supervision or are you limited in any way in performing any of the following daily activities: bathing, dressing, toileting, meal preparation, eating, mobility, housekeeping or managing medications? ❑ Yes ❑ No

5. Have you ever been diagnosed or treated by a health care professional for stroke/ Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA) or cerebral aneurysm? ❑ Yes ❑ No

6. Within the past 5 YEARS, have you been medically advised that you will need surgery, which has not been performed? ❑ Yes ❑ No

7. When walking 4 blocks or climbing a flight of stairs, do you experience any difficulties such as shortness of breath, dizziness, leg cramps, pain, discomfort or restricted motion? ❑ Yes ❑ No

8. Have you had a DUI or had your driver's license suspended? ❑ Yes ❑ No

9. Do you now, or have you ever, used any tobacco products including cigarettes, electronic cigarettes, cigars, pipes, chewing tobacco, marijuana, etc? ❑ Yes ❑ No
   a. How long have you or did you use tobacco products? _____
   b. If you have quit using tobacco or marijuana products, when was your last use? _____

10. Have you ever used restricted or controlled substances except as prescribed by a licensed physician? ❑ Yes ❑ No

11. Do you drink alcoholic beverages? ❑ Yes ❑ No
    a. If yes, please indicate average consumption per week? _____

12. During the past 5 years, have you been counseled, treated or hospitalized for the use of alcohol or drugs? ❑ Yes ❑ No

13. Do you, any health care providers or anyone else you know, have any concerns over your present health? ❑ Yes ❑ No

14. Have you ever been diagnosed or treated by a member of the medical profession or had symptoms of any of the following conditions? ***(Please review the following list carefully. Place an X in the box next to those that apply. If you checked any of the following, please provide details on Page 11)***

- ❑ Acquired Immune Deficiency Syndrome (AIDS) / AIDS Related Complex (ARC) / HIV Positive
- ❑ Attention-Deficit Disorder (ADD) or Attention-Deficit/Hyperactivity Disorder (ADHD)
- ❑ Alcoholism, Drug or Substance Abuse
- ❑ ALS (Lou Gehrig's Disease)
- ❑ Alzheimer's Disease or Dementia
- ❑ Amputation
- ❑ Aneurysm
- ❑ Angina
- ❑ Arrhythmia
- ❑ Arthritis
- ❑ Atrial Fibrillation
- ❑ Asthma, Chronic Obstructive Pulmonary Disease (COPD), Emphysema, or Chronic Lung Disease
- ❑ Auto-Immune Disease
- ❑ Blood Clotting Disorder
- ❑ Blood Disease: Anemia, Sickle Cell, or Bleeding Disorder
- ❑ Bypass Surgery
- ❑ Cancer (External) Any Form
- ❑ Cancer (Internal) Any Form
- ❑ Carotid Artery Disease
- ❑ Cerebral Vascular Disease
- ❑ Cirrhosis of the Liver or other Liver Disease
- ❑ Colitis
- ❑ Congestive Heart Failure or Coronary Artery Disease
- ❑ CPAP or BiPAP Machine
- ❑ Cystic Fibrosis
- ❑ Diabetes, Diabetes with Insulin or Pre-Diabetic
- ❑ Dizziness
- ❑ Eating Disorders: Anorexia, Bulimia
- ❑ Fibromyalgia or Chronic Fatigue
- ❑ Fractures
- ❑ Glaucoma, Macular Degeneration or other Eye Disorder
- ❑ Heart Attack, Angioplasty or Coronary Stent
- ❑ Heart Valve Impairment or Replacement
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Huntington's Chorea
- ❑ Hyperglycemic / Hypoglycemic
- ❑ Incontinence / Bladder or Bowel Control
- ❑ Joint Disorder or Replacement
- ❑ Kidney Disease or Failure
- ❑ Leukemia or Lymphoma
- ❑ Lupus
- ❑ Memory Loss or Cognitive Impairment
- ❑ Meniere's Disease
- ❑ Mental / Nervous Disorder
- ❑ Motor Neuron Disease
- ❑ Metabolic Syndrome
- ❑ Migraine or Chronic Headaches
- ❑ Multiple Sclerosis
- ❑ Muscular Dystrophy
- ❑ Obesity
- ❑ Organ Transplant
- ❑ Organic Brain Syndrome
- ❑ Osteopenia / Osteoporosis
- ❑ Paralysis
- ❑ Parkinson's Disease
- ❑ Peripheral Neuropathy
- ❑ Vascular Disease
- ❑ Psychiatric Disorder (Anxiety Disorder, Depression, Bipolar Disorder, etc.)
- ❑ Raynaud's Syndrome
- ❑ Retinitis Pigmentosa
- ❑ Rheumatoid Arthritis
- ❑ Schizophrenia
- ❑ Scleroderma
- ❑ Seizure Disorder
- ❑ Single / Multiple Transient Ischemic Attack (TIA)
- ❑ Sleep Apnea or Sleep Disorders
- ❑ Spine or Back Disorders including Scoliosis
- ❑ Stroke
- ❑ Tremor
- ❑ Weight Loss Surgery: Gastric Bypass, Lap Band or other method

❑ **Check this box if you have not been diagnosed or treated for any of the conditions listed above.**

If you answered yes to any of the following, please provide details on Page 11.

15. Have you ever been diagnosed, advised of, or received medical treatment by a member of the medical profession for any condition not listed in question 14 on page 9 (other than routine physical exams with normal findings)? ❑ Yes ❑ No

16. During the past 5 YEARS, have you: *(Place an X in the box next to those that apply)*

a. Sought medical advice or treatment for any of the following conditions? ❑ Yes ❑ No

❑ Confusion/Disorientation ❑ Falling ❑ Pain, Tingling, Hot or Cold Sensation

❑ Deterioration of Vision ❑ Loss of Appetite ❑ Tremors

❑ Fainting ❑ Numbness ❑ Unstable Gait

b. Used or been advised to use any of the following: ❑ Yes ❑ No

❑ Limb Braces ❑ Scooter ❑ Wheelchair

❑ Cane ❑ Walker ❑ Other: _____

17. Do you have or have you ever had a pending or active Workers' Compensation Claim? ❑ Yes ❑ No

Claim # if available _____

18. Have you ever had genetic testing? ❑ Yes ❑ No

If yes, what for:_____

Outcome: _____

19. Have you been hospitalized, been advised to have, or had surgery, medical care, EKG, x-ray, imaging, diagnostic test, cardiac testing, sleep studies or confined to any facility in the last five (5) years? *If yes, please provide details below. Additional space on page 11.* ❑ Yes ❑ No

Test Performed	Date	Reason	Results	Name & Contact Information of Medical Advisor

20. In the last 5 years, has a health professional recommended that you should have any surgeries, tests, or procedures (including diagnostic & screening procedures) that have not been performed? ❑ Yes ❑ No

21. Have any of your natural parents, brothers or sisters, either living or dead, ever suffered from any of the following conditions: Polycystic Kidney Disease, Cystic Fibrosis, Hemophilia, Multiple Sclerosis, Huntington's Chorea, Motor Neuron Disease, Muscular Dystrophy, Alzheimer's, Dementia or any other form of inherited disease? ❑ Yes ❑ No

22. Must provide family history.

Family Member	Health History	Age at Onset	Age	Age at Death	Cause of Death (if deceased)
Mother					
Father					
Sister(s)					
Brother(s)					

Additional space provided below.

Please Use Space Below to Explain "Yes" Answers

If you answered "Yes" or checked a box on any of the previous questions please explain below, giving full details including: Name, Phone Number and Address of Physician, Condition, Treatment Dates, and any resulting limitations.

Item #	Description – Dates – Details – Narrative
	Please attach additional page if necessary.

Medications and Supplements

List ALL Medications and Supplements you use regularly OR have regularly used within the past 5 YEARS. Please include prescription medications, non-prescription medications (Over the Counter – OTC), and dietary supplements.

Medication/Supplement	Reason, Frequency and Dosage	Currently Use
		❑
		❑
		❑
		❑
		❑
		❑

Please attach additional page if necessary.

❑ **I do not take any medications or supplements.**

Physician Information

Please provide information for primary physician and any additional treating physicians.

Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Applicant's Kaiser, HMO, PPO, or Medical I.D. Number: _____

Have you been seen by any other physician and/or medical facility in the past 5 YEARS? ❑ Yes ❑ No

Please provide additional physician's name, address, phone number and reason/outcome for visit. *Additional space on page 10.*

1. _____

2. _____

Other Long Term Care

1. Do you now have in force, or are you applying for, any other long term care, nursing home or home health care policy, rider or certificate (including a health care service contract, a health maintenance organization contract, or health insurance policy)? ❑ Yes ❑ No
   Please provide company names for the purpose of benefit coordination:
   _____

2. Other than the above, did you have a long term care policy, rider or certificate in force during the last 12 months? ❑ Yes ❑ No
   If yes, please explain: _____

3. Have you ever had an application for Life, Health or Long Term Care insurance declined, postponed, modified or rated? ❑ Yes ❑ No
   If yes, please explain: _____

Applicant Certification

I certify that I have reviewed all the information and notices contained in this application and that all information supplied on this application 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 misrepresented, sanctions that could include rescission of my coverage or a benefit denial may be applied. If I have submitted intentionally fraudulent statements, I understand that my name may be submitted to the relevant authority for criminal prosecution.

I understand that the Plan I am applying for has been approved by the Trustees of the National Peace Officer and Fire Fighters Benefit Association (NPFBA), but does not qualify for Medi-Cal spend-down protection under the California Partnership for Long Term Care.

I understand that based on the medical information provided, I may receive a preferred, standard, or modified rating. The standard rating will have an elimination period of 90 days, while the preferred rating will have an elimination period of 60 days. A modified rating will be an elimination period agreed upon by the applicant and the Trust. Modified ratings are sometimes offered in lieu of a denial of coverage. Certain other riders and exclusions may be added to the certificate with agreement of both parties. I will have the opportunity to accept or deny the certificate if it is not issued on a preferred basis. If I deny the certificate of coverage, I will receive my full-prepaid payment within 30 days of my decision.

Additionally, I understand that if I use or if I have used any tobacco or marijuana products within the last 36 months, I will be issued a certificate of coverage on a standard basis and I will automatically have a 90-day elimination period if my application is approved by NPFBA.

This coverage will not be effective until the "Statement of Continuing Good Health" has been signed and returned on a form provided by the Administrator. This Statement of Good Health confirms that all information on the initial application continues to be correct and that nothing has changed since the original application was submitted.

No coverage will be provided for any job related injury or an injury caused by a third party where a cash settlement was provided in lieu of future medical coverage. Keep this in mind whenever you are offered cash in lieu of future medical coverage. This is particularly important in workers' compensation claims.

I have read and understand the above statements concerning information that may be fraudulent or misrepresented, and the probable penalty of making such statements.

I agree that I shall abide by the related provisions as noted in the NPFBA Plan Documents and Corporate Bylaws. Under the terms of the Plan, any dispute not resolved through the Plan's claim procedure will be resolved by binding arbitration with the American Arbitration Association.

_____

Signature of Applicant **Date**

I certify that the information in this application for Long Term Care (LTC) coverage with the National Peace Officers and Fire Fighters Benefit Association Trust is accurate and complete to the best of my knowledge.

_____

Print Name as it appears in Applicant Information of Application

_____ _____

Social Security Number **Date of Birth**

Authorization For Release Of Information – HIPAA Compliant

Must be completed for application to be processed.

Who May Request or Use Information: This information may be disclosed to and used or disclosed by: National Peace Officers and Fire Fighters Benefit Association (NPFBA), California Public Safety Administrators, Inc. (Plan Administrators for NPFBA), ExamOne, or an evaluating physician.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose any and all individually identifiable health information or records about me including but not limited to medical records, reports, pharmaceutical records, drugs, diagnostic testing, and lab work: licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, pharmacy related service organization or medically related facility, the Veterans Administration, care provider or evaluators, or other organization, institution or person that has knowledge or records of me and my health.

I also agree and understand that:

- this authorization is needed for the purpose of gathering information for making eligibility, underwriting, and risk rating determinations.
- If I do not sign this authorization, my application for long-term care coverage under the NPFBA Long Term Care Plan may not be processed and my eligibility for long-term care benefits under the Plan may be denied.
- I may revoke this authorization at any time, except to the extent that:
  - action has already been taken in reliance on it before my revocation, or
  - NPFBA has a right to contest my long-term care benefits claim or coverage.
- To revoke this authorization, I must notify the NPFBA, PO Box 31, Martell, CA 95654, in writing.
  - If I do revoke this authorization, I understand that my application for long-term care coverage may not be processed and my eligibility for long-term care coverage benefits may be denied.
  - If I do not revoke this authorization, it will be valid for 36 months from the date I sign it, at which date it will expire.
- My health information may be redisclosed and may be no longer protected by applicable law, including Federal health information privacy regulations. This can occur only if such redisclosure is required or allowed by law (for example, in response to a subpoena).
- A copy of this authorization is as valid as the original.

By my signature below, I attest that I have read and understand the terms of this authorization and that I agree to the terms of this authorization.

_____

Applicant Name (Please print)

_____

Signature of Applicant

Last 4 of SS# _____ **Date**_____

National Peace Officers and
Fire Fighters Benefit Association

1-877-582-0003, Option #2 • Fax **(209) 223-2966**

PO Box 31 • Martell, CA 95654-0031

www.NPFBA.org

CA Lic #0544968

Administrator: California Public Safety Administrators, Inc.

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