

# WHOLE LIFE LONG TERM CARE RIDER PACKET INSTRUCTIONS TO AGENT

It is **EXTREMELY IMPORTANT** that the following instructions are followed precisely:

1. Form OOC LTC-WL20 G MD Outline of Coverage (the first 5 pages of the packet):
  - a. the amount of the annual premium for this rider is to be filled-in on Page 5 of the form, then
  - b. the form is to be given to the Applicant *prior* to completion of the application form. DO NOT submit to Lafayette Life Home Office.
2. Form 2035 LTC (LAPSE) MD Protection Against Unintentional Lapse:
  - a. the applicant may choose to complete Part 1 or Part 2 of the form, however, it must be completed, signed and sent with the application to the Home Office.
3. Form 2035 LTC (QUES) MD Long Term Care Questionnaire:
  - a. this form must be completed in full and signed by both the applicant and by you, then sent with the application to the Home Office.
4. **Form 2035 LTC (RPL) Notice to Applicant Regarding Replacement:**
  - a. **This form is required *ONLY* when an existing accident and sickness or long term care insurance is being replaced. If not, do not complete.**
  - b. **For base policy replacement, complete regular state required replacement form.**
  - c. **Send any signed replacement forms, if required, with the application to the Home Office.**
5. 2035-LTC (STATEMENT)
  - a. This form is to be completed whenever a Long Term Care Rider is applied for. This form must be completed and sent with the application to the Home Office.

NOTE: If replacement is involved, but not for a Long Term Care policy or Rider, you MUST complete the proper regular state required replacement forms.

FORMS ATTACHED TO THIS INSTRUCTION SHEET ARE AS FOLLOWS:

OOO LTC-WL20 G MD  
2035-LTC (LAPSE) MD  
2035-LTC (QUES) MD  
2035-LTC (RPL) (2 separate pages)  
2035-LTC (STATEMENT)

LTCWL-MD

**The Lafayette Life Insurance Company**  
Home Office: 1905 Teal Road, P.O. Box 7007, Lafayette, IN 47903  
(765) 477-7411  
(Hereafter called: We, Our or Us)

**LONG TERM CARE ACCELERATED BENEFIT INSURANCE RIDER**

**OUTLINE OF COVERAGE**

**FORM NUMBERS: LTC-WL20 G MD & LTC-WL20U G MD**

**Caution:** The issuance of this Long Term Care Insurance Rider is based upon responses to the questions on your Policy application. A copy of your application is attached to your Policy at the time of delivery of the Policy and the Rider. If your answers are incorrect or untrue, the Company has the right to deny benefits or rescind your Policy and Rider. The best time to clear up any questions is now, before a claim arises! If for any reason, any of your answers are incorrect, contact the Company at this address: 1905 Teal Road, P.O. Box 7007, Lafayette, IN 47903.

**Notice to Buyer:** This Rider may not cover all of the costs associated with long-term care incurred by the Insured during the period of coverage. The buyer is advised to review carefully all Policy limitations.

**This policy is not a Medicare Supplement policy. It is not designed to fill the “gaps” of Medicare. If you are eligible for Medicare, review the Medicare Supplement Buyer’s Guide available from the company.**

1. This coverage is provided by a rider attached to an individual life insurance policy.
2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the Policy and Rider. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual Policy and Rider contain governing contractual provisions. This means that the Policy and Rider set forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY AND RIDER CAREFULLY!**
3. **FEDERAL TAX CONSEQUENCES.** This Rider is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. We suggest you contact your personal legal, tax, or investment advisor for advice regarding the tax consequences of this Rider.
4. **TERMS UNDER WHICH THE RIDER MAY BE CONTINUED IN FORCE OR DISCONTINUED.**
  - a) **RENEWABILITY: THIS RIDER IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of your Policy and Rider, to continue this Rider in force as long as you pay your premiums on time. The Lafayette Life cannot change any of the terms of your Policy or Rider on its own.
  - b) This Rider will remain in force until the earliest of the following dates:
    - 1) The date on which the Basic Amount has been reduced due to the payment of Long Term Care Benefits by the lesser of \$180,000 or 72% of the Basic Amount as of the date the initial confinement or services began;

- 2) The date that the Policy terminates except that benefits payable for confinement in a Long Term Care Facility or services received from a Home Health Care Agency or Adult Day Care which began prior to termination will continue without interruption, but shall be limited to the maximum amount of monthly benefit available under this Rider and all other applicable provisions of this Rider;
  - 3) The date of death of the Insured except with respect to claims incurred prior to death;
  - 4) The date a Nonforfeiture Option under the Policy becomes effective;
  - 5) The date we receive your written request for termination of this Rider;
  - 6) The date we make payment to the Owner under any Accelerated Benefit Rider attached to the Policy.
- c) For each month you receive a Long Term Care Benefit, we will waive the premium for the Policy to which the Rider is attached. This premium includes the premium for this Rider. We will stop waiving this amount on the first monthly date after the Long Term Care Benefits cease unless the Insured otherwise qualifies for waiver of premium under the Policy.
- d) The premium for this rider is guaranteed; we cannot change the premium.

#### 5. **TERMS UNDER WHICH THE RIDER MAY BE RETURNED AND PREMIUM REFUNDED.**

- a) If you are not satisfied with the coverage being provided to you, you may return the Rider to us at our Home Office in Lafayette, Indiana within 30 days after you receive it and you will receive a full refund of premiums you have paid for this Rider.
- b) The Death Benefit of the Policy includes a refund of premiums for this Rider paid for any period after the Insured's death. The Net Cash Value of the policy available upon surrender includes a refund of premiums for this Rider paid for any period after the date of surrender.

6. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company. Neither The Lafayette Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

7. **LONG TERM CARE COVERAGE.** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital, such as a nursing home, in the community or in the home.

The Policy and Rider provide coverage in the form of a monthly benefit for covered long term care confinements, or services from a Home Health Care Agency or Adult Day Care, subject to Policy and Rider limitations, waiting periods and maximum benefits periods.

#### 8. **BENEFITS PROVIDED BY THIS RIDER.**

Long Term Care Benefits are paid only if the Insured is confined in a Long Term Care Facility or receiving services from a Home Health Care Agency or an Adult Day Care.

- a) **LONG TERM CARE BENEFIT.** The Long Term Care Benefit payable for each month that the Insured is confined in Long Term Care Facility or receiving services from a Home Health Care Agency will be the lesser of \$5,000.00 or 2% of the Basic Amount at the time the initial confinement or services begin, less any loan balance at the time of each benefit payment multiplied by the ratio of the amount of the reduction in the Policy's Cash Value as a result of each benefit payment to the Cash Value prior to that reduction.

The Long Term Care Benefit payable for each month that the Insured is receiving services from an Adult Day Care will be the lesser of \$2,500.00 or 1% of the Basic Amount at the time the initial services begin, less any loan balance at the time of each benefit payment multiplied by the ratio of the amount of the reduction in the Policy's Cash Value as a result of each benefit payment to the Cash Value prior to that reduction.

To receive this benefit, the Insured's confinement in a Long Term Care Facility or the services the Insured receives from a Home Health Care Agency or Adult Day Care must be medically appropriate or required because of the Insured's inability to perform at least 2 of the 6 Activities of Daily Living. Before we can determine whether the care and services received are Medically Appropriate, we must receive a copy of the treatment plan. If possible, the Insured's physician should submit a copy of the treatment plan to us prior to the time care and services are received. Activities of Daily Living include: dressing, eating, toileting, transferring from bed to chair, maintaining continence and bathing. The Insured must also be confined or receiving services for a 90 day Waiting Period.

- b) **WAIVER OF PREMIUM.** For each month you receive a Long Term Care Benefit, we will waive the premium for the Policy to which the Rider is attached. This premium includes the premium for this Rider. We will stop waiving this amount on the first Monthly Date after the Long Term Care Benefits cease unless the Insured otherwise qualifies for waiver of premium under the Policy.
- c) **TERMINATION OF BENEFITS.** The benefits provided by this Rider will terminate on the earliest of:
  - 1) the date the Policy Basic Amount has been reduced due to the payment of Long Term Care Benefits by the lesser of \$180,000 or 72% of the Basic Amount as of the date the initial confinement or services began;
  - 2) the date the policy terminates;
  - 3) the date of death of the Insured;
  - 4) the date a Nonforfeiture Option under the Policy becomes effective;
  - 5) the date we receive your written request for termination of this Rider; or
  - 6) the date we make payment to the Owner under any Accelerated Benefit Rider attached to this Policy.

## 9. LIMITATIONS AND EXCLUSIONS.

- a) **Pre-Existing Condition Limitation.** A Pre-Existing Condition is a condition for which medical advice or treatment was recommended by or received from a Physician within 6 months preceding the effective date of the Rider. The Insured will not be eligible for Long Term Care Benefits due to confinement in a Long Term Care Facility or services received from a Home Health Care Agency or Adult Day Care resulting from a Pre-Existing Condition if the confinement or services begin within six (6) months following the effective date of the Rider.
- b) The following limitations apply to determining eligibility for Long Term Care Benefits under this Rider:
  - 1) The Insured's Physician from whom we receive the Insured's treatment plan:
    - (a) must be legally licensed by the state in which he practices medicine and performs surgery as a doctor of medicine (M.D.) or as a doctor of osteopathy (D.O.);
    - (b) must NOT be you, the Insured, or a member of your or the Insured's immediate family (e.g., parents, spouse, siblings, children, including natural, adopted, step, son-in-law, daughter-in-law); and
    - (c) should NOT have a financial interest in the facility, agency, center or provider administering such plan since the plan may then NOT be considered Medically Appropriate.

- 2) If the benefit is due to confinement to a Long Term Care Facility, it must be a facility, or that part of one, which:
  - (a) Is licensed by the jurisdiction in which it is located;
  - (b) Is engaged in providing, in addition to room and board accommodations, nursing care and related services on a continuing inpatient basis to 6 or more individuals;
  - (c) Is supervised by a Registered Nurse;
  - (d) Provides, on a formal prearranged basis, a Nurse who is on duty or on call at all times;
  - (e) Has a planned program of policies and procedures developed with the advice of; and periodically reviewed by, at least one physician; and
  - (f) Maintains a clinical record of each patient.

A Long Term Care Facility may be a distinct part of a hospital or other institution. It is NOT a place that is primarily used:

- (a) for rest;
- (b) for day care;
- (c) for educational care;
- (d) as a retirement income or community living center; or
- (e) for the care and treatment of mental diseases or disorders, drug addiction, or alcoholism.

- 3) If the benefit is due to services received from a Home Health Care Agency, that agency:
  - (a) must be a provider of home health care services under the Medicare program;
  - (b) must be licensed or accredited by state law as a Home Health Care Agency; or
  - (c) may refer to services provided by a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN).
- 4) If the benefit is due to services received from an Adult Day Care, the Adult Day Care must provide a program:
  - (a) for six (6) or more individuals;
  - (b) of social and health related services;
  - (c) during the day;
  - (d) in a community group setting; and
  - (e) for the purpose of supporting frail, impaired, elderly or other adults with disabilities.

c) Benefits are not provided for confinement or services:

- 1) Due to alcoholism, drug addiction or chemical dependency, unless as a result of medication prescribed by a Physician;
- 2) Due to self-inflicted injuries or attempt at suicide while sane or insane;
- 3) For treatment, provided without cost to the Insured, in any facility contracted for or operated by the United States government;
- 4) Due to mental, nervous, psychotic or psychoneurotic deficiencies or disorders without demonstrable organic disease or similar forms of senility or senile dementia;
- 5) Due to injury or sickness caused by war or any act of war, declared or undeclared;
- 6) For any work related sickness or injury for which treatment provided is by Worker's Compensation;
- 7) Resulting from committing or attempting to commit a felony; or
- 8) Outside the United States of America.

10. **RELATIONSHIP OF COST OF CARE AND BENEFITS.** Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this Rider may be adjusted. The benefits available under this Rider will NOT increase over time. This Rider provides no opportunity to buy additional benefits.
11. **ALZHEIMER'S DISEASE & OTHER ORGANIC BRAIN DISORDERS.** Benefits are provided for services or confinements resulting from a sickness or illness of at least 90 days that requires substantial assistance in performing at least two (2) activities of daily living or that requires substantial supervision due to severe cognitive impairment such as Alzheimer's disease.
12. **PREMIUM.** Your annual premium for this Rider is \$ \_\_\_\_\_ .
13. **ADDITIONAL FEATURES.**
  - a) **THIS COVERAGE IS MEDICALLY UNDERWRITTEN.** It is very important for all questions on the application to be answered correctly and completely. If, for any reason, the answers are incorrect or incomplete, the Policy and Rider may be void and we may deny you benefits or rescind your Policy.
  - b) **EFFECT ON THE POLICY OF PAYMENT OF LONG TERM CARE BENEFITS.** The Rider is an acceleration of the Policy's Basic Amount. Payment of any benefits under the Rider will reduce any amount payable for death, surrender, or maturity of the Policy.

**THIS POLICY AND RIDER MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH THE INSURED'S LONG TERM CARE NEEDS.**

**THE LAFAYETTE LIFE INSURANCE COMPANY**

1905 Teal Road, PO Box 7007  
Lafayette IN 47903-7007

**PROTECTION AGAINST UNINTENTIONAL LAPSE**

The applicant has the right to designate at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy for nonpayment of premiums. You have the right to change this designation at any time.

**This designation does not constitute acceptance of any liability on the third party for services provided to the Insured.**

Please send Notice of Termination to the following:

Name \_\_\_\_\_

Street Address \_\_\_\_\_

Apt No \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name \_\_\_\_\_

Street Address \_\_\_\_\_

Apt No \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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**WAIVER OF PROTECTION AGAINST UNINTENDED LAPSE**

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice.

\_\_\_\_\_  
Date

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

**THE LAFAYETTE LIFE INSURANCE COMPANY**

**1905 Teal Road, PO Box 7007**

**Lafayette IN 47903-7007**

Individual Product Operations Department

New Business Section

Phone: 800-243-6631 Fax: 888-558-9329

**LONG TERM CARE ACCELERATED BENEFIT QUESTIONNAIRE**

- |  | <b>YES</b>               | <b>NO</b>                |
|--|--------------------------|--------------------------|
| 1. Do you have long-term care coverage in force or applied for?<br>If yes, please list the name of the company and specify the amount of the daily benefit. _____<br>_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Did you have a long-term care policy in force during the last twelve (12) months?<br>If yes, please list the name of the company and when the coverage lapsed.<br>_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. If this policy is issued, will any accident and sickness or long-term care coverage be replaced? If yes, name of company? _____<br>_____                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you applied for long-term care coverage and been issued coverage other than applied for, declined or postponed?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you covered by Medicaid?  | <input type="checkbox"/> | <input type="checkbox"/> |

I hereby represent, to the best of my knowledge and belief, that all the above statements are complete and true.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ yr \_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Proposed Insured

**CAUTION:** If your answers on this application are incorrect or untrue, The Lafayette Life Insurance Company has the right to deny benefits or rescind your policy and rider.

**FOR AGENT USE ONLY:** Please list any other health insurance policies you have sold to the applicant.

List policies sold that are still in force: \_\_\_\_\_

List policies sold in the past five (5) years that are no longer in force: \_\_\_\_\_

**Outline of Coverage:** I acknowledge that an Outline of Coverage was delivered to the applicant prior to presentation of the application.

\_\_\_\_\_  
Signature of Agent

\_\_\_\_\_  
Date

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

THE LAFAYETTE LIFE INSURANCE COMPANY  
1905 Teal Road, PO Box 7007  
Lafayette IN 47903-7007

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

According to your application or information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by The Lafayette Life Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the rider. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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

STATEMENT TO APPLICANT BY AGENT:  
(Use additional sheets, as necessary.)

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

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

\_\_\_\_\_  
Signature of Agent

Type Name and Address of Agent below:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
Date

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

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

THE LAFAYETTE LIFE INSURANCE COMPANY  
1905 Teal Road, PO Box 7007  
Lafayette IN 47903-7007

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According to your application or information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by The Lafayette Life Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the rider. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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

**STATEMENT TO APPLICANT BY AGENT:**  
(Use additional sheets, as necessary.)

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

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

\_\_\_\_\_  
Signature of Agent

\_\_\_\_\_  
Type Name and Address of Agent below:

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

\_\_\_\_\_  
Date

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

**THE LAFAYETTE LIFE INSURANCE COMPANY**

1905 Teal Road, PO Box 7007

Lafayette, IN 47903-7007

I am applying for Long Term Care Rider, Form # LTC-WL20 G, to be attached to a whole life insurance Policy. This Rider will accelerate the death benefit of such life insurance Policy in the event of my Chronic Illness and confinement in a Long Term Care Facility, or receipt of professional services in my home from a Home Health Care Agency, or in Adult Day Care as defined in the Rider.

I understand that this Rider does not provide any inflation protection feature to increase the amount of Long Term Care Benefit available. I understand that to protect myself from the inflationary increases in the costs of long term care I must rely on other resources.

I understand that home health care is included in the Rider.

I understand that this Rider does not develop any nonforfeiture benefits in addition to those provided by the Policy to which the Rider is attached. The only nonforfeiture benefits are the regular Cash Value and Net Cash Value that develops under the Policy.

It has been fully explained to me and I have been informed:

- (1) Of my right to designate a person to receive any notice of termination;
- (2) That this Rider does not provide any inflation protection feature to increase the amount of Long Term Care Benefit available;
- (3) That home health care is included in the Rider; and
- (4) That the Rider does not develop any nonforfeiture benefits in addition to those that develop under the Policy to which the Rider is attached.

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Date

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Signature of Applicant

**THIS FORM TO BE ATTACHED TO THE POLICY**