Yale University

RetirementGuard

PRE-APPLICATION QUESTIONNAIRE
IF YOU HAVE QUESTIONS
CALL 1.888.793.6111
CONVERSATIONS ARE CONFIDENTIAL

SECTION 1: Underwriting

Note: If any question in PART A below is answered "YES", you will not be offered coverage at this time. DO NOT SUBMIT THIS PRE-APPLICATION.

PART A - *Check the box if you have ever received medical advice, consultation or treatment for any of the following:*

Diabetes Treated with Insulin
Amyotrophic Lateral Sclerosis
Any Diabetes with Skin Ulcers
Multiple Joint Replacements
Any Joint Deformities
Kidney Disease

Liver Cirrhosis
Hepatitis B,C,D, or E
Stroke or Transient Ischemic Attach (TIA)
Memory Loss, Alzheimer's Disease, or Dementia
Bipolar Disorder, Schizophrenia
Psychosis, Mental Retardation

Myasthenia Gravis
Multiple Sclerosis
Parkinson's Disease/Parkinsonism
Muscular or Neurological Conditions causing Limits
Post-Polio Syndrome
Lupus (SLE)
Scleroderma
Amputation-Due to Disease
Organ or Bone Marrow Transplants
Brain or Spinal Tumors-benign or malignant
Metastatic Cancer, Multiple Myeloma
Pulmonary Embolism
Carotid Artery Disease
Peripheral Vascular Disease
AIDS - Acquired Immune Deficiency Syndrome**

** You need not check YES if you have only tested positive for Human Immunodeficiency Virus (HIV).

In the PAST YEAR have you needed assistance or supervision in taking medication, or performing these activities of daily living: Bathing, Continence, Dressing, Eating, Toileting, Transferring?

yes no

In the PAST YEAR have you used any Medical Equipment: Wheelchair, Walker, Motorized Scooter, Quad Cane, Canadian Crutches, Ventilators, Oxygen, Stair life, or Home Intravenous Medications?

yes no

In the PAST YEAR have you been admitted to a nursing home, assisted living facility, psychiatric hospital,OR alcohol/drug rehabilitation?

yes no

STOP! If any question in PART A above was answered "YES", you will not be offered coverage at this time. DO NOT SUBMIT THIS PRE-APPLICATION. Call us at 1.888.793.6111.

PART B - *You must answer each question by checking YES or NO.*

Note: If any question in PART B below is answered "YES", an 'Attending Physician Statement (APS)' will be required from your physician and you will need to fill out a full application. Please contact us at 1.888.793.6111 or helpme@retirementguard.com to continue. We will forward to you all the necessary forms you will need to complete your enrollment.

In the PAST 180 days have you been absent due to illness or injury for more than 5 consecutive days?

yes no

In the PAST YEAR have you been hospitalized overnight (except for uncomplicated childbirth) OR been advised to have surgery, OR been diagnosed with cancer AND received OR been advised to receive Radiation or Intravenous Chemotherapy?

yes no

In the PAST YEAR have you been referred to or received medical advice, consultation or treatment from any physician specializing in any of the following: Neurology (*Nerves*), **Nephrology** (*Kidney/Renal*)**, Pulmonary** *(Respiratory)***, OR Hematology** (*Blood)***?**

yes no

In the PAST YEAR have you been declined, postponed, or had your benefits modified for a long term care application?

yes no

If any question in PART B below is answered "YES", an 'Attending Physician Statement (APS)' will be required from your physician and you will need to fill out a full application. contact us at 1.888.793.6111 or helpme@retirementguard.com, our conversation will be treated confidentially.

PART C - *Physician and Prescription Medication Information*

Please enter the Name, Address & Phone number of Physician

Please list the names, dosage and reason of all Prescription Medications you have taken in the last two years

SECTION 2: Benefit Selection *(Complete all of the following):*

	Essential				Preffered
Benefit	Option 1	Option 2	Option 3	Option 4	Option 5
Mass Health Exemption	Yes	Yes	Yes	Yes	Yes
Daily Benefit	$150	$200	$300	$200	$250
Minimum Duration	2 years	3 years	5 years	3 years	5 years
Guaranteed Purchase Option	Yes	Yes	Yes	No	No
3% Automatic Inflation	No	No	No	Yes	Yes

Visit our web site to determine your premium rate based on your age and marital status.

Premium Amount for Age and Marital Status Go to: Rates and Benefit Options

After reviewing the rates for your age and marital status, indicate below the Plan Option that you prefer.

Plan 1 **Plan 2** **Plan 3** **Plan 4** **Plan 5**

Please enter that Plan's monthly premium amount:

NOTE:

Should you wish to elect a slightly different benefit from the options we have provided, please indicate below.

Daily Benefit: *(select one)*

100% of the amount can be paid for care at home, assisted living or a nursing facility.

$150 $200 $250 $300

Minimum Benefit Duration

This is the minimum time your benefit will last—it could be longer. Example: A $200 daily benefit with a 3 year duration. If only $100 was used daily, it will last 6 years. ***If you don't use it —you don't lose it.***

(select one)

2 Years 3 Years 5 Years

Benefit Increase Option

Guaranteed Purchase*: Every 2 years you will be 'invited' to increase your daily benefit by 10%—regardless of your health status. If you elect to increase your benefit your premium will increase.*

3% Compound*: Every year your daily benefit will automatically increase 3%. Your premium is designed to stay level.*

(select one)

Guaranteed Purchase Option 3% Compound - No Maximum

Shared Care
If your benefit duration as been exhausted, this is an extra pool of money that can be used by you, your spouse/partner or any combination.

Call 1.888.793.6111 or email: helpme@retirementguard.com for details and cost.

2 Years Shared Care (additional) to be shared by spouse/domestic partner

SECTION 3: Premium Payment Method

Premium Mode

Monthly

Annual (7% discount for annual premium)

(select one of the payment methods below)

I'd like the monthly Premium amount to be automatically debited from my checking account

I'd like to write one check annually for an additional discount (above)

I'd like to have the monthly Premium automatically debited from my VISA or MASTERCARD

SECTION 4: Personal Information

First Name

Middle Initial

Last Name

Gender

M F

Home Address

Mailing Address (if different)

City

State

ZIP Code

Home / Eve Phone

Day / Cell Phone

E-mail

Social Security Number * *(you may opt to provide your SSN at a later date, but it will be required)*

Date of Birth

SECTION 5: Marital Status

Marital Status

- Married
- Domestic Partner
- Individual (Single or Widowed)

Do You have a Spouse / Domestic Partner who is

- Applying for coverage at the same time, or
- Already has a long-term care policy
- Not Applying for coverage

Spouse / Domestic Partner's First Name

Spouse / Domestic Partner's Last Name

Spouse / Domestic Partners's Social Security Number* *(you may opt to provide the SSN at a later date, but it will be required)*

SECTION 6: Employment Information

Do you work outside your home for at least 30 hours per week?

yes   no

My Employer is Boston Medical Center

Other Employer Name

I am the

Employee   Spouse/Partner