

Application to Equitable Life & Casualty Insurance Company for Long Term Care Insurance

Applicant _____ Sex _____ Date of Birth Mo/Day/Year _____ Age _____ Height _____ Weight _____ Social Security Number _____

Spouse _____ Sex _____ Date of Birth Mo/Day/Year _____ Age _____ Height _____ Weight _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Telephone (_____) _____ Best Time to Call _____ Beneficiary _____

Requested Effective Date _____ Premium Paid _____ Mode A S Q MBD

EquiCare Applicant <input type="checkbox"/> Spouse <input type="checkbox"/>	SelectCare Applicant <input type="checkbox"/> Spouse <input type="checkbox"/>
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2002 Tax Qualified 2002 Non-Tax Qualified

NURSING HOME/ASSISTED LIVING BENEFITS
 Select a daily benefit amount from \$50 to \$250

Daily Amount	Benefit Period	Elimination Period
\$ _____	<input type="checkbox"/> 1 Year	<input type="checkbox"/> 0 Days
	<input type="checkbox"/> 2 Years	<input type="checkbox"/> 30 Days
	<input type="checkbox"/> 3 Years	<input type="checkbox"/> 90 Days
	<input type="checkbox"/> 4 Years	<input type="checkbox"/> 180 Days
	<input type="checkbox"/> 5 Years	<input type="checkbox"/> 365 Days
	<input type="checkbox"/> Unlimited	

OPTIONAL HOME CARE BENEFITS
 Select coverage that is less than or equal to your Nursing Home selections.

Home Care Daily Amount	Benefit Period	Elimination Period
\$ _____	<input type="checkbox"/> 1 Year	<input type="checkbox"/> 0 Days
	<input type="checkbox"/> 2 Years	<input type="checkbox"/> 7 Days
	<input type="checkbox"/> 3 Years	<input type="checkbox"/> 30 Days
	<input type="checkbox"/> 4 Years	
	<input type="checkbox"/> 5 Years	
	<input type="checkbox"/> Unlimited	

NURSING HOME/ASSISTED LIVING BENEFITS

Daily Amount	Benefit Period
<input type="checkbox"/> \$50	<input type="checkbox"/> 1 Year
<input type="checkbox"/> \$75	<input type="checkbox"/> 2 Years
<input type="checkbox"/> \$100	

Elimination Period
 A 100 calendar day elimination period is automatic for these benefits.

OPTIONAL HOME CARE BENEFITS
 Applicant Spouse

The Daily Amount for Home Care Benefits is \$50. The Maximum Benefit Period is 180 service days. The Elimination Period is 30 service days.

OPTIONAL BENEFITS AVAILABLE ON ALL PLANS

Alternate Payor: _____ Relationship _____

Address _____ City _____ State _____ Zip _____

I understand that an Alternate Payor is a person other than myself who will receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. My Alternate Payor will not be notified until thirty (30) days after a premium is due and unpaid. I elect NOT to designate any other person to receive such notice, and waive my right to an Alternate Payor: Applicant Spouse

Joint Applicants: Select the Paid-up Survivor Benefit or the Spousal Discount: Paid-up Survivor Spousal Discount

Inflation Protection: Automatic Flexible Periodic None
Refusal of inflation protection: I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. I realize that based on current health care costs trends, the benefits provided by a long term care plan which do not have meaningful inflation protection may be significantly diminished in terms of real value to me, depending on the amount of time which elapses between the date I purchase the policy and the date on which I first become eligible to use them. Specifically, I have reviewed EquiCare Plan 2002 and SelectCare Plan 640, and I reject all the offered inflation protection options. Applicant Spouse

Nonforfeiture Benefit: Shortened Benefit Period None
Refusal of nonforfeiture option: I have reviewed the outline of coverage and the explanation of nonforfeiture benefits in EquiCare Plan 2002 and SelectCare Plan 640 and I reject the offered nonforfeiture option. Applicant Spouse

NAME AND ADDRESS OF DOCTOR USUALLY CONSULTED

Applicant's Doctor

Name _____ Date Last Consulted _____ Phone (____) _____
 Address _____ City _____ State _____ Zip _____

Spouse's Doctor

Name _____ Date Last Consulted _____ Phone (____) _____
 Address _____ City _____ State _____ Zip _____

MEDICAL HISTORY - Answer each of the following questions.

If the answer to any part of question 1 is "Yes," a policy cannot be issued to the person to whom the answer applies.

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | Applicant | | Spouse | |
| | Yes | No | Yes | No |
| 1. During the past 2 years have you had or been treated for: | | | | |
| a. Diabetes requiring more than 40 units of insulin daily, or any insulin dosage for more than 5 years, or with peripheral neuropathy, retinopathy or other organ involvement? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Alzheimer's disease, senile dementia, organic brain syndrome, or memory loss? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Stroke, TIA (transient ischemic attack), or CVA (cerebrovascular accident)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Internal cancer, malignant melanoma, leukemia, Hodgkin's disease or hemophilia? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Systemic lupus, Lou Gehrig's disease (ALS), multiple sclerosis, or Parkinson's disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Myasthenia Gravis, kidney dialysis, cirrhosis or amputation due to sickness? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If the answer to any part of question 2 is "Yes," please circle the condition and provide details below (use additional pages if necessary).

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|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | Applicant | | Spouse | |
| | Yes | No | Yes | No |
| 2. During the past 2 years have you: | | | | |
| a. Been diagnosed with any of the following: chronic obstructive pulmonary disease (COPD), other chronic lung disorder, emphysema, a condition requiring coronary bypass surgery, open heart surgery or pacemaker implant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Smoked cigarettes? If "Yes," how many per day? Applicant ____ Spouse ____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Had arthritis treated with steroids, gold shots or immuno-suppressant drugs? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had any condition requiring the use of a 4 prong cane or walker to assist you? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Been paralyzed, disabled or needed assistance in performing daily living activities or used oxygen at home? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Had a heart attack, arrhythmia or recurrent spells of dizziness or confusion? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Seen any doctor or medical practitioner OTHER than the one listed, been advised to have surgery but not done so, received home health care, or been confined to a nursing home or assisted living facility? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Applicant	Spouse	Condition	Last Date of Service	Name and Address of Doctor or Other Health Care Provider
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			

PRESCRIPTION DRUGS - list all you are currently taking (use additional pages if necessary)

Applicant	Spouse	Prescription Name	Dosage & Frequency	Reason for Prescription	Doctor Prescribing
<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>				

PREFERRED RATE PROFILE (FOR EQUICARE PLANS ONLY)

Please complete all questions on this page if you would like to be considered for Preferred Rates.

If the answer to any of these questions is "YES", please circle the condition.

	Applicant		Spouse	
	Yes	No	Yes	No
During the past 5 years have you:				
a. Been confined to a hospital or treated by a doctor for any of the following: cancer (including melanoma but not other skin cancer), stroke, fracture of the spine or hip from osteoporosis, phlebitis, epilepsy, heart disease, emphysema, COPD (chronic obstructive pulmonary disease), chronic lung disease, chronic kidney disease, chronic liver disease or any peripheral vascular disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Been given a prescription for medication to treat arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Been diagnosed or treated for alcoholism, drug or substance abuse, mental or emotional disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Used any tobacco products, including cigarettes, pipe, cigar or chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Within the last year, have you had any changes in prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES, describe _____				

Can you walk 4 blocks (approximately 1/4 mile) at a normal pace without any difficulty such as: shortness of breath, dizziness or leg cramps?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- Do you currently work outside the home?

Applicant:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES,	<input type="checkbox"/> Full time (30+ hours per week)	<input type="checkbox"/> Part time (10-30 hours per week)
Spouse:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES,	<input type="checkbox"/> Full time (30+ hours per week)	<input type="checkbox"/> Part time (10-30 hours per week)
- Do you currently do any volunteer work?

Applicant:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES,	<input type="checkbox"/> Full time (30+ hours per week)	<input type="checkbox"/> Part time (10-30 hours per week)
Spouse:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES,	<input type="checkbox"/> Full time (30+ hours per week)	<input type="checkbox"/> Part time (10-30 hours per week)
- Do you have any hobbies or participate in outside activities on a regular basis?

Applicant:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, describe _____
Spouse:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, describe _____
- Do you currently drive an automobile?

Applicant:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, about how many days each week? _____
Spouse:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, about how many days each week? _____
- Have you taken any overnight trips in the last 12 months?

Applicant:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, where _____
Spouse:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, where _____
- Do you receive disability income, workers compensation, or any state or Social Security disability benefits?

Applicant:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, explain disability _____
Spouse:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, explain disability _____
- With whom do you live? Alone Spouse Other _____
- Do you use a 4-prong cane, hospital bed, or other physical assistance device?

Applicant:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, what _____
Spouse:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, what _____
- Do you need assistance with cooking, housekeeping, shopping or using transportation?

Applicant:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, describe _____
Spouse:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, describe _____

I have received an Outline of Coverage, a Long Term Care Shopper's Guide and, if over age 65, a Medicare Buyers Guide.

I HAVE READ AND FULLY UNDERSTAND the questions and my answers on this application. To the best of my knowledge and belief they are true and complete. I understand the Company may conduct a telephone interview with each Applicant regarding the answers. I understand and agree the policy applied for will not take effect until issued by the Company. No agent is authorized to extend, waive or change any terms, conditions or provisions of the policy.

I AUTHORIZE any medical professional, hospital, medical care institution, insurer, Medical Information Bureau, Inc., consumer reporting agency, employer, or other person having records or knowledge of me or my physical or mental health, or any other information bearing on my insurability, to give Equitable Life & Casualty Insurance Company, or any consumer reporting agency acting on the Company's behalf, any such information.

This authorization shall be valid for a period of 2 years after the date it is signed. A photographic copy of this authorization shall be as valid as the original. I, or my authorized representative, will be given a copy of this authorization upon request. An investigative consumer report may be obtained and if such a report is obtained, I may request to be interviewed in connection with the preparation of that report. I, or my authorized representative, may request a copy of the report. If a consumer report is obtained, I request to be interviewed: Applicant YES NO Spouse YES NO.

Caution: If your answers on this application are incorrect or untrue, the Company has the right to deny benefits or rescind your policy.

Dated at (City and State) _____ this _____ day of _____.

Signed Applicant _____

Signed Spouse (if applying) _____

Signed Agent _____ Agent Number _____

Send policy to: Applicant Agent

Form A-LTC (99) A copy of your application will be attached to your policy if issued by the Company.

BANK DRAFT AUTHORIZATION

By signing the authorization below and attaching a voided check for proper encoding of your personal account number, we will start you on your Bank Draft service free of charge. **Remember to attach a voided check**

Authorization to My Bank

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks drawn on my account and payable to the order of Equitable Life & Casualty Insurance Company provided there are sufficient funds in my account. I agree that your rights in respect to each such check shall be the same as if it were a check drawn and signed by me. This authority remains 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. I further agree that if any such check is dishonored, you shall be under no liability even if it results in the loss of insurance.

Date

X _____
Signature, **EXACTLY** as it appears on Bank Records

AGENT STATEMENT - All questions must be completed

1. Did you personally interview the applicant(s) and witness the signatures? Yes No

2. Please state the name and relationship of any other person present when this application was taken.

Name _____ Relationship _____

3. Did you review the application for correctness and any omissions? Yes No

4. In the event we are unable to issue the policy as applied for, would the applicant(s) accept an alternative policy?

Yes No

5. Do you wish the applicant(s) to be considered for the issuance of a life insurance policy?

Yes No If Yes, Face Amount \$ _____

Beneficiary _____ Relationship _____

Agent's Signature _____ Date _____