

**SUPPLEMENTAL APPLICATION FOR OTHER COVERAGE,
 SUITABILITY SURVEY & COVERAGE COMPARISON**
(all sections must be completed)

Name of Applicant(s) _____

Did anyone, other than the applicant(s), attend the sales presentation? Yes No

If yes, Name: _____ Relationship: _____

OTHER COVERAGE

	Applicant		Spouse	
	Yes	No	Yes	No
Did the applicant(s) have another long term care policy or certificate in force, including health care service contract, health maintenance organization contract?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES, what company? _____ policy # _____				
Did the applicant(s) have another long term care insurance policy or certificate in force during the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES, what company? _____				
If lapsed, when did it lapse? _____				
Do the applicant(s) intend to replace any of your medical or health insurance coverage with this policy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES, what company? _____ policy # _____				
<i>Remember to complete a Replacement Notice.</i>				
List any health insurance policies you sold the applicant that are still in force _____				

List any health insurance policies you sold the applicant in the past five years that are no longer in force _____				

Did you inform the applicant(s) of services covered by Medicare or Medicaid for nursing home and home health care? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If the applicants are replacing similar coverage now in force, have you determined that coverage is not excessive compared to health care costs and total premiums? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No Replacement Involved				

FINANCIAL INFORMATION AND LIVING ARRANGEMENTS

a. Applicant(s) estimated annual income: \$15,000 or less \$15,000-\$30,000 \$30,000-\$50,000 \$50,000+

b. Applicant(s) estimated total assets: \$25,000 or less \$25,000-\$50,000 \$50,000-\$100,000 \$100,000+

c. Who estimated the above amounts? Applicant(s) Agent

d. What funds are available to the applicant(s) to pay for this coverage?
 Income Savings Pension Children will pay Other

e. Does the applicant(s) live alone? Yes No
 If NO, with whom does the applicant(s) live? _____ How long? _____

f. Is there a spouse who has not applied? Yes No Why? _____

g. Does the applicant(s) own or rent their home? Own Rent

h. Type of dwelling: Private Home Condo Mobile Home Retirement Home
 Nursing Facility Apartment Other, please explain _____

i. Does the applicant(s) need any assistance in performing routine daily activities?
 Yes No If YES, please explain: _____

j. Does the applicant(s) have a current driver's license? Yes No
 How often does applicant(s) drive? _____

COVERAGE COMPARISON

	Equitable		Other	
1. Does the policy provide benefits for the following long-term care expenses:	Yes	No	Yes	No
• Skilled, intermediate and custodial/personal care in a Nursing Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Assisted Living Facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Home health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. What is the maximum daily amount the policy will pay:				
• Nursing Home	\$	_____	\$	_____
• Assisted Living Facilities	\$	_____	\$	_____
• Home health care	\$	_____	\$	_____
• Other _____	\$	_____	\$	_____
3. How long are benefits payable:				
• Nursing Home		_____ days		_____ days
• Assisted Living Facilities		_____ days		_____ days
• Home health care		_____ days		_____ days
4. Is there a lifetime limit on the total amount of policy benefits?	Yes	<input type="checkbox"/> No <input type="checkbox"/>	Yes	<input type="checkbox"/> No <input type="checkbox"/>
If "Yes," how much?		\$ _____		\$ _____
5. Is there a lifetime limit on the total days benefits are paid?	Yes	<input type="checkbox"/> No <input type="checkbox"/>	Yes	<input type="checkbox"/> No <input type="checkbox"/>
If "Yes," how long?		_____ days		_____ days
6. Are benefits adjusted for inflation?	Yes	<input type="checkbox"/> No <input type="checkbox"/>	Yes	<input type="checkbox"/> No <input type="checkbox"/>
If "Yes," how much per year?		_____ %		_____ %
		<input type="checkbox"/> Compound		<input type="checkbox"/> Compound
		<input type="checkbox"/> Simple		<input type="checkbox"/> Simple
7. What is the elimination or deductible period before benefits are payable:				
• Nursing Home		_____ days		_____ days
• Assisted Living Facilities		_____ days		_____ days
• Home health care		_____ days		_____ days
8. Is there a waiting period for pre-existing conditions?	Yes	<input type="checkbox"/> No <input type="checkbox"/>	Yes	<input type="checkbox"/> No <input type="checkbox"/>
If "Yes," how long?		_____ days		_____ days
9. Is the policy guaranteed renewable for life?	Yes	<input type="checkbox"/> No <input type="checkbox"/>	Yes	<input type="checkbox"/> No <input type="checkbox"/>
10. Is waiver of premium provided?	Yes	<input type="checkbox"/> No <input type="checkbox"/>	Yes	<input type="checkbox"/> No <input type="checkbox"/>
11. What is the annual premium of the policy, including endorsements or riders?	\$	_____	\$	_____

On this date, I personally met with the applicant for the purpose of insurance solicitation. I compared the benefits and cost of any existing or other proposed insurance program and/or discussed the suitability of the insurance program which I proposed. It has been determined by the applicant and myself that the insurance program proposed by Equitable Life & Casualty is suitable for the applicant's insurance needs.

Agent's Signature

Date

I acknowledge the above agent met with me on this date, made necessary inquiries concerning my insurance needs, and proposed a program of insurance suitable for my needs.

Applicant's Signature

Date