Long Term Care Underwriting — You've

Q: Why are UA's LTC Underwriting Guidelines strict?

A: There is a much higher risk associated with Long Term Care plans because of the low cost of premiums in association with the high amount of benefit payment. Unlike Medicare Supplement policies, which can be field underwritten based on yes/no applications, LTC plans require more advanced help from the Home Office in underwriting. United American does not work with a reinsurer, so the company absorbs all the risk associated with the product.

Q: How soon should I submit my LTC applications?

A: Apps are stale dated after 30 days and have to be resubmitted. It is important to get those completed apps to the Home Office as soon as possible to get the process moving.

Q: What's the average length of time for a Long Term Care policy to be issued?

A: UA's Underwriting Department tries to make a final decision on policies within 45 days. Underwriters review each application individually — if it fits the required guidelines, it will be issued. What can dramatically slow down the process is a customer not being available for a paramed exam or if a physician fails to respond to a request for an Attending Physician's Statement (APS) in a timely manner.

Q: How can I help speed the process?

A:

- ☑ Know whether or not your state has special rates and app/brochures. Use the proper paperwork — especially if you work in more than one state.
- ☑ Read carefully, the General Underwriting Guidelines for LTC Classic and LTC Gold Series provided to you.
- ☑ Provide to the underwriters as much information on the prospect as possible — personal observations about mobility, living conditions, attitude, etc. — on a separate piece of paper.
- ☑ Make sure the paramedical exam has been scheduled and the confirmation number has been recorded on the application before submitting the policy to the Home Office.
- ☑ If an Attending Physician's Statement (APS) is necessary, get the name of the applicant's personal physician who is most likely to have the complete medical records.
- ☑ Call the physician's office and ask how much the fee for an APS is and include this information with the application. Sometimes the physician's fee is more than the check we send. A request from their accounting department for additional monies can delay their sending of the APS to UA — slowing the entire process.
- ☑ Make sure ALL sections and questions on the application are completed.
- ☑ Don't ask for benefits or riders that are not available with the plan selected.
- ☑ Be aware of issue limits.

Q: What are the minimum underwriting requirements?

A: **Applicants age 40 to 69:** Applications will be verified by telephone based on the day and time specified by the applicant. However, if the Unlimited benefit is requested, a paramed exam will be required in all cases instead. After reviewing the app, underwriters will decide whether an Attending Physician's Statement (APS) will be necessary based on the amount at risk or various medical conditions.

Applicants age 70-84: A LTC paramed exam will always be required, and at the underwriter's discretion, an APS may also be ordered. If the Unlimited benefit is applied for or the amount at risk exceeds $200,000, an APS will always be required as well. (Unlimited coverage is not available for ages 80-84; or on the Home Health Care or Home Health and Community Care Riders.)

Got Questions, We've Got Answers.

Q: What is a paramed exam and an Attending Physician's Statement (APS)?

A: **Paramed exam:** A specialist will come by the prospect's home to conduct a face-to-face interview; cognitive survey; mobility evaluation; prescription drug survey; and an over-the-counter drug survey. In addition, the specialist will take the applicant's height, weight and blood pressure measurements as well as ask questions about medical history and activities of daily living. Prepare the applicant to be asked questions during the cognitive survey which generally guage awareness and memory to avoid misunderstanding. On the surface these questions may seem childlike and very basic, but are necessary nonetheless.

APS: This is a health questionnaire completed by the applicant's primary care physician. In many cases, the Home Office will also request a copy of the prospect's medical history.

Q: What conditions should the Agent look for?

A: The presence of one or more of the following condition(s) results in a decline and should not be submitted:

Alcohol or Drug Abuse Treatment	**Dementia**	**Muscular Disease**
Alzheimer's Disease	**Diabetes**	**Muscular Dystrophy**
Aneurysm	**Emphysema**	**Osteoporosis**
Angioplasty	**Hodgkin's Disease**	**Paget's Disease**
Bone or Joint Disease	**Immune System Disorder**	**Parkinson's Disease**
Chronic Obstructive Pulmonary	**Internal Cancer**	**Rheumatoid Arthritis**
Cirrhosis of the Liver	**Kidney Dialysis**	**Seizures or Convulsions**
Congestive Heart Failure or Heart Attack	**Leukemia**	**Stroke**
	Mental or Nervous Disorder	**Systemic Lupus Erythematosus**
Crohn's Disease	**Multiple Sclerosis**	

Underwriters must determine the applicant's ability to remain self sufficient and live independently. As a result, if the prospect has multiple conditions not listed above, a decline may also result if determined that self-sufficiency may be impaired in the future. Along with the prospect's medical history, mental awareness and physical abilities, items such as the home environment and social support of the proposed insured must also be considered. Individuals who are currently using a hospital bed, wheelchair, walker, cane, crutches, catheter, oxygen equipment, respirator or dialysis machine are not qualified for coverage.

Q: Can the Maximum Benefit Periods for the Nursing Home, HHC and HHCC be different?

A: Yes. As long as neither the HHC (Home Health Care) nor HHCC (Home Health and Community Care) Maximum Benefit Periods exceed the Maximum Nursing Home Benefit Period Amount.

Q: Can the Daily Benefit Amounts for Nursing Home HHC and HHCC be different?

A: Yes. As long as neither the HHC or HHCC Daily Benefit Amounts exceed the selected Nursing Home Daily Benefit Amount.

Q: Can different elimination periods be selected for each optional rider?

A: No. The elimination period selected on the Base Policy (Qualified Nursing Home) will be the same for any optional riders selected.