The Prudential Insurance Company of America

Long-Term Care Insurance

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PRODUCER GUIDE AND FIELD UNDERWRITING MANUAL

IFS-A100680 Ed. 2/05

Prudential Financial

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The decision to purchase long-term care insurance is an important one that clients should not take lightly. In making this decision, the company providing the policy is almost as important as the coverage itself. People need to be sure they are buying their long-term care insurance from a company they can count on.

For over a century, Prudential has distinguished itself as one of the leaders in the insurance and financial services industry. You already know that Prudential has been helping to provide solutions to people's protection and accumulation needs for over 125 years and currently serves more than 15 million individual and institutional customers. What you may not know is that Prudential has been providing long-term care insurance since 1986. We have over 18 years of experience servicing customers with their long-term care insurance needs.

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LTC3℠ long-term care insurance, issued by The Prudential Insurance Company of America, was developed in response to input from long-term care insurance producers and financial professionals like you. In developing this product, we used the experience and expertise we gained from selling prior individual long-term care insurance products. We listened to our customers, considered changes in the long-term care marketplace and learned from our competitors' products. The result is a flexible individual long-term care insurance product that you will find to be very competitive in the marketplace.

Introduction to Long-Term Care Insurance

WHAT IS LONG-TERM CARE?

Long-term care (LTC) includes a variety of services for people with prolonged physical illnesses, disabilities, or cognitive disorders (such as Alzheimer's Disease). Long-term care services may include, but are not limited to, home health care, which can range from personal care or help with daily activities such as bathing and dressing, to skilled nursing services, respite care,* adult day care, and care in a nursing home or assisted living facility.**

Long-term care is generally defined as the care of people who have chronic, debilitating conditions and who need assistance with standard Activities of Daily Living (ADLs).

The six standard Activities of Daily Living are:

- bathing
- toileting
- dressing
- transferring from a bed to a chair
- eating
- continence

Providing long-term care for someone can be physically and emotionally draining. It can also be very expensive and could financially drain a family in only a few short years.

** Respite care is a specific benefit to give the primary caregiver a break from caregiving, which could be anywhere from a few hours to a few weeks.*

*** In California an "Assisted Living Facility" is known as a "Residential Care Facility."*

WHY IS THE INTEREST IN LONG-TERM CARE GROWING?

Despite all the planning and saving that many Americans are doing today, there is still one important challenge that is often overlooked—the need to protect against the financial drain of disability or chronic disease. Health insurance and government-sponsored programs such as Medicare and Medicaid have their limitations. Disability income insurance partially covers lost wages during an illness or accident, but what about the costs associated with the additional care needed during this time?

Long-term care is becoming one of the most important issues facing American families today. This is due in large part to a number of social and demographic factors.

To begin with, people are aging. Older Americans are living longer and living better then ever before. However, after the age of 65, Americans have more than a 70% chance of needing some form of long-term care.[1] The basic question is: Will people live well during these years, or will they be physically dependent on others because of serious health problems?

CONSIDER THESE FACTS:

- The probability of a house fire is about 1 in 1200. Having a major auto accident is 1 in 240. Needing long-term care—about 1 in 2.[2]
- More than half of the women and about one-third of the men who reach age 65 will spend some time in a nursing home.[3]
- 80% of adults over the age of 65 are estimated to have one or more chronic conditions.[4]

Since the need for long-term care increases as we age, our aging population poses a greater need for this type of coverage. Costs for long-term care represent the largest out-of-pocket medical expense faced by older Americans today.

Although the long-term care issue is not just for the elderly, people age 45 – 65 and older are the primary market for these products. The main reason for this is that the chances of needing long-term care increase significantly as people age. The price of long-term care insurance is, therefore, lower for people who purchase policies in their 50s than it is for someone over 65.

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WHY MEDICARE MAY NOT BE THE ANSWER

Medicare is a federally financed and administered health insurance program primarily for those age 65 and over, although certain other groups may also be covered. It offers time limited coverage associated with post-acute care. Post-acute care helps patients after an illness and assumes recovery. When recovery is not expected, the patient will need what is called chronic care. The actual services provided under post-acute and chronic care are often the same. What is different is that Medicare does not cover chronic care even if the service is the same.

WHY MEDICAID MAY NOT BE THE ANSWER

Medicaid is a state/federal program for the poor and medically needy. Although rules vary by state, in most areas a single person is allowed no more than $2,000 in personal assets to qualify for assistance and must contribute all but a very small percent of their income toward the cost of their care. In addition, individuals on Medicaid may have to relinquish their choices regarding the type, amount, provider, and even location of the care they receive. Due to these requirements and limitations, Medicaid is not a viable option for many people.

DISABILITY INCOME INSURANCE IS PARTIAL INCOME REPLACEMENT

Short and long-term disability income insurance is designed to partially replace an individual’s income. It does not cover the costs of long-term care.

WHY TRADITIONAL HEALTH INSURANCE IS NOT THE ANSWER

Most long-term care does not entail medical services. Additionally, care is not directed by the onset of an acute illness with recovery in mind. As a rule, non-acute, non-medical care is not covered by most group and individual health insurance, HMOs, or retiree health plans. Health insurance is not meant to cover the type of care required by most people in need of long-term care. Health insurance may offer home care or nursing home coverage, but only if skilled care, intended to help a person get better, is used. As discussed above, once progress stops, the care received is essentially maintenance, such as assisting with the Activities of Daily Living. This type of “maintenance” care is considered non-skilled and is generally not covered. For example, few people realize that health insurance often will not pay benefits for expenses incurred by a stroke victim whose maximum restorative ability has been reached.

FAMILY CARE IS OFTEN NOT ENOUGH

The vast majority of people who take care of someone needing assistance with daily living activities are family members. Consider the fact: Family caregivers who provide care 36 or more hours weekly are more likely than non-caregivers to experience symptoms of depression or anxiety. For spouses the rate is six times higher; for those caring for a parent the rate is twice as high.[5] While some people see this as the natural solution, it is creating a huge strain on families. Caregivers who are leaving work to care for family members are feeling a financial strain. Family members who are attempting to provide 24-hour support are finding that it is emotionally and physically draining, and they may not be trained to provide the care needed.

Even those family members who prefer to take on the responsibility cannot provide care 24 hours a day, 7 days a week. LTC insurance can provide the funds to hire a caregiver to help.

So as you can see, long-term care insurance can help to fill a critical gap.

WHY BUY LONG-TERM CARE INSURANCE?

The benefits of long-term care insurance include:

PRESERVING INDEPENDENCE

Long-term care insurance can help individuals maintain their independence should they need to depend on others for support with Activities of Daily Living. Being able to plan for, select, and finance care helps maintain independence. It can mean a better quality of life not only for the client but for family and friends as well.

PROTECTING SAVINGS AND ASSETS

Long-term care insurance can help protect savings and assets against the need to liquidate them should long-term care be needed. As discussed earlier, the cost to provide long-term care can be prohibitive especially if that care is needed for an extended period of time. An average family could not afford this expense without draining their savings or selling off their assets. And, in general, people do not want to deplete assets to qualify for Medicaid.

PREVENTION AGAINST BEING A BURDEN

A long-term care insurance policy can be the difference between "taking care of yourself" and becoming a burden to your family. In today's society, many

people find themselves in a situation where they are caring for both their aging parents and their young children, often while maintaining a household where both husband and wife work. Add to this equation the need to help someone with the Activities of Daily Living, and this becomes almost impossible to juggle emotionally, physically, and financially.

With the assistance of LTC insurance, the client may be able to remain at home. The benefits can be used to pay caregivers to provide assistance in the home.

PROVIDING CHOICES

The type, provider, and location of long-term care services is directly related to the ability to pay for the care of choice. With the benefits from long-term care insurance available, options remain open.

TAX ADVANTAGES

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). This legislation clarified the tax status of long-term care insurance premiums and benefits and defined the provisions of policies known as federally tax qualified insurance.

The benefits a client may receive under a tax-qualified policy should not be considered taxable income as long as the insured is chronically ill (as defined by the Internal Revenue Code) and the benefits are used to pay for qualified long-term care services (also defined by the Internal Revenue Code).

In addition, premiums for long-term care insurance may be tax deductible as a medical expense (subject to certain limitations) for federal income tax and treated as a credit or a deductible for the purpose of state income tax filing in many states. The agent should advise clients to consult a tax advisor with respect to the tax implications of ownership of a long-term care insurance policy in their state.

LONG-TERM CARE INSURANCE TODAY

Long-term care insurance has changed significantly and rapidly over the past 10–20 years. The older generation of long-term care insurance policies had many limitations such as requiring a mandatory prior hospital stay or inadequate coverage such as few or no home care benefits or insufficient inflation protection.

To help clarify this point, let's take a look at what LTC3℠ has to offer.

Notes

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LTC3SM

PRODUCT DESCRIPTION (STATE VARIATIONS MAY APPLY)

LTC3SM is an individual, comprehensive long-term care insurance product that was developed in a way that literally allows clients to customize the long-term care insurance protection of their choice.* In fact, there are many combinations —not counting the availability of broad Facility Daily Benefits range of $50 to $500 per day (subject to state minimum benefits). In addition, LTC3SM has an array of built-in standard benefits created to provide a high-quality base on which to build the exact coverage the client needs.

** The amount of benefits and the premium will vary with the benefits selected.*

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RATING CLASSES: PREFERRED, STANDARD I AND STANDARD II

If an applicant does not qualify for these three rating classes, coverage may be denied. Please note, long-term care insurance cases are rated differently than life insurance cases. A person acceptable for life insurance may not necessarily be approved for long-term care insurance. Refer to Underwriting Rating/Classification Categories in the Underwriting section for more information.

POLICY DESIGN

Prudential's LTC3SM is a guaranteed renewable individual long-term care insurance policy, which 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.

Premiums are based on the client's age and coverage options chosen. A long-term care insurance policy from Prudential is guaranteed renewable. This means your client has the right to continue their policy so long as they pay their premiums on time and have not exhausted their Lifetime Maximum. Prudential has the right to change premium rates in the future but only on a class basis. An insured's rates cannot be increased due to his or her increasing age or declining health, nor can it be increased based on how many claims are filed. In most states, Prudential would need to obtain regulatory approval before increasing premiums.

COVERAGE

Long-term care services are paid at either the Facility Daily Benefit rate or the Home Care Daily Benefit rate.

Services Paid at the Facility Daily Benefit level are:

- Nursing Home Care
- Care in an Assisted Living or Residential Health Care Facility
- Adult Foster Care or Board and Care Facility
- Hospice Care (Facility or Home-Based): Not subject to Elimination Period
- Respite Care (regardless of site of care)
- Bed Reservation

Services Paid at the Home Care Daily Benefit level are:

- Home Health Care (referred to as Home Care in CA)
- Homemaker Services
- Personal Care
- Adult Day Care

Prudential's LTC3℠ long-term care insurance will cover the services listed above. Clients may select the provider they wish as long as licensure and Plan of Care requirements are met. They do not have to select services at the time of purchase.

FACILITY DAILY BENEFIT: $50 – $500

In most states, the Facility Daily Benefit ranges from $50 to $500 in $10 increments. When selecting a Facility Daily Benefit, clients should consider the cost of nursing home care in the area where they think care will be provided. The client should consider any other income that may be available to supplement their coverage, since lower benefits mean lower premiums.

HOME CARE DAILY BENEFIT: 50%, 75%, 100% OR 150% OF FACILITY DAILY BENEFIT

The Home Care Daily Benefit is calculated as a percentage of the Facility Daily Benefit. While it may vary by state, Prudential offers a choice of 50%, 75%, 100% and 150% of the Facility Daily Benefit selected.

For example, if a $100 Facility Daily Benefit is selected and the client chooses a 50% Home Care Daily Benefit, the policy would provide up to $50 a day for Home Care.

Consider more Home Care coverage for clients whose intention is to remain at home.

LIFETIME MAXIMUM: 2YRS., 3YRS., 4YRS., 5YRS., 6YRS., 10YRS., UNLIMITED

Pool of Money:

Although the Lifetime Maximum is expressed in years, the Lifetime Maximum Benefit is what is called a Pool of Money. The Pool of Money is the total amount of money available to pay benefits under the long-term care insurance policy. The value of the Pool is calculated at purchase by multiplying the selected Facility Daily Benefit by the number of days in the Lifetime Maximum the client selected. For example, assume the client selected a Facility Daily Benefit of $100 and a Lifetime Maximum of three years. The initial Pool of Money (Lifetime Maximum Benefit) would be: $100 × (365 × 3) or $109,500.

After the value of the Pool is first established, inflation protection can increase policy benefits and the Pool, while claims payments can reduce the amount of the Lifetime Maximum Benefit. Use of coverage other than Care Management services reduces the Pool.

It's important to note that even though you may have selected a 5 year Lifetime Maximum Benefit, should you have money left in your pool after 5 years, you would still be eligible for benefits until your pool of money is depleted.

On the Policy Anniversary Date,* adjustments to the Lifetime Maximum Benefit are made as shown below.

**Each month/day of a year following the Policy Effective Date.*

Calculation of new Lifetime Maximum: WITHOUT INFLATION ADJUSTMENT

Assume:	Original Lifetime Maximum Benefit is	$109,500
	Inflation Protection Option is **None**	
	Claims during past policy year equal	$10,000

On the Policy Anniversary date, a new Lifetime Maximum Benefit is calculated as follows:

Step 1:	Subtract claims paid during prior year	$109,500 – $10,000
	New Lifetime Maximum Benefit	**$99,500**

During the next year, assume $15,000 in claims were paid.

On next Policy Anniversary Date, calculation of the Lifetime Maximum Benefit would be:

Step 1:	Subtract claims paid during prior year	$99,500 – $15,000
	New Lifetime Maximum Benefit	**$84,500**

Calculation of new Lifetime Maximum: WITH AUTOMATIC COMPOUND INFLATION BENEFIT—NO MAXIMUM OPTIONAL RS ADJUSTMENT

Assume:	Original Lifetime Maximum Benefit is	$109,500
	Automatic Compound Inflation Benefit	
	Claims during past policy year equal	$10,000

On the Policy Anniversary date, a new Lifetime Maximum Benefit is calculated as follows:

Step 1: Multiply current Lifetime Maximum Benefit by Inflation Factor
$109,500 × 1.05 = $114,975

Step 2: Subtract claims paid during prior year
$114,975 – $10,000
New Lifetime Maximum Benefit **$104,975**

During the next year, assume $15,000 in claims were paid.

On next Policy Anniversary Date, calculation of the Lifetime Maximum Benefit would be:

Step 1: Multiply current Lifetime Maximum Benefit by Inflation Factor
$104,975 × 1.05 = $110,223.75 or
$110,224 (amounts = to $.50 or greater are rounded up to the next dollar)

Step 2: Subtract claims paid during the year
$110,224 – $15,000
New Lifetime Maximum Benefit **$95,224**

ELIMINATION PERIOD (EP)*: 30, 60, 90, 120, 180, 365 DAYS

The Elimination Period (EP, also known as the Benefit Waiting Period in some states) is cumulative and needs to be met only once in a lifetime. It does not need to be satisfied to use Home Support Services, Private Care Consultant, Hospice Care benefits or Respite Care benefits. The EP will begin on the date

you are certified by a Licensed Health Care Practitioner as having a Chronic Illness or Disability.

The EP is counted in calendar days. Each day your Chronic Illness or Disability continues counts towards satisfying the EP.

The client is not required to receive services for a day to qualify. Each day will count in satisfying the EP whether or not a qualified long-term care service is used or whether charges were incurred.

HOME CARE DAILY PAYMENT OPTIONS

LTC3℠ long-term care insurance offers various ways to collect benefits and options for collecting benefits under Home Care. Each is designed to meet a particular client need. It is important to understand the differences in order to explain them and help guide the client's selection.

Daily Benefit

Claims may be made against this benefit for Eligible Charges incurred up to the Home Care Daily Benefit on any given day. Unused money is saved in the pool for later use.

CASH ALTERNATIVE* (BUILT INTO THE BASE POLICY)

The Cash Alternative is provided in the policy and provides a fixed monthly benefit instead of being reimbursed for Eligible Charges for Home Care. The Cash Alternative Benefit allows clients to accept a reduced amount of the Home Care Daily Benefit as a monthly cash benefit, in lieu of reimbursing Eligible Charges incurred for Home Care. This monthly cash payment can be used to compensate informal caregivers. It must be elected on a monthly basis at the time of claim and cannot be combined with any other Facility Care or Home Care Benefits payable that month.

This payment option pays the total of the Home Care Daily Benefit times 40% times the number of days in the month the client has a Chronic Illness or Disability regardless of whether services were provided. For example, if the Home Care Daily Benefit is $50, in a 30 day month, the Cash Alternative Benefit would pay $600 ($50 × 40% × 30 days).

The Cash Alternative Benefit cannot be used with the Cash Benefit Rider or the Flexible Cash Benefit Rider. This Benefit is subject to the Elimination Period and reduces the Lifetime Maximum.

Monthly Benefit

The optional Monthly Benefit Rider allows greater flexibility in using services when they are needed. This method of payment pays up to the total of the Home Care Daily Benefit times the number of days in the month for covered services at any time during that month, but not more than the actual charges incurred. The monthly pool (e.g. $50 Home Care Daily Benefit × 30 days = $1500) can be used as needed during that month. There is no daily limit, per-service limit, or maximum per week. Unused money is saved in the pool for later use. If the client satisfies the EP on a day other than the first of the month, the total benefits of the monthly pool will be pro-rated based on the number of days remaining in the month. If the client is eligible for the entire month, the monthly pool is calculated as discussed above.

This benefit is subject to the Elimination Period and reduces the Lifetime Maximum.

Cash Benefit Rider*

While this benefit is the most flexible, it is also the most expensive. The optional Cash Benefit Rider revises the Policy to pay a fixed monthly indemnity benefit to the client, in lieu of reimbursing Eligible Charges incurred for Home Care. Having a cash payment puts the client in control of directing funds for caregiving. The monthly cash payment can be used to compensate informal caregivers in addition to licensed professionals, if the client deems this the best use of funds. No bills need to be submitted; payment of the monthly cash benefit is linked to having a Chronic Illness or Disability.

This payment option pays the total of the Home Care Daily Benefit times the number of days in the month. For example, the amount payable on a policy with a Cash Benefit Rider and $100 Home Care Daily Benefit for a 30 day month would be $3000 ($100 × 30 days). Benefits under the Cash Benefit Rider are paid every month regardless of whether charges are incurred.

The Cash Benefit Rider is not available with an Unlimited Lifetime Maximum, 150% Home Care, and negates the Cash Alternative Benefit in the base policy.

**Eligibility for benefits under the Cash Benefit Rider is subject to the same requirements that apply to other payment options including submission of a Plan of Care and a monthly claim form.*

Using the Cash Benefit Rider

As an indemnity benefit, moneys received under the Cash Benefit Rider may be disbursed at the discretion of the policyholder. Contract and exclusion language regarding approved providers, types of care, or geographical limitations do not apply. This means the policyholder can use their Cash Benefit Rider benefits to pay directly for among other things:

- Informal caregiver services received from family members, friends, and neighbors
- Long-term care expenses incurred outside the U.S.

Using the Cash Benefit Rider Outside the United States

Clients may receive payment under the Cash Benefit Rider outside the United States under the following conditions:

- A U.S. Licensed Health Care Practitioner must use Prudential's assessment tool and report the assessment findings in English.
- Once the assessment has been completed a U.S. Licensed Health Care Practitioner must certify whether the policyholder has a Chronic Illness or Disability.
- After eligibility is established, reassessments following the same requirements as the original assessment are performed at least once a year. After completion of the Elimination Period and as long as eligibility continues, benefits will be payable without submission of bills.
- Prudential will make every effort to arrange for an assessment or reassessment. However, Prudential cannot guarantee that a U.S. Licensed Health Care Practitioner (LHCP) can be located in remote locations.
- All payments under the Cash Benefit Rider will be paid to the policyholder or their designee in U.S. currency.

Special Notice Regarding the Cash Benefit Rider and the Flexible Cash Benefit Rider: ***Since benefits paid under these Options are made without regard to costs incurred by a client, part of the benefits could be considered taxable income. If the benefits paid under these Options are in excess of the daily limit as prescribed by law (refer to 2005 Tax Guide), they could be considered taxable income. This daily limit is indexed for inflation. Agents should advise clients to consult a tax advisor with respect to the tax implications of ownership of a long-term care insurance policy with the Cash Benefit Rider or the Flexible Cash Benefit Rider.***

FLEXIBLE CASH BENEFIT RIDER

The Flexible Cash Benefit Rider is an optional rider that is intended for those clients who want the flexibility of the Cash Benefit Rider but need a more affordable benefit. It allows clients, at time of claim, to receive 50% of their Home Care benefit in cash for each day in the month they are benefit eligible. This payment option equals the total of the Home Care Daily Benefit times 50% times the number of days in the month. For example, if the Home Care Daily Benefit is $50, in a 30 day month, the cash payment portion of the benefit would be $750 ($50 × 50% × 30 days). This amount would be paid whether or not charges were incurred.

In addition to the cash portion, clients can also be reimbursed for Eligible Charges incurred for Home Care in the same calendar month they elected to receive the cash portion. For each day Eligible charges are incurred 50% of the Home Care Daily Benefit is available to pay such charges.

Total combined benefits paid per day are limited to the Home Care Daily Benefit. In no event would the total monthly benefit exceed 100% of the Home Care Daily Benefit times the number days during the month that the client was certified as having a Chronic Illness or Disability.

It is intended to cover both formal as well as informal expenses and allows the client the opportunity to choose whether to be paid on a cash basis only, or a combination of both cash and reimbursement. If friends or family are providing care, the client can make a claim to receive only the 50% cash payment provided by this benefit. When more professional services are needed, this benefit can also reimburse for the additional formal care that is needed.

The Flexible Cash Benefit Rider negates the Cash Alternative Benefit in the base policy. It is not available with the Cash Benefit Rider, an Unlimited Lifetime Maximum, or 150% Home Care Daily Benefit. It cannot be used for Home Health Care, Homemaker Services, or Personal Care Services received outside the United States. (See International Benefit.) This benefit is subject to the Elimination Period and reduces the Lifetime Maximum.

INFLATION PROTECTION

The cost of nearly everything we purchase tends to increase over time. Long-term care services are no different. Coverage bought today but not used for 20 years may not provide the protection it did originally. That's where inflation protection comes in—to help keep pace with the rising costs of health care services and maintain the worth of the client's long-term care coverage.

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When determining which option to recommend for the client, you should consider how far into the future the client's need for long-term care may arise. All states require the client to be offered the Automatic Compound Inflation Benefit—No Maximum Rider. The more time expected to pass, the greater the potential effect of inflation on the cost of care: the greater the effect of inflation, the higher the possible out-of-pocket expense to the client. Simply put, as a rule, the younger the client, the greater the need for inflation protection.

With LTC3[SM], there are five inflation protection options. Except where benefit limits have been reached under the Automatic Compound Inflation Benefit—2X Maximum Rider, all offers and increases will continue even if the client is in benefit.

None

There is no inflation protection in the base policy. Therefore, the policy alone provides no protection against increases in the cost of long-term care services due to inflation.

Guaranteed Purchase Option*

Under the Guaranteed Purchase Option (GPO), benefits do not automatically increase every year. Rather, an increase in coverage will occur every three years enabling the client to purchase additional coverage without further underwriting. Policy Benefits will be increased by 5% compounded annually over the three year period. For example, assume the current Facility Daily Benefit was $100. Annually compounded by 5% for three years, the new Facility Daily Benefit would be $116 ($100 × 1.05 × 1.05 × 1.05 = $115.76). Therefore, the increase to the Facility Daily Benefit would be $16. The premium for the additional $16 in coverage will be based on the client's attained age.

This increase will be automatic and is deemed to be accepted unless a written declination is received. No evidence of insurability is required. Increases are made even if the client has met the benefit eligibility criteria or is on claim.

Due to the fact that each increase of additional coverage is priced at an older age, over time the premium for coverage equivalent to that under the Automatic Compound Inflation Benefit No Maximum Rider will be significantly higher under the GPO Rider. Therefore, GPO protection may not be the most cost-effective protection for clients whose expected utilization is more than 10 years in the future.

**The GPO rider is not available with Paid Up at Age 65 or 10 Years Paid Up Limited Payment Options. It also is not available with Premium Reduction at Age 65, Joint or Survivor Waiver of Premium or the Shared Care rider.*

Automatic Simple Inflation Benefit Rider*

On each policy anniversary date, the client's current Policy Benefits will automatically increase by 5% of the original Policy Benefits. For example, assume the original Facility Daily Benefit was $100. On the first policy anniversary the Facility Daily Benefit would increase to $105 ($100 + ($100 × .05 = $5)). On the second policy anniversary, the client's Facility Daily Benefit under this rider would increase to $110 ($105 + ($100 × .05 = $5)). Increases will equal the same dollar amount each year. Although the premium for the Automatic Simple Inflation Benefit Rider is usually lower than that of the Automatic Compound Inflation Benefit No Maximum Rider, the Facility Daily Benefit under each option will be approximately equivalent for about 10 years. This means that where the client's expected utilization is about 10 years in the future, the Automatic Simple Inflation Benefit Rider might be a cost-effective choice.

**Not available in Delaware, Indiana, or Wisconsin.*

Automatic Compound Inflation Benefit—2X Maximum Rider*

On each policy anniversary date, the client's Policy Benefits will automatically increase by 5% of their previous year's Policy Benefits under this optional rider. When their original Facility Daily Benefit has doubled, it will cease increasing.

For example, assume the original Facility Daily Benefit was $100. Through yearly compounding, it reaches $200. Under this option, the Facility Daily Benefit would remain at $200 for the duration of the policy.

**Not available in Connecticut or Indiana.*

Automatic Compound Inflation Benefit—No Maximum Rider

On each policy anniversary date, the client's Policy Benefits will automatically increase by 5% of their previous year's Policy Benefits under this optional rider. There is no limit to the growth of the Policy Benefits.

Inflation protection is an important feature of any long-term care insurance policy. The table on the following page shows the five LT3℠ inflation protection options and what each of them could mean to the client in terms of available coverage over time.

TC3—INFLATION BENEFIT RIDER OPTIONS

Assume: Initial Facility Daily Benefit of $100

Benefit Increase Option	None	GPO (Guaranteed Purchase Option)	Automatic Simple Inflation Benefit	Automatic Compound Inflation Benefit—2X Maximum	Automatic Compound Inflation Benefit—No Maximum
Policy Anniversary	**Facility Daily Benefit**	**Facility Daily Benefit**	**Facility Daily Benefit**	**Facility Daily Benefit**	**Facility Daily Benefit**
1st	$100	$100	$105	$105	$105
2nd	$100	$100	$110	$110	$110
3rd	$100	$116	$115	$116	$116
4th	$100	$116	$120	$122	$122
5th	$100	$116	$125	$128	$128
10th	$100	$155	$150	$163	$163
15th	$100	$208	$175	$200	$208
20th	$100	$240	$200	$200	$265
21st	$100	$278	$205	$200	$278

WAIVER OF PREMIUMS

Premiums will be waived when both the eligibility criteria and the Elimination Period are satisfied. They will continue to be waived as long as the client is eligible for benefits under their policy. Premium waiver will begin on the day following the date the Elimination Period is met.

WAIVER OF PREMIUM OPTIONS*

JOINT WAIVER OF PREMIUMS BENEFIT RIDER

The Joint Waiver of Premiums Benefit Rider is available if both Spouses/Partners have purchased a Long-Term Care Insurance Policy issued by Prudential. In addition, both policies must have been issued at the same time or within 6 months of one another. Under the Joint Waiver of Premium option, when premium is waived due to eligibility for one Spouse or Partner, premiums will be waived for both Spouses or Partners. Premiums will resume following the death or ineligibility of the eligible Spouse/Partner. When premiums resume, they shall be pro-rated to the date of the ineligibility unless an insured for whom premiums were waived had selected a Limited Payment option and during the waived period the payment period elapsed.

For example, if the insured had selected the 10 Year Paid Up Limited Payment option and there were three more years payable, if premiums were waived three or more years under the Joint Waiver of Premium, no further premiums would be due when the waiver was no longer in effect.

If either Spouse or Partner dies or lapses, the Rider shall terminate for the remaining Spouse/Partner. If the remaining Spouse/Partner wishes to establish the option with another partner, both must be underwritten even if both already hold active Prudential policies.

**This benefit is not available with the Guaranteed Purchase Option Inflation rider or the Shared Care benefit rider.*

SURVIVOR WAIVER OF PREMIUMS BENEFIT RIDER*

The Survivor Waiver of Premiums Benefit Rider option is available if both Spouses/Partners have purchased an Individual Long-Term Care Insurance policy issued by Prudential. If one Spouse/Partner dies after 10 years of premium payment with no claims by either client during the first 10 years the policies and this rider was in-force, the survivor's premium will be permanently waived.

If either Spouse or Partner dies prior to the 10th policy anniversary, lapses, or goes into claim prior to activating benefits under this option, the Rider shall terminate for the remaining Spouse/Partner.

If a Spouse/Partner wishes to reestablish the option with another partner, both must be underwritten.

**This benefit is not available with the Guaranteed Purchase Option Inflation rider or the Shared Care Benefit rider.*

STANDARD BASE POLICY BENEFITS (EXCEPT AS NOTED, THE FOLLOWING BENEFITS ARE STANDARD IN ALL LTC3SM POLICIES)

INTERNATIONAL COVERAGE BENEFIT

The International Coverage Benefit provides benefits for Qualified Long-Term Care Services that are received outside of the United States as a resident in an Out-of-Country Nursing Home or Home Health Care, Homemaker Services, or Personal Care Services. Benefits for Eligible Charges will be paid up to 75% of the International Coverage Facility Daily Benefit or International Coverage Home Daily Care Benefit according to the services used. International Coverage Benefits do not include Bed Reservation, Hospice Care, Respite Care, Home Support Services, Alternate Plan of Care, or Private Care Consultant Benefits when incurred outside of the United States.

Payment of International Coverage benefits is limited to 365 days over the lifetime of the Policy. These benefits are subject to the Elimination Period and reduce the Pool of Money.

International Coverage Benefits are not available with the Cash Alternative Benefit, and the Flexible Cash Benefit Rider. This coverage is subject to the Elimination Period and reduce the Lifetime Maximum.

RESTORATION OF BENEFITS

The Lifetime Maximum will be restored if the client who had been receiving benefits:

a) is neither receiving benefits under their policy nor has exhausted their Lifetime Maximum Benefit; and
b) they are reassessed by a Licensed Health Care Practitioner as no longer having a Chronic Illness or Disability; and
c) remains ineligible for benefits for a period of at least six consecutive months,

then the client's Lifetime Maximum Benefit will be restored to what it would have been had no claims been paid under the policy. The Lifetime Maximum may be restored only once during the client's lifetime. This benefit is not applicable if the Unlimited Lifetime Maximum is selected.

HOME SUPPORT SERVICES

When it comes to providing quality long-term care coverage, assisting clients to stay at home for as long as possible is one of the priorities of LTC3℠. That's why Prudential offers the Home Support Services feature to cover items that are important in helping clients maintain independence.

Home Support Services benefits are designed to provide coverage for things that make staying at home possible. Clients can use this benefit to purchase things like a personal emergency response system or to make home modifications (ramps, grab bars in the bathroom, etc.). It can also be used to provide caregiver training to the client's informal caregiver on transferring techniques, giving a bed bath, and use of assistive devices. With this training, the caregiver may be able to meet the needs of the client at home more effectively.

This feature provides funds for such things as:

- Assistive Devices
- Durable Medical Equipment not covered by Medicare
- Home Modifications
- Emergency Medical Response Systems
- Caregiver Training
- Transportation Services

The Home Support Services benefit equals 50 times the Facility Daily Benefit and may be used prior to meeting the Elimination Period. Claims against Home Support Services reduce the Lifetime Maximum benefit.

ALTERNATE PLAN OF CARE

As the need for long-term care has grown, so have the types of services to meet that need. Thirty years ago, nursing homes predominated, and home health care was scarce. Ten years ago, nursing home services were still prominent, but home care and the choices for care in the community had grown tremendously. Today, assisted living facilities/residential health care facilities are again changing the way long-term care is delivered. Tomorrow there may be other services.

Because it is impossible to predict what new forms of long-term care are likely to be developed in the years ahead or what the specific needs of each client might be, Prudential's LTC3℠ Alternate Plan of Care feature enhances the

value of the client's coverage by being open to consideration of new ideas and adaptable to forms of care not specifically mentioned elsewhere in the policy. Subject to Plan of Care requirements and qualification under federal tax regulations, Prudential will consider such services on a case-by-case basis.

CARE MANAGEMENT

When the need for long-term care arises, most policyholders and their families need help in understanding and adjusting to the changes long-term care can bring. This help falls into two categories: process assistance and personal assistance. The Prudential policy recognizes both.

Prudential Benefit and Resource Information Services

Benefit and Resource services focus on process assistance. These services involve such issues as how to make a claim, establishing eligibility, information about finding providers, and generally helping the client through the administrative requirements of accessing benefits efficiently and effectively. Benefit and Resource Information Services are provided by or arranged by Prudential's Long-Term Care Customer Service Center.

This benefit does not reduce the Lifetime Maximum Benefit and is not subject to the Elimination Period.

Private Care Consultant*

The Private Care Consultant Benefit provides personal assistance. While the substance of personal assistance services may be less obvious than process assistance services, they can be equally as important. Private Care Consultant services focus not on the mechanics of providing care and claiming benefits but on supporting the client and their family on a level that goes beyond direct provision of care.

Frequently, long-term care services are needed in the wake of a crisis. To guide the client through what may be difficult times, LTC3℠ provides funds to pay for the services of an independent patient/family advocate. The Private Care Consultant is selected and retained solely by the client and is not connected with Prudential.

**Not available in Texas.*

While a Private Care Consultant can provide some of the services covered under the Prudential Benefit and Resource Information Services benefit such as locating long-term care providers, their primary concern is giving practical support for the emotional needs of the client and their family. Types of assistance include counseling, education, and personal oversight of care quality. For example, the patient/family advocate may be someone who can visit the client's home and point out or arrange for changes to make it more comfortable. Or, the advocate could keep out-of-town family members up-to-date on care issues, concerns, or options. Having someone on site can be vital in keeping caring but separated families in touch with the well being of their loved one.

This benefit is an annual pool equal to 20 times the Facility Daily Benefit. Use is not subject to the Elimination Period, nor will using the benefit reduce the client's Lifetime Maximum Benefit.

RESPITE CARE

Like the Private Care Consultant Benefit, Respite Care supports both clients and their families. Prudential recognizes that to be effective, caregivers need a break. We also recognize that the informal care provided by the caregiver may need to be replaced by formal care, possibly, at an increased expense. Therefore, LTC3℠ provides up to 21 days per year under the Respite Care Benefit.

Services claimed under the Respite Care Benefit will be paid up to the Facility Daily Benefit regardless of the site of care or the client's Home Care Daily Benefit. Benefits paid under the Respite Care Benefit reduce the Lifetime Maximum Benefit but are not subject to the Elimination Period.

BED RESERVATION

If the client is in a nursing home or assisted living/residential health care facility and must leave for a period of time (up to 60 days annually), this benefit will pay the nursing home or assisted living/residential health care facility its customary rate up to the Facility Daily Benefit cost while the client is away from the facility. This allows the facility to hold the client's bed until the client returns.

The Bed Reservation Benefit reduces the Lifetime Maximum Benefit and is subject to the Elimination Period. The Bed Reservation Benefit may not be claimed on the same day as other services.

NON-FORFEITURE

Shortened Benefit Period Rider* (This rider must be purchased at policy issue)

The Shortened Benefit Period Rider is the optional Non-Forfeiture Benefit available under the LTC3℠ long-term care insurance policy. If the client selects this option and the policy ends due to nonpayment of premium, and neither of the two following conditions apply, coverage under the policy may be extended.

The Shortened Benefit will NOT take effect if:

1) the policy ended before its third anniversary, or
2) the client has already received benefits that equal or exceed the total amount of premiums paid for the policy.

Under the Shortened Benefit Period option, benefits will be payable based on the Facility Daily Benefit in effect on the date coverage would otherwise have ended. However, there will be a reduced Lifetime Maximum Benefit. A reduced Lifetime Maximum Benefit means that benefits will be paid for a shortened benefit period. The reduced Lifetime Maximum Benefit will equal the greater of:

1) 30 times the policy's current Facility Daily Benefit at the time of lapse up to the Lifetime Maximum Benefit in effect on the date the coverage would otherwise have ended; or
2) the total amount of premiums paid for the policy, less the sum of all benefits paid on the client's behalf while the policy was in force.

For example, if the client selected a $100-a-day Facility Daily Benefit, had no claims, and had paid a premium of $1200 for five years, available Shortened Benefit Period coverage would be calculated as follows:

$100 × 30 = $3,000 (minimum amount available)

$1,200 × 5 = $6,000 Total Premiums paid prior to termination (higher than minimum).

Shortened Benefit Period = $6,000

**State variations may apply.*

Contingent Non-Forfeiture Benefit

Although Prudential takes great pride in its ability to set stable premiums, rate increases are a possibility. Therefore, in the unlikely event that premium increases occur that go beyond certain set percentages and the client feels he cannot maintain the policy, this benefit automatically provides a choice of two options:

1) lower Lifetime Maximum Benefit that will enable the client to receive value for premiums paid; or
2) reduced benefit options to keep premium about the same as before the rate increase.

The Contingent Non-Forfeiture Benefit is one of the basic LTC3℠ benefits. It works as follows: if the client does not have an optional Shortened Benefit Period Rider on his policy and there is a substantial increase to the premium as defined below, then he may choose to cancel coverage

The client's other choice under the Contingent Non-Forfeiture Benefit is to select alternative benefits such as a longer Elimination Period or a lower Facility Daily Benefit, resulting in a lower premium, but enabling the client to keep the policy in-force.

Substantial Premium Increase

A Substantial Premium Increase is one that results in a cumulative increase to the Initial Annual Premium that is equal to or exceeds a certain percentage of that premium. It does not include premium increases that result from a voluntary purchase of additional coverage. The limits of cumulative increase as a percentage of the Initial Annual Premium are based on the client's age as of the Policy Effective Date shown in the Schedule of Policy Benefits. The table below shows the cumulative increase that will trigger the Contingent Non-Forfeiture Provision.

SUBSTANTIAL PREMIUM INCREASE TABLE

PREMIUM AGE	PERCENT OF INCREASE	PREMIUM AGE	PERCENT OF INCREASE
Less than 30	200%	72	36%
30 – 34	190%	73	34%
35 – 39	170%	74	32%
40 – 44	150%	75	30%
45 – 49	130%	76	28%
50 – 54	110%	77	26%
55 – 59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

RETURN OF PREMIUM UPON DEATH RIDER (THIS RIDER MUST BE PURCHASED AT POLICY ISSUE)

The Return of Premium Upon Death Rider refunds the total amount of premiums paid minus any benefits that have been paid or, are payable, when the policyholder dies. This benefit will be paid even if, at the time of death, the client is receiving benefits and premiums have been waived. However, waived premiums are not considered to be paid premiums and will not be included under this provision.

This rider is not available with the Shared Care Rider. Benefits that are claimed under this rider are subject to the Elimination Period and reduce the Lifetime Maximum.

SHARED CARE RIDER (THIS RIDER MUST BE PURCHASED AT POLICY ISSUE)

The Shared Care Rider allows one “Shared Care Partner” to access benefits available under the other “Shared Care Partner’s” Policy once his/her own Lifetime Maximum is exhausted. Furthermore, if one Shared Care Partner dies, the surviving Partner’s Lifetime Maximum will be increased by the amount of the deceased Partners remaining Lifetime Maximum, if any.

If one Shared Care Partner exhausts the other's benefits, the Partner who is not in benefit can purchase a new Long-Term Care Insurance Policy from Prudential on a guaranteed issue basis with a Lifetime Maximum of two years. Benefits for this policy can go up to those that were in effect when the policy limits were exhausted. This policy will be rated based on the age of the Partner at the time he/she purchases this new policy and is not available to anyone age 90 or older on the day his/her Lifetime Maximum was exhausted.

In order to access this benefit, certain conditions must be met. Both Shared Care Partners must purchase a policy and this rider, and at the same time, have identical plan designs, including inflation options. The Premium Payment Options must be identical as well.

The Shared Care Rider is not available with certain other benefits including Return of Premium at Death, the Guaranteed Purchase Option, Joint and Survivor Waiver of Premiums Riders, and Unlimited Lifetime Maximum. This rider is subject to the Elimination Period and reduces the Lifetime Maximum.

PREMIUM PAYMENT OPTIONS*

10 Year Paid Up**

The lifetime premium obligation can be paid in 10 annual increments. The minimum age for purchase of the 10 Year Paid Up option is 40 and the maximum age for purchase is 75.

Paid Up At Age 65**

The lifetime premium obligation can be paid in equal increments (not less than 10) that will create a paid-up policy by the purchaser's 65th birthday. The maximum age for purchase of the Paid Up At Age 65 option is 54.

If a policy lapses under either option, there is no return of premium or consideration of premiums paid except as may be covered by the policyholder's nonforfeiture option or state/federal requirements. The topic of Payment Options should be discussed carefully with your client. Once a policy is issued, a change from a lifetime pay to a limited pay (Paid Up at Age 65 or Ten Pay) or vice versa cannot be made on the same policy. In order to accommodate this change, the current policy would be terminated and a new policy would be issued. Additional medical underwriting may be be required and no credit for premiums paid will be provided.

** Limited pay options are not available in Florida or Pennsylvania.*
*** Clients in New Jersey and Tennessee who elect one of these payment options must also purchase the Non Forfeiture Benefit (Shortened Benefit Period Rider).*

Premium Reduction at Age 65

The Premium Reduction at age 65 is a lifetime payment plan that reduces the clients' premiums by 50% at age 65. It is available to clients age 60 or younger. If policy benefits are increased after age 65, the additional premium will not be reduced. Persons electing a 10 year Paid Up At Age 65 option may not increase benefits (other than to drop their Premium Payment option) under their policies after the first year.

PREMIUM INCREASES

Premiums are based on the client's age and coverage options chosen. A long-term care insurance policy from Prudential is guaranteed renewable. This means your client has the right to continue their policy so long as they pay their premiums on time and have not exhausted their Lifetime Maximum. Prudential has the right to change premium rates in the future but only on a class basis. An insured's rates cannot be increased due to his or her increasing age or declining health, nor can it be increased based on how many claims are filed. In most states, Prudential would need to obtain regulatory approval before increasing premiums.

DISCOUNTS

Depending on the state of sale, the following discounts are available:

SPOUSE/PARTNER DISCOUNT

This discount includes both married individuals and those people who are not married but meet the definition of "Partners."

Spouse/Partner discounts are also available for Common Law and Partners in civil unions in states where such arrangements are legally recognized (subject to state availability).

The following requirements must be met in order to be eligible for the Partner discount:

1. be over age 18;
2. have lived together for at least 12 consecutive months preceding the date of the application;
3. have a serious and committed relationship;
4. not be legally married, nor a Partner to anyone else; and
5. be "financially interdependent." "Financially interdependent" means that the

Partners must share the cost of food and housing. While they do not have to contribute equally or jointly for each of these expenses, each must be responsible for such costs.

Persons potentially eligible under this discount include siblings, parent/child, other familial relationships, domestic partners, or any two individuals of either sex who have established a stable, committed association with the clear and expressed expectation of long-term cohabitation.

The discount has two levels. A single married individual or Partner who applies for and is issued a Prudential Long-Term Care Insurance policy qualifies for a 15% discount. Two Spouses or Partners who apply for and are issued each qualify for a 30% discount on each policy.

**This discount may not be available in some states.*

PREMIUM PAYMENT MODES

The client may elect to remit premium in any of the following modes:

- Annual
- Semiannual
- Quarterly
- Monthly (Electronic Fund Transfer (EFT/Pru-Matic only)

ELECTRONIC FUND TRANSFERS

For EFT, one month's prepayment is acceptable. However, two month's premium ensures that there is no need to back bill in situations where an effective date misses the transmission to the bank. While the need to back bill will not happen often, the Agent and the client should be aware that it might be necessary. Prudential will notify the client if this is the case.

**EFT requires a signed authorization that must be completed on the application. A minimum of two months' premium is required for applicants who select EFT, except all applicants in California and applicants age 65 and over in New Hampshire where one month's premium is acceptable.*

BENEFIT ELIGIBILITY

CLAIM PROCESS

It is important for the client to know that they should begin the claim process by calling Prudential's Long-Term Care Customer Service Center at 1-800-732-0416, to notify Prudential of a claim. Early awareness by Prudential will facilitate a timely claim review. It is preferred that the client or his representative call Prudential as far in advance as possible before beginning to use long-term care services.

Once notified of a claim, Prudential can arrange for a Licensed Health Care Practitioner to evaluate and provide an assessment of the client's condition. The Licensed Health Care Practitioner will complete the evaluation tool and return the assessment to Prudential. A Licensed Health Care Practitioner must certify that the client has a Chronic Illness or Disability in order to be eligible to receive benefits. There is no charge to the client for the assessment and therefore no impact on their Lifetime Maximum benefit in the policy.

The client has the right to arrange for and select their own Licensed Health Care Practitioner. In this event, the assessment must be completed in-person using Prudential's Assessment Form, and returned to Prudential as soon as possible after completion. The form can be obtained by calling the Long-Term Care Customer Service Center (1-800-732-0416). If the client arranges for and selects their own Licensed Health Care Practitioner, assessment expenses will be borne by Prudential.

BENEFIT TRIGGERS

Clients become eligible to receive benefits under the policy when they are assessed and certified as having a Chronic Illness or Disability.

A Chronic Illness or Disability is one in which there is:

- A loss of the ability to perform, without Substantial Assistance, at least two Activities of Daily Living due to a loss of functional capacity that is expected to last for a period of at least 90 consecutive days. Activities of Daily Living are: bathing, continence, dressing, eating, toileting, and transferring; or
- Severe Cognitive Impairment, which requires Substantial Supervision to protect the client from threats to their health and safety.

PLAN OF CARE REQUIREMENT

If clients are eligible, a written Plan of Care must be developed consistent with the clients' needs. A written Plan of Care describes the type, frequency, and anticipated duration of long-term care services that are needed, as well as the types of providers who are needed to render the services. It must be developed and approved by a Licensed Health Care Practitioner.

The Plan of Care will be used to determine benefits based on the benefit options the client has selected.

The choice of providers of the needed long-term care services will remain up to the client. Once it is confirmed that the client has a Chronic Illness or Disability, a Plan of Care is developed. Charges for the Plan of Care, if any, and any ongoing care management expenses can be made against the Private Care Consultant Benefit.

The client or his representative must submit a claim form, the bill for covered services, and a copy of the Plan of Care in order to receive payment for those services. A Plan of Care is necessary regardless of the services the client intends to use. If the Cash Benefit Option is selected, bills need not be submitted for services rendered, but the Plan of Care and a claim form are still required.

POLICY EXCLUSIONS (STATE VARIATIONS MAY APPLY)

There are some special circumstances that limit or exclude the availability of benefits under this policy. No benefits will be payable if any of the following situations apply:

1. Illness, treatment or medical conditions arising out of
   a) War or an act of war, whether declared or undeclared, while you are insured; or
   b) Your participation in a felony, riot or insurrection; or
   c) Alcoholism and drug addiction.
2. Treatment provided in a government facility, unless payment of the charge is required by law or services provided by any law or governmental plan under which you are covered. This does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.
3. Charges for services or supplies for which no charge would be made in the absence of insurance.

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4. Charges for care or treatment provided outside the United States except as described in the International Coverage benefit.

NON-DUPLICATION OF MEDICARE BENEFITS

Benefits under the Policy are not payable for expenses for Qualified Long-Term Care Services to the extent that:

1. Such expenses are reimbursable under Medicare; or
2. Such expenses would be reimbursable under Medicare but for the application of a deductible or coinsurance amount.

This provision does not apply if the following situations apply.

1. Such expenses are reimbursable under Medicare as a secondary payer.
2. Claim is under the Cash Alternative Benefit, Cash Benefit Rider, or Flexible Cash Benefit Rider, if any.

COORDINATION WITH OTHER PRUDENTIAL INDIVIDUAL LONG-TERM CARE INSURANCE POLICIES

Benefits under the clients' Policy may be reduced if we also pay benefits for Eligible Charges under any other Prudential Individual Long-Term Care Insurance Policy. Benefits will be reduced under this Policy only when payment under this Policy and all other Prudential Individual Long-Term Care Insurance Policies combined would exceed the actual amount incurred for Eligible Charges. In no event will we pay more under this Policy than the difference between the clients' actual expenses and the amount payable by his other Prudential policies.

If the client is insured under more than one Prudential Individual Long-Term Care Insurance Policy with a similar Coordination provision, the policy with the earliest effective date will be deemed primary and will pay its benefits first. Thereafter, payment will be made under any additional policy (secondary coverage) in order of effective date, from the earliest to the latest. A Prudential policy without a similar Coordination provision will pay first, without any reduction in its benefits.

Notes

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Marketing Long-Term Care Insurance

PRESALE ISSUES: THINGS TO KNOW BEFORE SELLING LTC3℠

LICENSURE

Licensing

To sell LTC3℠ long-term care insurance, you must:

a) Be licensed to sell life and health insurance;

b) Be appointed to sell life insurance for Prudential;

c) Be licensed and appointed to solicit long-term care insurance products at the time the presentation is made in the state where the applicant resides; and

d) Pass the Long-Term Care PLN (Prudential Learning Network). (Prudential Career Agents only.)

Requirements to sell individual long-term care insurance will be checked when the first application is submitted. Policy documents are issued according to the applicant's state of residence.

Additional Requirements

Certain states require additional licensing, testing, or education prior to marketing, selling, soliciting, or otherwise contacting a person for the purpose of marketing long-term care insurance. You may be required by law to demonstrate your knowledge of long-term care insurance and the appropriateness of such insurance by passing a test required by the state and maintaining appropriate licenses.

If your state requires a specific long-term care insurance license, please enclose a copy of it with your first application submission.

SALES PRACTICES

Out-of-State and Solicitation

If the application uses the applicant's secondary residence as the state of issue, the applicant must meet state residency requirements. The agent uses the forms and applications and meets the licensing/appointment and continuing education requirements of the applicant's State of Residence.

Product Availability

LTC3℠ long-term care insurance is filed in all states although certain benefits or options may vary. As a matter of policy, product availability requirements must be followed. For example, it would not be appropriate to take the resident of one state into another state for the purposes of purchasing a benefit or options not available in the client's resident state.

Sales Practices

Agents selling LTC3℠ long-term care insurance must adhere to the following established sales practices:

Establish marketing procedures to assure that any comparison of policies will be fair and accurate.

Establish marketing procedures to assure excessive insurance is not sold or issued.

Use only Prudential approved marketing material.

Inquire and otherwise make every reasonable effort to identify whether a prospective applicant for long-term care insurance already has any accident and sickness or long-term care insurance policies as well as the types and amounts of any such insurance. If the applicant has existing long-term care insurance and does not intend to replace this coverage, consider whether the existing coverage is an indemnity or expense incurred plan, and review the relationship of cost of care and maintaining the existing coverage against total benefits. Excessive insurance is costly and unnecessary and advise the applicant accordingly.

In addition to general unfair trade practices that apply to all products sold, the following acts and practices are prohibited:

Twisting: Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

High pressure tactics: Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

Cold lead advertising: Making use, directly or indirectly, of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

IDENTIFYING CLIENTS WITH LTC NEEDS

The risk of needing long-term care does rise steeply with age. After the age of 65, Americans have more than a 70% chance of needing some form of long-term care.[6]

REASONS PEOPLE GENERALLY PURCHASE LONG-TERM CARE INSURANCE

ASSET PROTECTION

Given the high cost of institutional and other types of formal care, many clients choose to purchase long-term care insurance to insure against these costs and protect their assets. There are various federal and state initiatives to encourage the purchase of long-term care insurance. Federal and state tax laws may allow deductions or credits, to a varying extent, for premiums paid for long-term care insurance contracts. Some states have created partnership programs which are intended to provide some level of asset protection to individuals who purchase an approved policy; these policies may afford some protection against the normal Medicaid eligibility 'spend-down' rules. Note that partnership programs have very specific requirements in the states where they are offered. While Massachusetts is not a partnership state, if an individual buys a qualifying long-term care insurance policy and, at the time he enters a nursing home, if his policy provides two years of nursing home care, pays a minimum amount per day and doesn't require an elimination period of more than 365 days, he may be eligible to qualify for certain MassHealth (Massachusett's Medicaid Program) exemptions. Since state laws and interpretations of state Medicaid eligibility requirements are subject to change, this should never be presented as a guarantee or promise of protecting assets from Medicaid consideration.

The first step is to understand what motivates individuals to purchase long-term care insurance.

Research shows that people generally buy long-term care insurance because they have:

- A personal experience, such as a friend or relative who needed long-term care
- A desire to maintain independence and not become a burden to their family
- Confidence in the company offering the long-term care insurance
- Sufficient financial assets that they want to protect
- Awareness and concern of the long-term care issue

With the above in mind, consider the specific information that follows:

Gender: Historically, women have been the caretakers of other family members and friends and may have had experience caring for others. Since understanding the need is a major factor in purchasing coverage, knowing the impact of providing and paying for care can make women an ideal target market.

Marital Status: Over 75% of the Prudential Long-Term Care Insurance buyers are married, and the vast majority of married couples tend to buy long-term care insurance for both spouses.* This may be because married people want to avoid becoming a burden on their spouse and children. Married couples in their 50s or 60s with moderate to high income and assets are prime target markets. The purchase decision is often part of their joint retirement planning process.

**Based on Prudential Long-Term Care policies sold through December 2004.*

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TARGET EXISTING CLIENTS

The first place to look for long-term care insurance prospects is within your existing client base. Inform all your clients that Prudential offers an individual long-term care insurance product. Go back to your existing clients who are thinking about retirement planning and see if they would benefit from a long-term care insurance policy. Remember, an illness or situation requiring long-term care can be expensive. Retirement savings can be wiped out to pay for it. Make long-term care insurance a part of your extensive client planning process, which should include retirement planning and/or estate planning.

Look for your existing clients who:

- Have Disability Income insurance
- Have annuity products
- Own luxury cars, vacation homes, boats, etc.
- Have life insurance in excess of $200,000
- Are small business owners
- Have significant investments
- Live in affluent areas
- Are approaching retirement or beginning to plan for it
- Have paid off mortgages and college costs
- Have estate planning concerns

SELLING THE RIGHT COVERAGE

Planning for potential long-term care expenses is now recognized as a part of a solid retirement plan. Long-term care insurance is an excellent vehicle to help protect individuals and families from one of the greatest financial risks they may face in their lifetimes. However, long-term care insurance is not for everyone. There are situations in which people should not buy long-term care insurance, and you should not recommend it. Determining what might be appropriate for your client means considering suitability.

AGE

A good time to approach a client regarding the purchase of long-term care insurance is when a client is in their 40s or 50s. This is because people generally do not start thinking they may need long-term care before this time; also, long-term care insurance premiums are in most cases lower, and health is generally better than at older ages. However, the ideal time may not be right for your client.

Illnesses such as Multiple Sclerosis or accidents can strike at any time, creating a need for long-term care. On the other hand, while long-term care insurance is generally less expensive at early ages, there are situations which would make it appropriate for a couple in their late 70s to purchase a policy. The premiums may be higher at older ages, but so are the chances of requiring long-term care in the foreseeable future. If the annual premiums are less than the cost of a few months of long-term care, it may be a wise choice.

FINANCES

The ideal market is a client with assets from $100,000 to $1.5 million and an income greater than $30,000 for a single individual and $50,000 for a married couple. Those with assets in excess of $2 million might consider self-insuring, but given the potential risk, they may prefer a long-term care insurance policy so they do not have to spend their own money on this type of care. The general rule regarding income is that long-term care insurance premiums should not exceed 5% of income.

Although affordability is a major consideration when helping a client make the decision to purchase a long-term care insurance policy, there are situations in which a client's income could be relatively low but purchase still indicated.

Take, for example, the situation of a client with $15,000 in income in an area with a high average per capita income who shows interest in long-term care insurance. At first glance it would seem like long-term care insurance would be inappropriate, but after speaking with the client, you determine that while their income is modest, due to developments in the area, their home and property have appreciated significantly over time. Additionally, the client wishes to pass the land to their children.

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It is possible that even in this situation a long-term care insurance policy may be appropriate. The increased value of the house and its surrounding land and the desire to leave them to the children may make purchase worthwhile. In that case you might want to suggest that the client discuss the situation with the children who may want to share the premium costs to help prevent the liquidation of the home and land should the client need long-term care.

So as you can see, every situation should be evaluated individually. This is why an individual analysis of each potential client's needs is important.

STATE SUITABILITY REQUIREMENTS

To determine whether a sale is suitable, you must take the following points into consideration:

- The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage
- The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs
- The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement

Before recommending a long-term care insurance product, you should do a complete needs analysis to determine if there is indeed a need.

Three basic questions to help determine a need are:

- Do they already have long-term care insurance coverage?
- Can they afford it?
- Which policy might be appropriate?

To determine the client's need, review and consider income, assets, and the regional cost of nursing homes and in-home care.

If paying the premium on a long-term care insurance policy offering adequate protection significantly lowers the client's standard of living, long-term care insurance is probably not an affordable option.

As part of meeting state suitability requirements, the agent must provide the client a copy of "Things You Should Know Before You Buy Long-Term Care Insurance" and in some states, the "Potential Rate Increase Disclosure Form." The agent may also be required to present the "Long-Term Care Insurance Personal Worksheet" (may vary by state) to the applicant at or prior to completing an application in these states where required.

For a list of states where suitability is required, you may check the Field Office Forms database.

The completed Personal Worksheet must be returned to Prudential together with the application in those states where required. Prudential will use the answers on the Personal Worksheet together with its suitability standards to determine whether issuing long-term care insurance coverage to an applicant is appropriate.

If the applicant declines to provide his/her financial information OR if the applicant is below the threshold of suitability, a letter will be sent out advising him/her that they may not be suitable for LTC coverage. The applicant will be given 60 days to respond to Prudential advising whether or not they would still like to purchase LTC coverage.

UNDERSTANDING POTENTIAL OBJECTIONS

Finding the potential client and determining need are the first steps. The next step is to overcome objections—many of which are unspoken. Below are some of the common beliefs clients have. Knowing them can help the agent work with the client to discuss and clarify misconceptions.

COMMON MYTHS ABOUT THE NEED FOR LONG-TERM CARE INSURANCE

MYTH 1

The government or my personal health insurance will cover me.

Medicare, conventional health insurance, and HMOs generally cover only skilled care provided by nursing homes and home health care agencies. Medicare does cover some home health aide services but only if a person is receiving skilled care. Most long-term care is not skilled care. Disability insurance does not cover long-term care either. Medicaid also has strict limitations and requirements before it will cover long-term care expenses.

MYTH 2

I don't need long-term care insurance; Medicaid will cover me.

It is true that Medicaid—the state/federal health care program for the poor—does cover long-term care expenses. However, this assistance requires individuals to accept limitations they may not be comfortable with. In order to qualify for Medicaid, a person usually cannot have more than $2,000 in personal assets including bank accounts, IRAs, investment accounts, or any real estate other than the home they live in. Any assets over this amount must be exhausted before being eligible for Medicaid. The person is allowed to keep only $30 to $50 per month from their income. All the rest must be applied toward the cost of their care. In addition, as a Medicaid recipient, the individual has no control over the type of care received, who will provide it, or where it will be provided. Many people are not willing to give up their assets or the independence and choice that come from having them.

In an effort to avoid the cost of long-term care and the impoverishment necessary for eligibility under Medicaid, some people transfer their assets or place them in trusts. This tactic may seem an attractive alternative to purchasing long-term care insurance, because the individual reasons that they will have saved the cost of long-term care insurance premiums and protected their assets. However, there are distinct drawbacks to this tactic.

The first drawback is that eligibility for Medicaid, through real or artificial impoverishment, may deprive the client of choice—choice of the location, amount, type, and service providers. The second and perhaps most important drawback to planned reliance on Medicaid is that it must be done prior to needing care. To anticipate Medicaid eligibility, the client must divest well in advance on the chance they might require services. The client could spend

years with no control over or access to their assets. The cost of long-term care insurance should be weighed against the loss of choice, independence, and financial freedom.

MYTH 3

Long-term care is exclusively for the elderly.

You may feel that you are too young to think about long-term care. But, sadly, long-term care problems can materialize at any age.

- Approximately 40% of long-term care policies will be used for people ages 18-64.[7]

Because no one can predict when they might need long-term care, it is not just a problem for the "older generation." People of all ages need long-term care.

Should the client's health suddenly change in the future, they may not be able to purchase the coverage needed at that time.

MYTH 4

I can pay the costs myself if I need care.

The average annual cost of a nursing home is over $61,000 or over $168 per day.[8]

Personal assets of most individuals are often inadequate to cover the costs of long-term care. Many individuals and families would quickly see their savings depleted if they were required to pay these expenses directly.

MYTH 5

My spouse and/or children will take care of me.

When you consider this option, have you thought about the real consequences?

- Family caregivers who provide care 36 or more hours weekly are more likely than non-caregivers to experience symptoms of depression or anxiety. For spouses the rate is six times higher; for those caring for a parent the rate is twice as high.[9]

Families may very well want to take care of their loved ones, but can they handle it on their own? And, if they can, for how long can they do it? Could the client's spouse or children lift this person if they needed help bathing or moving from a bed to a wheelchair? Do the family members have other responsibilities including taking care of young children or working outside the home? Certain illnesses, like Alzheimer's, make it difficult to care for someone in the home.

MYTH 6

Long-term care insurance is too expensive; I can't afford it.

Long-term care insurance can be expensive, but the cost of not having long-term care insurance can be much greater. Today, a person could easily spend more than $50,000 in one year on long-term care services. It would take 30 years of saving $1500 per year to accumulate this amount. And that would just cover one year of care! (The average length stay in a nursing home is two to two and a half years.[10]) And, in 20 years that $50,000 may triple. If purchased at younger ages, however, long-term care insurance can be relatively inexpensive.

Notes

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Selling: Things To Know When Selling LTC3SM

FORMS AND COMPLIANCE

Applications and other related sales material should be selected based on the client's state of residence, since the policy documents issued to the client will also be based on state of residence. The Agent Statement is the place to indicate agent information and, if two or more agents are submitting the case, the Commission Split. The application should contain and the policy should be delivered to a valid U.S. address in the state of application. Of course, the agent must be appropriately licensed as a resident agent, or hold a non-resident agent license for the client's residence state. The form also provides questions to verify you have met continuing education requirements (where applicable).

PREMIUM INCREASES

Premiums are based on the client's age and coverage options chosen. A long-term care insurance policy from Prudential is guaranteed renewable. This means your client has the right to continue their policy so long as they pay their premiums on time and have not exhausted their Lifetime Maximum. Prudential has the right to change premium rates in the future but only on a class basis. An insured's rates cannot be increased due to his or her increasing age or declining health, nor can it be increased based on how many claims are filed. In most states, Prudential would need to obtain regulatory approval before increasing premiums.

COMPLETING THE APPLICATION

Applications must be taken in-person. As stipulated in the Agent's Statement, agents should meet with applicants to verify the applicant's health and mental status. However, occasionally circumstances dictate that the agent cannot be present when the application is taken. On a case-by-case basis, with prior approval of the Underwriting Department, exceptions will be considered. If such an exception is granted, a face-to-face assessment with a cognitive evaluation may be required.

The information the agent gathers and observations they make during the visit with a client are critical in helping the underwriter make a sound judgment. The agent is, in essence, "the eyes and ears" of the underwriter.

As a matter of practice it is expected agents will meet with their clients to take the long-term care insurance application in person and witness their signature.

This enables the agent to carry out good Field Underwriting by observing the prospective insured in their home and surroundings.

Completing the application accurately and thoroughly is essential, as it becomes a part of the contract when a policy is issued. Failure to complete all portions of the application may result in unnecessary delays while the missing information is being obtained.

General Instructions:

- Please read all questions carefully.
- Use black ink to record complete responses.
- Print all information and be certain that all required signatures are obtained.
- Indicate if this application is for a new policy, coverage change, or reinstatement.
- Please be certain to mail completed applications and all required forms to Prudential as soon as possible to expedite processing.

The following is a guide for completing each part of the application:

1. APPLICANT INFORMATION

Using the form approved for use in the applicant's state of residence, print complete name and title as they should appear on the policy. This section is important for identification and statistical purposes, as well as conveyance of when and where to contact the applicant. If applicable, information regarding the Spouse or Partner should also be included.

2. INSURANCE HISTORY

Provide details regarding any other insurance coverage and replacement intentions. This information is required to meet company and state mandates. In those states where Prudential has been approved to sell Partnership policies, any conversion from a regular long-term care insurance policy to a Partnership-approved policy is considered to be a replacement.

If the policy is a replacement, the agent must complete and provide the client with the form: Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance.

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3. MEDICAL HISTORY

Part 1 - Insurability Profile – This section is critical to determine whether the applicant is eligible to be considered for issuance of coverage. Please be sure each question is carefully reviewed. IF ANY OF THESE QUESTIONS ARE ANSWERED "YES," WE RECOMMEND YOU DO NOT SUBMIT THE APPLICATION.*

**State Exceptions: Kansas and Virginia require submission of the Application, regardless of response.*

4. MEDICAL HISTORY

Part 2 - Personal Profile – Nonmedical information and information regarding activity are important adjuncts to the medical history. The Primary Care Doctor's name, address, phone number, and date and reason last seen are necessary to request medical records, as is verification that a doctor has been seen in the past two years.

5. MEDICAL HISTORY

Part 3 - Health Profile – This section serves to outline the applicant's medical history. Every question should be answered either "Yes" or "No." Any "YES" answers require complete details, dates, physicians' names, addresses, and phone numbers. If more space is needed, please use the additional Medical Information page, and if necessary, an 8 1/2" × 11" sheet of paper. When using an additional sheet of paper include the applicant's name, social security number, and signature on the paper, as well as your own name, signature, and the date.

6. MEDICAL HISTORY

Part 4 - Medications – This section lists all medications the applicant is taking; why the medication is being taken; the dose and frequency; and how long the medication has been taken. Indicate if the Primary Care Physician prescribes the medication, or if not, give the name, address, and phone number of the prescribing physician. If the applicant is taking more than seven medications, an Additional Medical Information Page is provided for your convenience.

7. NOTIFICATION OF UNINTENTIONAL LAPSE

The ability for applicants to designate a third party for notification in the event of unintentional lapse is required on all applications. This section must be completed even if the applicant does not wish to name a designee.

8. APPLICANT AGREEMENTS

This section requires the applicant's signature, the agent's signature as witness, and the date. As a matter of practice, it is expected that the agent review in-person these important statements to be certain the client understands them and to witness their signature. If Electronic Funds Transfer is selected, complete the EFT Section under Applicant Agreements.

9. PLAN DESIGN SELECTION

To ensure the desired coverage is issued, please make the plan selections carefully. Failure to complete this Form may result in policy delays or rejection of the application.

A) Indicate the dollar amount for the Facility Daily Benefit.

B) Choose the Lifetime Maximum Benefit.

C) Choose the desired Elimination Period desired in days.

D) Choose the appropriate Inflation Protection* Option Rider desired. If no Inflation Protection is desired, indicate by "None."

Note: If the applicant does not select the Automatic Compound Inflation Benefit—No Maximum Rider, the client's rejection of this inflation offering must be confirmed by checking the appropriate box or by signature where required. Make sure this agrees with Applicant Agreements section.

E) For Home Care Daily Benefit, indicate the desired "Factor" choice by checking 50%, 75%, 100% or 150%. For example, if the Facility Daily Benefit is $100 and the factor is 50%, the Home Care Daily Benefit would be $50.

F) Select the Payment Option. The default election is Lifetime.

G) Select the Home Care Payment Option by electing the Daily Benefit (standard), the Monthly Benefit Rider, the Cash Benefit Rider, or the Flexible Cash Benefit Rider.

** In Texas the mandated offer of compound inflation protection must be rejected before other forms of inflation protection can be offered.*

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H) Select the Premium Payment Mode by checking the appropriate box. Only one option can be selected.

I) Select the appropriate Waiver of Premiums option by checking Standard or the Joint Waiver of Premiums and/or Survivor Waiver of Premiums Rider(s).

J) Select the Return of Premium Upon Death Rider or None.

K) Select the Shared Care Rider or None. If elected, insert Shared Care Partner's Name, and make sure both Partners have elected identical Plan Selections.

L) Record the full modal premium and the amount of cash submitted with application.

M) Select either "Yes" or "None" to indicate the applicant's preference regarding the Non-Forfeiture Benefit Rider.

N) Indicate the applicable discount by checking "Yes" or "No" for Spouse/Partner, ESP or Affiliation. The Affiliation Code must be included on the Plan Design for administrative purposes. The name of the Affiliation should also be indicated.

10. AGENT'S STATEMENT

The Agent's Statement is a very important document. The agent should meet personally with their client(s) to take the long-term care insurance application(s) and witness the signature(s). This enables the agent to carry out good Field Underwriting by observing the potential insured in their home and surroundings. The Agent's Statement is an affirmation of many aspects of Field Underwriting, and it should be completed factually and thoroughly.

This information is not shared with the applicant. For the convenience of the agent, guidelines to assist with the premium classification are included in the Application Kit. Prudential's Height and Weight Guide is also included.

QUALIFYING THE APPLICANT PRIOR TO APPOINTMENT

The agent's evaluation of a client's ability to meet the company's criteria for insurability is an important part of the underwriting process. Qualifying for health during the initial phone contact is key in helping conserve valuable time and expense.

The following general questions are suggested for an overview of the client's health. Based on the responses, additional information should be obtained as appropriate. A review of the Uninsurable Medical Conditions and Uninsurable Situations should be made to determine that none apply to the client.

- In general, how has your health been?
- Do you take any prescription medication?
- Do you have any history of heart, lung, or circulatory problems?
- Do you have any history of cancer, diabetes, stroke, Parkinson's Disease, or other significant medical conditions?
- Do you require any assistance with daily activities?
- Have you been hospitalized, been confined to a nursing home, or needed home health care in the past five years?
- Have you undergone any surgery recently, or is any surgery planned for the near future?

APPLICATION PROCESSING TIME

It generally takes about 30 days to process an application from the date of application until the policy is issued. The bulk of the time is spent awaiting medical records from the applicant's physician(s). It is important to establish realistic time frame expectations with the applicant. The agent should help the client understand the importance of underwriting and the value of the medical records in the process. Additionally, the agent should ask the applicant to notify their doctor that medical records will be requested and ask the doctor to expedite fulfilling the request. When the applicant calls the physician with this information, the time it takes to retrieve the medical records is greatly reduced.

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Submitting An Application

All questions on the application must be completed accurately and in full. Missing information can cause a delay in processing or result in the application being returned.

Along with the completed Application and Plan Design Selection forms, the following forms must be submitted:

- State-specific Replacement Form (if applicant is replacing existing coverage)
- State-specific Personal Worksheet in those states where required*
- State-specific Agent Statement
- Authorization for Release of Health-Related Information
- Conditional Premium Receipt
- Premium Funding Form
- Any other state-mandated forms

All forms are subject to state variation.

**Please consult the Field Office Forms database for a complete listing of states where the Personal Worksheet is required.*

Completed applications and required forms (when applicable) are to be returned to Prudential in the self-addressed, prepaid envelopes along with the premium payment of full modal premium. **All applications are to be submitted with full modal premiums.**

The address for LTC New Business/Applications is:

Regular Mail
Prudential
Long-Term Care Customer Service Center
PO Box 8519
Philadelphia, PA 19101

Overnight Address
Prudential
Attn: LTC/Individual
2101 Welsh Road
Dresher, PA 19025

The policy receipt address is:

Prudential
Long-Term Care Customer Service Center
PO Box 8519
Philadelphia, PA 19101

The address for money received after the policy has been issued (i.e. with policy delivery receipt):

Regular Mail
Prudential-ILTC-ID3-Feed
36233 Treasury Center
Chicago, IL 60694-6200

Overnight Address
Harris Trust and Savings Bank
Attn: Remittance Processing Division
311 West Monroe Street
7th Floor, Lockbox 36233
Chicago, IL 60606

Call Customer Service with any questions 1-800-732-0416.

OTHER REQUIRED FORMS

The following forms must be left with the applicant:

A Shopper's Guide to Long-Term Care Insurance

The publication, *A Shopper's Guide to Long-Term Care Insurance,* must be provided to all prospective applicants of a long-term care insurance policy. An agent must deliver the Shopper's Guide prior to the presentation of an application. State variations apply.

Outline of Coverage

The Agent must deliver a copy of the Outline of Coverage to the client in conjunction with any application. **Do not submit the Outline of Coverage with the application to Prudential. When completing the Outline of Coverage, the agent must either fill in the Premium Calculation page manually or provide the client with a print out of the proposal page from the PruQuote program.**

Guide to Health Insurance for People with Medicare

This must be left with clients age 65 and over.

Conditional Premium Receipt

The agent is required to complete the Premium Receipt whenever payment is accepted in consideration of an application for insurance. The receipt shall be signed by the agent and the applicant. A copy should be left behind with the applicant and the other copy should be mailed back to Prudential. State variations apply.

Authorization for Release of Health-Related Information

The agent must submit an authorization (which the Applicant must sign) with the application and leave a copy with the applicant for his records.

Federal HIPAA Notice of Privacy Practices

Under HIPAA, we must provide this notice which describes how Prudential may use and disclose medical information it may have about a long-term care insurance applicant or insured, and how the individual can access that information.

Gramm-Leach-Bliley Act Privacy Notice

This Privacy Notice should be left with the applicant. It describes our policies and practices regarding customer information, including the circumstances in which Prudential Financial companies may disclose customer information in order to allow affiliated companies and others to tell our customers about other products and services. It describes how we handle information about our customers, how we protect it, and the choices our customers have.

Things You Should Know Before You Buy Long-Term Care Insurance

Potential Rate Increase Disclosure Form

Replacement Notice (if replacement is made)

Health Interview Brochure

To avoid processing delays, here is a checklist to help ensure your application is submitted in "good order":

- HIPAA Authorization is present
- Agent's Statement is present and complete
- Suitability Forms are present and complete (these forms consist of The Disclosure Form, The Personal Worksheet, and The Potential Rate Increase Disclosure Form) (where applicable)
- EFT Form is present and the correct amount is filled in
- All questions on application are fully completed
- Agent's license/appointment is up-to-date and agent is licensed in the state where the agent resides
- Preferred Health Discount is quoted correctly and sufficient money has been collected
- Request for split commissions is clearly documented
- The most up-to-date application is being used
- The handwriting is legible
- All signatures are present

Notes

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LTC3SM Application Checklist

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

The agent must submit an authorization with the application and leave a copy with the applicant for his records.

APPLICATION SUBMISSION CHECKLIST

The following is a checklist of the forms needed to file an application for coverage.

TO BE SUBMITTED IN APPLICATION PACKAGE*

**Forms included in state application kits*

1. *LTC3SM Application and Plan Design Selection Form

Purpose:	Gathers information regarding eligibility and choice of benefits.
Instructions:	Completed by agent and applicant. Must be signed by applicant.

2. *Agent's Statement

Purpose:	A checklist for the agent.
Instructions:	To be completed and signed by agent.

3. *Long-Term Care (Suitability) Personal Worksheet

Purpose:	Determines financial suitability. Mandated.
Instructions:	In states where this is required, agent is to complete, sign, and have applicant sign.

4. *Replacement Notice

Purpose:	A notice to applicants regarding replacement of accident/sickness or long-term care insurance. Mandated if client is replacing coverage.
Instructions:	Agent to complete (when applicable), sign, have applicant sign, submit a copy, and leave a copy behind with applicant.

5. Deposit

Instructions:	Preferred Rating Class is given with the approval of any underwriter. Submissions with less than full modal premium or with Preferred Rating Class will not stop the policy from being issued, but may stop commissions from being released until full modal premium is received.

6. Copy of PruQuote Illustration

7. A copy of the Conditional Premium Receipt

8. A copy of the signed Authorization for Release of Health-Related Information

9. Premium Funding Disclosure Form

Instructions:	If the applicant indicates he/she will be paying premiums for the long-term care insurance policy by withdrawing from or liquidating a current life insurance policy or annuity, the applicant must complete this form. It must be signed by the agent and the agent's managing supervisor and submitted together with the application.

Variations

A) *Disclosure Form - CALIFORNIA

Purpose:	Medi-Cal Disclosure note for the state of California for applicants age 65+.
Instructions:	Applicant to complete and sign. One copy to be left with applicant and one copy to be submitted in application package.

B) *Replacement Waiver - VIRGINIA

Purpose:	A requirement for the state of Virginia.
Instructions:	Agent and applicant to complete and sign. To be submitted in application package.

C) *Agent Certification Form – GEORGIA

D) *Policy Illustration Form - MASSACHUSETTS

TO BE LEFT WITH THE CLIENT

1. *Suitability Disclosure (Things You Should Know Before You Buy LTC Insurance)

Purpose:	A Checklist for the applicant. Mandated.
Instructions:	Leave-behind for all applicants

2. LTC Shoppers Guide (state variations apply)

Purpose:	Mandated by the NAIC.
Instructions:	A leave-behind for all applicants, when application is taken.

3. Guide to Health Insurance for People with Medicare

Purpose:	Mandated by the NAIC.
Instructions:	A leave-behind for applicants 65 and older, when application is taken.

4. *Replacement Notice

Purpose:	A notice to applicants regarding replacement of accident/sickness or long-term care insurance. Mandated if client is replacing coverage (when applicable).
Instructions:	Agent to complete, sign, have applicant sign, keep a copy, and leave a copy behind with applicant.

5. *Outline of Coverage with Client Copy of PruQuote Illustration

Purpose:	Detailed explanation of all the LTC policy benefits and riders.
Instructions:	Agent to complete and leave behind with the applicant.

6. *Conditional Premium Receipt

Purpose:	Provides proof of payment when accepting modal premium from client.
Instructions:	Agent to complete, sign, have applicant sign, leave behind with applicant, and return a copy with the application.

7. Pre-Health Interview brochure

Purpose:	Prepares the applicant for the health interview.
Instructions:	A leave-behind for all applicants, when application is taken.

8. Potential Rate Increase Disclosure Form

Purpose:	To inform the client of options they can exercise in the event of a premium rate increase in the future.
Instructions:	Only applicable for states that have adopted it. Leave behind with the applicant.

9. Federal HIPAA Notice of Privacy Practices and Medical Authorization Form

Authorization for Release of Health-Related Information	The agent must submit an authorization (which the applicant must sign) with the application and leave a copy with the applicant for his records.
Federal HIPAA Notice of Privacy Practices	Under HIPAA, we must provide this notice which describes how Prudential may use and disclose medical information it may have about a long-term care insurance applicant or insured, and how the individual can access that information.

REPLACEMENT

The LTC3℠ application and/or Agent's Statement have been designed to include questions to elicit information about whether the applicant has another long-term care insurance policy and whether the purchase of an LTC3℠ policy will involve replacement of existing coverage.

If a sale involves the applicant's replacement of existing coverage, the agent must furnish the applicant with a Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance. One copy of the notice is to be retained by the applicant. An additional copy, signed by both the agent and the applicant, must be sent to Prudential with the completed application.

REPLACEMENT REPORTING

In some states, Prudential is required to annually report the 10% of its agents with the greatest percentages of lapses and replacements. Replacements are measured by the agent's amount of replacement sales as a percent of their total annual sales. The lapse rate is determined by the number of lapses of long-term care insurance policies sold by the agent as a percent of their total annual sales. Reported replacement and lapse rates alone do not constitute a violation of insurance laws or necessarily imply wrongdoing. However, the reports are for the purpose of more closely reviewing agent activities regarding the sale of long-term care insurance.

REPLACEMENT COMMISSIONS

Certain states have placed limitations on the amount of commission or compensation payable when a long-term care insurance policy is sold to replace existing coverage. Oftentimes, the commission is limited to the renewal commission, instead of first year, but there can be exceptions. The states with limitations on commission for replacement sales include Alabama, California, Delaware, Indiana, Kentucky, New York, North Carolina, Pennsylvania, and Wisconsin.

POST-SALE ISSUES: AFTER THE LTC3℠ POLICY IS SOLD

POLICY DELIVERY

The following must be presented to the insured at policy delivery:

- The policy
- A copy of the application and any amendments
- A schedule of policy benefits
- A policy delivery receipt
- Any state-required forms (Disclosure Statements, etc.)

The agent is expected to deliver the policy in person, in order to visually verify that the applicant's health has not materially changed since taking the application.

The required materials should be delivered to the applicant as soon as possible upon receipt. **The policy delivery receipt must be signed and returned to Prudential within 30 days of the effective date.** Prepaid Business Reply Envelopes are included in each state policy fulfillment kit.

All policies will be mailed to the agent for delivery to the client.

CHANGES IN BENEFITS

A request to increase or decrease benefits requires certain forms. If you are not sure which form is required, contact Case Development at 1-888-743-7111.

Decrease in Benefits

- Use Benefit Change Form
- Use the issue age to calculate a reduction in premiums
- There is no medical underwriting required for a decrease

Once a decrease is processed, any future request for increase requires medical underwriting.

Increase in Benefits

- Increases requested within 30 days after the effective date do not require a new medical application and can be done using the Change Request Form mentioned above.
- Increases requested beyond the 30 days after the effective date may require a new application and underwriting review.

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There are limitations on requests to increase benefits. Contact Underwriting or Case Development for details.

REFUNDS

If Prudential receives a client's request to cancel coverage, the client may be eligible to receive a prorated refund of any unearned premium. We will determine if such a refund is warranted. Unearned premium refunds are also made upon the death of the client.

REINSTATEMENTS (GUIDELINES MAY VARY BY STATE. CONTACT YOUR REGIONAL SALES MANAGER.)

Lapse Due to Chronic Illness or Disability

If, due to a chronic illness or disability, a person's policy lapses because of nonpayment of premiums, a reinstatement can be requested.

- The request must be made within five months of the date premiums were due.
- Prudential must confirm the chronic illness or disability.
- All back premiums must be paid prior to reinstatement.
- Upon reinstatement, the level of coverage will be the same level of coverage that existed prior to the termination.
- All benefits paid prior to the reinstatement will count toward the Lifetime Maximum.

Voluntary Lapse

If the policy lapses because the client voluntarily fails to pay the premium, they may be eligible to reinstate the policy. The person may request reinstatement if the request is made within 90 days of the date the last notice of unpaid premium was given by Prudential. The former client will be required to submit satisfactory evidence of insurability before coverage is reinstated.

The agent should not accept past-due premiums to reinstate a client without also obtaining an application to request reinstatement.

Notes

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Introduction to Underwriting

The purpose of this manual is to assist you in evaluating the potential impact on underwriting of diagnoses and conditions which you may encounter as you assist an applicant in completing an application for Long-Term Care (LTC) Insurance. This manual is by no means intended to be all-inclusive. If you encounter a condition or situation that is not addressed in the manual, please call the LTC Underwriting Hotline at (800) 800-8542 (9:00 a.m.–5:00 p.m. EST) prior to writing the Application.

The impairments in the Medical Conditions Guidelines are presented as single diagnoses or conditions followed by the Stability Indicator (Minimum Stability/Waiting Period), presented in months. Complicating factors or multiple diagnoses should be considered as they may necessitate lengthening the Stability Period or may be Uninsurable.

If your CLIENT HAS NOT MET THE STABILITY INDICATOR for a given condition listed in the Medical Conditions Guide, DO NOT WRITE AN APPLICATION.

If your client has one of the UNINSURABLE CONDITIONS OR UNINSURABLE SITUATIONS, DO NOT WRITE AN APPLICATION.

Notes

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Prudential's Underwriting Philosophy and Primary Underwriting Requirements

We conduct thorough underwriting at the time of application. We believe this serves to improve our risk pool, enable favorable financial results, and ensure equitable treatment of our agents, applicants, and policyholders. Most importantly, thorough underwriting at the time of application helps assure that rescission activity will be greatly minimized.

Prudential obtains medical records (which we refer to as an Attending Physician's Statement or APS) for all applicants aged 65 and older. For applicants aged 64 and younger, medical records will be ordered at the underwriter's discretion. Experience has shown that medical records provide the best evidence of an applicant's state of health.

An APS is required from the Primary Care Physician if seen within the last two years. If there is more than one Primary Care Physician, an APS may be ordered from each. An APS is also required from any specialist seen in the past two years for a significant medical condition (e.g. cardiac, diabetes, pulmonary, cancer, etc.). APSs are not generally required for dentists, optometrists, chiropractors, ophthalmologists, dermatologists, podiatrists, or allergists.

Additionally, based on the age of the applicant, we obtain an in-person Health Interview to gather information regarding current functionality and cognition.

PRIMARY UNDERWRITING REQUIREMENTS*

Age	Application	Health Interview	Medical Records
<72	YES	NO	YES
72+	YES	YES	YES

* *The table above represents the requirements ordered routinely for applicants. The underwriter may, at his/her discretion, order additional requirements in a specific case.*

Prudential's issue ages are 18 to 79; however, to be eligible to apply, ALL APPLICANTS, AGES 72 AND OLDER, MUST HAVE BEEN SEEN BY A PHYSICIAN IN THE PAST TWO YEARS. If they have not seen a physician within two years, do not take the application. Once the applicant has had a complete examination (at their own expense) by a physician, an application can be taken. Applicants ages <72 who have not seen a physician in the past two years will be subject to a Health Interview (ages 55–71) or Paramedical Exam (<55 years of age) which may be ordered at the underwriter's discretion.

Unique Factors in Long-Term Care Underwriting

The underwriting of Long-Term Care Insurance differs from the underwriting of other products (such as life insurance) in that one must consider many things, for which another type of insurance might not seem important. A few of these unique factors are listed below.

- Cognitive status
- Functional capacity
- The ability to perform the Activities of Daily Living (ADLs) (e.g. dressing, transferring)
- The ability to perform the Instrumental Activities of Daily Living (IADLs) (e.g. shopping, meal preparation)
- Medical histories that may result in a loss of independence or need for care (e.g. osteoporosis, falls, and fractures)
- Multiple medical problems (comorbids) which, in combination, are more significant than each problem alone (e.g. diabetes is a comorbid of heart disease)
- Multiple medications which may have adverse or cumulative effects
- Treatment modalities (e.g. current physical therapy)
- Chronological age vs. physiological age – There may be a significant difference between the applicant's chronological age and physiological age (e.g. the applicant may appear much younger or older than his/her actual age)
- Frailty - Serious disabilities can result from relatively minor accidents and illnesses
- Factors that play an important role in maintaining an applicant's personal independence are:
  - Working, either full or part-time
  - A spouse in good health
  - Family or friend(s) living in the household
  - Participating in hobbies and outside activities
  - The current ability to drive
  - The ability to travel and visit independently.

Notes

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Applicant Independence Factors

In addition to evaluating the Applicant's medical conditions according to the Stability Indicators in the Medical Conditions Guidelines, it is also important to evaluate their functionality and cognitive status to be certain they are fully independent. The following Independence Factors should assist you with that process:

- The Applicant should not have any functional limits, meaning they are independent in all Instrumental Activities of Daily Living and Activities of Daily Living. They should not need assistance from another person or any supervision or prompting to perform the following tasks:

IADLs	ADLs
Using the Telephone	Bathing
Managing Finances	Dressing
Taking Transportation	Transferring
Shopping	Control of Bowel/Bladder (Continence)
Laundry	Using the Toilet
Housework	Eating
Taking All Medications	
Preparing Meals/Cooking	

- The Applicant should be cognitively intact without any evidence of cognitive impairment, including Alzheimer's Disease, dementia, or other problems that interfere with the ability to think clearly and care for oneself independently. Applicants requiring prompting or cuing to perform IADLs or ADLs are not considered cognitively intact.
- The Applicant should be able to walk around, both inside and outside, without physical or supervisory assistance of another person. The Applicant should not wander or get lost.
- Because of the concern that any surgery might leave one dependent for a period of time post-operatively, there should be no surgery or diagnostic testing that is planned or has been recommended for the Applicant. If there is any surgery pending, postpone taking the Application for at least three months after recovery from surgery. If diagnostic testing is planned, postpone taking the Application until testing is completed and the diagnosis is made.

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Uninsurable Medical Conditions

These represent the most common uninsurable conditions you will encounter in taking an Application. There are additional, less common, uninsurable conditions that are included in the Medical Conditions Guidelines.

- Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex
- ADL/IADL Limitation - Needing Assistance or Supervision in performing any of the following: Bathing, Bowel or Bladder Control, Dressing, Eating, Transferring, Taking Medication, Toileting
- Alzheimer's Disease, Chronic Memory Loss, Frequent or Persistent Forgetfulness, Senility, Dementia, or Organic Brain Syndrome
- Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)
- Ataxia (any form)
- Autonomic Neuropathy
- Autonomic Insufficiency (Shy–Drager Syndrome)
- Cancer with Metastasis (Cancer that spread from the original site or location)
- Chronic Obstructive Pulmonary Disease (COPD) **in combination with**: current smoking; Congestive Heart Failure (CHF); Asthma; or Chronic Bronchitis
- Cirrhosis of the Liver
- Congestive Heart Failure (CHF) **in combination with**: Angina or Heart Attack; Angioplasty or Heart Surgery; Asthma or Chronic Bronchitis; Diabetes; Emphysema or Chronic Obstructive Pulmonary Disease; or Tuberculosis (TB)
- Congestive Heart Failure, diagnosed or symptomatic, within the past 12 months
- Diabetes treated with Insulin over 50 units
- Dialysis (Hemodialysis or Peritoneal)
- Emphysema **in combination with**: current smoking; Congestive Heart Failure (CHF); Asthma; or Chronic Bronchitis
- Giant Cell Arteritis (active)
- Hepatitis (chronic, active)
- HIV Positive
- Hospitalization (currently or anticipated)

- Huntington's Chorea
- Hydrocephalus
- Immune System Disorder
- Kaposi's Sarcoma
- Memory Loss
- Multiple Myeloma
- Multiple Sclerosis (MS)
- Muscular Dystrophy
- Pancreatitis (chronic)
- Paralysis (Hemiplegia, Paraplegia, Quadriplegia)
- Parkinson's Disease
- Phobias, Psychoneurosis (Treated with antipsychotic medication)
- Pulmonary Fibrosis
- Schizophrenia
- Scleroderma (active)
- Stroke or Cerebrovascular Accident (CVA)
- Transient Ischemic Attack (TIA) within the past five years; TIA in combination with Diabetes or any Heart Surgery; or multiple TIAs
- **Within the past 6 months**: Open Heart Surgery; Back or Spine Surgery
- **Within the past 12 months**: used Home Health Care or Adult Day Care; been medically advised to enter or has been confined to a Nursing Home, Assisted Living Facility, or other Long-Term Care Facility
- **Within the past 48 months**: Cancer of the Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas, Stomach, or Testes

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Uninsurable Situations

The following situations, although sometimes difficult to discern at time of Application, will preclude the Applicant from being issued Long-Term Care Insurance. These situations include, but are not limited to the following:

ADL Deficits - Anyone who requires the help of another person, for either physical or cognitive reasons, to perform any *one* of the following *Activities of Daily Living (ADLs):*

- Bathing
- Dressing
- Control of Bowel/Bladder (Continence)
- Using the Toilet
- Transferring out of Bed/Chair
- Eating

IADL Deficits - Anyone who requires the help of another person, for either physical or cognitive reasons, to perform *two* or more of the following Instrumental *Activities of Daily Living (IADLs):*

- Using the Telephone
- Managing Finances
- Taking Transportation
- Shopping
- Laundry
- Housework
- Taking all Medications*
- Preparing Meals/Cooking

Currently using or used in past 12 months any Long-Term Care Services:

- Home Health Care
- Nursing Home Care
- Adult Day Care
- Assisted Living Facility Care

Medical Appliance Use (Durable Medical Equipment - DME)

- Hospital Bed
- Respirator/Oxygen Equipment
- Walker
- Wheelchair
- Four-Pronged Cane
- Hoyer Lift
- Stairlift
- Motorized Cart

* *If an individual needs assistance in taking medications they are uninsurable, even if they are independent in all other ADLs and IADLs.*

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Rating/Classifications Categories

Prudential offers three underwriting rating/classification categories: Preferred, Standard I and Standard II.

A. Review the Uninsurable Medical Conditions and the Stability Indicators to determine if a given medical condition is insurable. If the Applicant meets the Stability Indicator* for their condition, they can qualify for a Standard I rate.

Examples:

1. If an Applicant admits to having had an angioplasty three or more months ago and is otherwise in good health, they could qualify for a Standard I rate.

2. If an Applicant admits to having had surgery for Stage 1 breast cancer 12 or more months ago, has had no recurrence, and is otherwise in good health, they could qualify for a Standard I rate.

The Following Conditions Are Exceptions Which Should Result In A Standard II rate:

1. Congestive Heart Failure (CHF) requiring daily prescription medication

2. Hodgkin's Disease

3. Leukemia

4. Lymphoma

5. Diabetes requiring daily, oral, or injectable prescription medication would result in a Standard II rate, and Diabetes controlled by diet and exercise only would be a Standard I rate.

6. Chronic Obstructive Pulmonary Disease (COPD) requiring daily prescription medication

7. Emphysema requiring daily prescription medication

* *The minimum length of time that is required from completion of any/all treatment for a condition, or to get it successfully controlled if chronic, to the time an Application can be submitted.*

B. Review the Weight and Height Guidelines.

The Applicant's weight and height must be within the acceptable ranges to qualify for a Standard I rate. The acceptable ranges are shown in the Weight and Height Guidelines (page 12) chart in this manual.

C. Smoking

If an Applicant smokes, be sure to indicate so on the Application. An Applicant can qualify for a Standard I rate even if they admit to smoking providing they smoke less than one package of cigarettes (or a similar equivalent of other tobacco products) daily and have no cardiac, respiratory, or vascular/circulatory conditions.

Medical conditions should be evaluated in accordance with the Stability Indicators in the Medical Conditions Guidelines (page 38). Applicants who do not qualify for a Standard I rating/classification as outlined above, but are otherwise insurable according to the Medical Conditions Guidelines, should be quoted a Standard II premium rate.

ISSUE AGE / RATING AGE

Issue ages are 18–79. The Applicant's age as of the date the Application is signed is what is utilized for rating and issue purposes.

Do not back date the Application, under any circumstances. However, you may request backdating to save age up to 30 days prior to the Application date. We will not be able to save age 79 if the Applicant has turned 80 by the date of the Application.

Weight And Height Guidelines

Below is a weight and height table that applies to both men and women. Obesity can introduce problems when treating other conditions such as functional or mobility deficiencies, diabetes, cardiac insufficiencies, etc. Any Applicant possessing a functional or physical impairment complicated with the build configuration listed below is considered a high risk. This applies to overweight as well as underweight.

HEIGHT	MINIMUM ACCEPTABLE STANDARD I AND II	MAXIMUM ACCEPTABLE STANDARD I	MAXIMUM ACCEPTABLE STANDARD II
4'11"	94 LBS	172 LBS	187 LBS
5'0"	97 LBS	178 LBS	193 LBS
5'1"	100 LBS	184 LBS	200 LBS
5'2"	104 LBS	190 LBS	206 LBS
5'3"	107 LBS	196 LBS	213 LBS
5'4"	110 LBS	203 LBS	220 LBS
5'5"	114 LBS	209 LBS	227 LBS
5'6"	118 LBS	215 LBS	234 LBS
5'7"	121 LBS	222 LBS	241 LBS
5'8"	125 LBS	229 LBS	248 LBS
5'9"	128 LBS	235 LBS	256 LBS
5'10"	132 LBS	242 LBS	263 LBS
5'11"	136 LBS	249 LBS	271 LBS
6'0"	140 LBS	257 LBS	278 LBS
6'1"	144 LBS	264 LBS	287 LBS
6'2"	148 LBS	271 LBS	294 LBS
6'3"	152 LBS	278 LBS	302 LBS
6'4"	156 LBS	286 LBS	311 LBS
6'5"	160 LBS	295 LBS	320 LBS

Notes

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Effective Dates

The effective date of the Policy is established by Prudential. It will be the date of approval by underwriting; however, because of systems administration issues, it cannot be the 29th, 30th, or 31st of the month. In this situation, the effective date will be the 1st day of the following month.

SPOUSAL/PARTNER APPLICATIONS - CONCURRENT APPLICATIONS FOR HUSBAND AND WIFE OR QUALIFIED PARTNERS

Occasionally, an Application is approved for one Spouse or Partner while the other Spouse or Partner is still pending an underwriting decision. A decision on both Applications is needed to determine the appropriate Spousal/Partner discount. The approved Spouse's/Partner's policy will not be issued until there is an underwriting decision regarding the pending Spouse's/Partner's Application; however, policy issue will not be delayed more than 30 days. Once a decision is reached on both, the effective date will be the date of approval.

JOINT SPOUSAL/PARTNER DISCOUNT

If both Spouses/Partners apply at the same time and both are issued, each qualifies for the "Joint" Spousal/Partner discount of 30%.

Example:

Spouse/Partner "A" Rate - $2240 × .7 = $1568

Spouse/Partner "B" Rate - $2400 × .7 = $1680

SINGLE SPOUSAL/PARTNER DISCOUNT:

If an Applicant applies alone, or both Spouses/Partners apply, but only one is issued a policy, the issued person qualifies for the "Single" Spousal/Partner discount of 15%.

Example:

Single Spouse/Partner Rate - $2000 × .85 = $1700

PARTNER DISCOUNT*

The following requirements must be met in order to be eligible for the Partner discount:

1. be over age 18;
2. have lived together for at least 12 consecutive months immediately preceding the date of the application;
3. have a serious and committed relationship;
4. not be legally married, nor a Partner to anyone else; and
5. be “financially interdependent.” “Financially interdependent” means that the Partners must share the cost of food and housing. While they do not have to contribute equally or jointly for each of these expenses, each must be responsible for such costs.

** This discount may not be available in some states.*

POLICY DELIVERY

When the policy is issued, it is sent to the agent for delivery to the policyholder. Included with the policy are: a “welcome” letter, any amendments, a copy of the Application, a schedule page, a policy delivery receipt with prepaid return envelope, and any state required forms. The policy and accompanying material should be delivered to the policyholder as soon as possible. **The policy delivery receipt must be signed by the policyholder and returned to Prudential within 30 days of the effective date.**

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Preferred Rating Class Guidelines

Good habits and good lifestyles should be rewarded. Prudential wants your client to receive that reward in the form of a special 15% Preferred Rating Class Discount available to those whose physical and health profiles are better than average.

While all decisions regarding the applicability of the discount must be made by underwriting after a full review of the Applicant's medical records, we have provided these guidelines to help agents estimate whether their client might be qualified. Simply ask the questions below. If the answers are as indicated, your clients could be eligible for the premium they deserve.

Client Must Answer "**Yes**" To All Of The Following Questions:

1. Is the Applicant within the attached height and weight guidelines? (See page 17)

2. Does the Applicant maintain a high level of activity outside the home? This may include, but is not limited to: full- or part-time employment, regular exercise, regular social activities, or volunteer activities?

3. Is the Applicant's blood pressure controlled to 140/90 or better as an average?

4. Has the Applicant refrained from smoking or using tobacco products within the past 36 months (three years)?

Client Must Answer "**No**" To All Of The Following Questions:

5. No prior history of:
   - Any cardiac condition requiring medication
   - Diabetes
   - Leukemia
   - Memory Loss
   - Rheumatoid Arthritis
   - Congestive Heart Failure
   - Hodgkin's Disease
   - Lymphoma
   - Osteoporosis

- TIA (Transient Ischemic Attack)
- Cancer (except skin cancer other than melanoma)
- Joint Replacement
- Chronic Pulmonary Disease (any respiratory condition that requires regular medication)
- The use of multiple medications. *This includes but is not limited to multiple medications used to control hypertension, multiple anxiety or depression medications and cholesterol lowering drugs or other circulatory medications.*
- Circulatory Disease (Cartoid Artery Disease, Coronary Artery Disease or Peripheral Vascular Disease)
- Any chronic condition that is progressing in severity with age
- Comorbids or combination of conditions will be individually considered

All answers to the above questions must be as noted for discount consideration.

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Preferred Rating Class Weight And Height Guidelines

Below is a weight and height table that applies to both men and women. Obesity can introduce problems when treating other conditions such as functional or mobility deficiencies, diabetes, cardiac insufficiencies, etc. Any Applicant possessing a functional or physical impairment complicated with the build configuration listed below is considered a high risk. This applies to overweight as well as underweight.

HEIGHT	MINIMUM PREFERRED	MAXIMUM PREFERRED
4'11"	99 LBS	128 LBS
5'0"	102 LBS	133 LBS
5'1"	106 LBS	137 LBS
5'2"	109 LBS	142 LBS
5'3"	113 LBS	146 LBS
5'4"	116 LBS	151 LBS
5'5"	120 LBS	156 LBS
5'6"	124 LBS	161 LBS
5'7"	127 LBS	166 LBS
5'8"	131 LBS	171 LBS
5'9"	135 LBS	176 LBS
5'10"	139 LBS	181 LBS
5'11"	143 LBS	186 LBS
6'0"	147 LBS	191 LBS
6'1"	151 LBS	197 LBS
6'2"	155 LBS	202 LBS
6'3"	160 LBS	208 LBS
6'4"	164 LBS	213 LBS
6'5"	168 LBS	217 LBS

Notes

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Underwriting Decision Terminology

The following terms and definitions may be helpful in understanding underwriting decisions:

1. Approved: Coverage is approved as applied for.

2. Approved With Modifications: Coverage is approved with reduced benefits due to the significance of the risk. Modifications may include one or more of the following:
   a) Reduced Daily Maximum
   b) Reduced Lifetime Maximum
   c) Increased Benefit Waiting Period
   d) Elimination of the Cash Benefit Rider
   e) Change in the Rating Category.

   If a policy is Approved With Modifications no additional Benefit Increases should be requested for at least two years.

3. Declined: Coverage is denied. The risk is too great to approve, even with modifications. If an Application is declined, a letter is sent to the Applicant with a copy to the agent. The reason for decline will be briefly explained, provided the medical condition is not of a sensitive nature. If we are unable to give the reason for decline (because it was of a sensitive nature) and the Applicant desires additional information regarding the reason for decline, they must write a letter to the underwriting department authorizing disclosure of the information to themselves, a physician of their choice, or to another third party. The letter must include the name and address of the person to whom this information should go, as well as the Applicant's signature and social security number.

4. Reconsideration Offer: An offer to review another Application at some specified later date/time. Reconsideration Offers will be made, when appropriate, to Applicants age <72. Applicants ages 72–79 will seldom be offered reconsideration because of greater possibility of rapid changes and deterioration of health.

5. No Reconsideration: This message is communicated to the agent only. There will not be an offer to review another Application at a later date because the risk is ongoing or cannot be predicted. "No Reconsideration" will be indicated for progressive medical conditions, medical conditions with an unfavorable prognosis and multiple medical conditions that combine poorly.

6. Approved As Applied For - No Increases Permitted: Coverage is issued with the maximum benefits acceptable for this risk. If a policy is Approved As Applied For – No Increases Permitted, no requests for additional Benefit Increases should be submitted for at least two years.

7. Appeals Process: There may be instances where the Applicant and/or their physician have additional information that they believe may affect our decision. If so, the decision can be appealed by providing the additional information accompanied with appropriate supportive documentation such as tests results and other clinical findings. Underwriting will review and consider the information and respond accordingly. Appeals should be mailed to the following address:

   Prudential
   Attn: Underwriting Department
   2101 Welsh Road
   Dresher, PA 19025

Completing the Application

The information you gather and observations you note during the visit with your client are critical in helping the underwriter make a sound judgment. You are, in essence, "the eyes and ears" of the underwriter.

As a matter of practice it is expected the agent will meet with their clients to take the Long-Term Care Insurance Application in person and witness their signature. This enables the agent to carry out good Field Underwriting by observing the prospective insured in their home and surroundings

Completing the Application accurately and thoroughly is essential, as it becomes a part of the contract when a policy is issued. Failure to complete all portions of the Application may result in unnecessary delays while the missing information is being obtained.

GENERAL INSTRUCTIONS:

- Please read all questions carefully.
- Use black ink to record complete responses.
- Print all information and be certain that all required signatures are obtained.
- Indicate if this Application is for a new policy, upgrade, inflation increase, or reinstatement.
- Please be certain to mail completed Applications and all required forms to Prudential as soon as possible to expedite processing.

The following is a guide for completing each part of the Application:

1. APPLICANT INFORMATION

Using the form approved for use in the Applicant's **state of residence**, print complete name and title as they should appear on the policy. This section is important for identification and statistical purposes, as well as conveyance of when and where to contact the Applicant. If applicable, information regarding the Spouse or Partner should also be included.

2. AGENT INFORMATION

Please identify your agent license and appointments as well as the distribution channel that appointed you. This information is essential to validate your license and process the Application.

3. INSURANCE HISTORY

Provide details regarding any other insurance coverage and replacement intentions. This information is required to meet company and state mandates. In those states where Prudential has been approved to sell Partnership policies, any conversion from a regular Long-Term Care policy to a Partnership approved policy is considered to be a replacement.

4. MEDICAL HISTORY

Part I - **Insurability Profile**

This section is critical to determine whether the Applicant is eligible to be considered for issuance of coverage. Please be sure each question is carefully reviewed.

IF ANY OF THESE QUESTIONS ARE ANSWERED "YES," DO NOT SUBMIT THE APPLICATION.*

* *State Exceptions: Virginia requires submission of the Application, regardless of response.*

5. MEDICAL HISTORY

Part II - **Personal Profile**

Non-medical information and information regarding activity are important adjuncts to the medical history. The Primary Care Physician's name, address, phone number, and the date and reason last seen are necessary to request medical records, as is verification that a doctor has been seen in the past two years.

6. MEDICAL HISTORY

Part III - **Health Profile**

This section serves to outline the Applicant's medical history. Every question should be answered either "Yes" or "No." Any "Yes" answers require complete details, dates, physicians' names, addresses, and phone numbers. If more space is needed, please use an additional 8 1/2" × 11" sheet of paper. When using an additional sheet of paper include the Applicant's name, social security number, and signature on the paper, as well as your own name, signature, and the date.

7. MEDICAL HISTORY

Part IV - **Medications List**

This section lists all medications the Applicant is taking, why the medication is being taken, the dose and frequency, and how long the medication has been taken. Indicate if the Primary Care Physician prescribes the medication, or if not the prescriber, give the name, address, and phone number of the prescribing physician. If the Applicant is taking more than seven medications, an Additional Medical Information Page is provided for your convenience.

8. NOTIFICATION OF UNINTENDED LAPSE

The ability for Applicants to designate a third party for notification in the event of unintentional lapse is required on all Applications. This section must be completed even if the Applicant does not wish to name a designee.

9. APPLICANT AGREEMENTS

This section requires the Applicant's signature, the agent's signature as witness, and the date. As a matter of practice, it is expected that the agent review in person these important statements to be certain the client understands them and to witness their signature.

10. MEDICAL AUTHORIZATION (INFORMATION RELEASE AUTHORIZATION)

This section requires the Applicant's signature and date and gives Prudential the authority to obtain the necessary medical information to evaluate the Application.

11. PLAN DESIGN SELECTION

To assure the desired coverage is issued, please make the plan selections carefully. Failure to complete this section may result in policy delays or rejection of the Application.

A) Indicate the dollar amount for the Facility Daily Benefit

B) For Home and Community-Based Care, indicate the desired "Factor" choice by checking either 50%, 75%, 100%, or 150%. For example, if the Facility Daily Benefit is $100 and the factor is 50%, the Home Care Daily Benefit would be $50.

C) Choose the Lifetime Maximum benefit.

D) Choose the actual Elimination Period desired in days.

E) Choose the appropriate Inflation Protection Option Rider desired. If no Inflation Protection is desired, indicate by "None."

Note: *If the Applicant does not select the 5% Automatic Compound Inflation Rider - No Maximum, their rejection of this inflation offering must be confirmed by checking the appropriate box.*

F) Select either "Yes" or "No" to indicate the Applicant's preference regarding the Non-Forfeiture Benefit Rider.

G) Select the HCBC Payment option by electing either the Daily Benefit (standard), the Monthly Benefit Rider, or the Cash Benefit Rider. If the Cash Benefit Rider is selected, the Calendar Day Elimination Period is automatically included.

H) Select the appropriate Waiver of Premium option by checking Standard, Joint Waiver of Premium, or Survivor Benefit. It is permitted to select both the Joint Waiver of Premium and the Survivor Benefit.

I) If the Restoration of Benefits Rider is desired, it must be selected at policy inception. It cannot be selected later. Indicate this selection by checking the Restoration of Benefits Rider. If the Restoration of Benefits Rider is not desired, check none.

J) Select the Premium Payment Mode by checking the appropriate box. Only one option can be selected. After the Premium Payment Mode is selected, indicate the full modal Premium and the amount of cash submitted with the Application.

K) Indicate the applicable discount by checking "Yes" or "No" for Spousal, Partner, or Affiliation. In order to qualify for an Affiliation Discount, prior approval is required by calling the Affiliation Sales Desk at 973-548-6632. Upon approval, the agent will be provided an Affiliation Code which must be included on the Plan Design for administrative purposes. The name of the Affiliation should also be indicated.

12. AGENT'S STATEMENT

The Agent's Statement is a very important document. As a matter of practice, it is expected that the agent will meet personally with his/her client(s) to take the Long-Term Care Insurance Application(s) and witness their signature(s). This enables the agent to carry out good Field Underwriting by observing the potential insured in their home and surroundings. The Agent's Statement is an affirmation of many aspects of Field Underwriting, and it should be completed factually and thoroughly.

This information is not shared with the Applicant. On the back of the Agent's Statement, for your convenience, we've included guidelines to assist you with the premium classification. Our Height and Weight Guide is also included.

13. USE OF PREMIUM RECEIPT

You are required to complete the Premium Receipt whenever money is accepted in consideration of an Application for insurance. The Premium Receipt must be signed by you and left with the Applicant. State variations may apply.

Notes

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Qualifying the Applicant Prior to Appointment

Your evaluation of a client's ability to meet the company's criteria for insurability is an important part of the underwriting process. Qualifying for health during the initial phone contact is key in helping conserve valuable time and expense. The following general questions are suggested for an overview of the client's health.

Based on the responses, additional information should be obtained as appropriate. A review of the Uninsurable Medical Conditions and Uninsurable Situations should be made to determine that none apply to the client.

- In general, how has your health been?
- Do you take any prescription medication?
- Do you have any history of heart, lung, or circulatory problems?
- Do you have any history of cancer, diabetes, stroke, Parkinson's disease, or other significant medical conditions?
- Do you require any assistance with daily activities?
- Have you been hospitalized, been confined to a nursing home, or needed home health care in the past five years?
- Have you undergone any surgery recently, or is any surgery planned for the near future?

Notes

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Application Processing Time

It generally takes about 30 days to process an Application from the date of application until the Policy is issued. The bulk of the time is spent awaiting medical records from the applicant's physician(s). It is important to establish realistic time frame expectations with the Applicant. Help them understand the importance of underwriting and the value of the medical records in the process. Additionally, please ask the Applicant to contact their doctor to advise them that medical records will be requested and to ask that they expedite fulfilling the request. When the Applicant calls their physician with this information, the time it takes to retrieve the medical records is greatly reduced. Information has been prepared for you to give to your client which explain the underwriting process as it applies to specific Applicants.

Notes

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The Interview Process

A Telephone Interview is not routinely required, but may be done to gather missing information and/or clarify unclear information.

The Health Interview takes approximately 45 minutes to complete; it may be longer or shorter depending upon the complexity of the Applicant's medical history. The Interviewer is a health care professional (Registered Nurse or Licensed Social Worker). The Health Interview is comprised of the following categories:

INTRODUCTION

The Applicant is informed that the purpose of the interview is to gather information for the insurer. The Applicant is advised that the Interviewer is unable to answer any questions regarding the policy. If they have such questions, they are advised to call their agent.

GENERAL INFORMATION

Basic questions are asked to gain a general understanding of the Applicant. Questions asked refer to topics like: employment, hobbies, activities, and living arrangements.

MEDICAL INFORMATION

The Applicant will be asked to supply names and addresses of any physicians they have seen within the past five years (10 for cancer). Additionally, they are asked about hospitals or rehabilitation facilities that they have been in. The Interviewer will read a preestablished list of medical diagnoses, similar to those found on the Application. The Applicant will be asked to respond negatively or positively to each. If the Applicant answers "Yes" to any of the questions, they will be asked to supply additional information regarding treatment and current status. Height, weight, and blood pressure readings are generally recorded.

MEDICATIONS

The Interviewer will ask about medications that the Applicant takes, both prescription and over the counter.

EQUIPMENT

The Applicant will be asked if they use any medical equipment.

COGNITIVE EXERCISES

The Applicant will be asked to participate in two brief memory exercises. One is a recall of words (Delayed Word Recall - DWR), and the other requires answering questions related to facts that the Applicant comes across on a daily basis (Short Portable Mental Status Questionnaire - SPMSQ).

FUNCTIONAL STATUS

The remainder of the interview deals with questions related to basic activities that are performed on a daily basis (Activities of Daily Living – ADLs and Instrumental Activities of Daily Living - IADLs). Most of these questions are basic, and Applicants find them easy to answer. Some of the activities asked about are: using the telephone, performance of household chores, and transportation. There are, however, some questions that may seem personal to the Applicant, but are important to help determine the Applicant's level of functional independence. These questions involve activities such as bathing, use of the toilet, and continence. Additionally, the Interviewer asks the Applicant to get up from their sitting position and walk across the room in an attempt to capture the most accurate picture of the client's mobility as possible. The same questions must be asked of all Applicants, regardless of age or geographic location. The Interviewers are sensitive professionals, trained to ask the questions according to a standard format, in a manner that the Applicant should hopefully not find overly personal or offensive.

VERIFICATION OF IDENTITY

At the end of the interview the Applicant will be asked to sign and date the Health Interview form. At this time, the Interviewer also asks to see a form of pictured identification, such as a driver's license or passport, to verify the Applicant's identity and signature.

Preparing Your Client for the Health Interview

The more your clients know and understand about the Health Interview, the more comfortable they'll be. The following information will help you prepare your client for the Health Interview:

- Advise all clients that a Health Interview may be required and give them a copy of the Health Interview brochure. For Applicants ages 72 and older, a Health Interview is required.
- Communicate the importance of the Health Interview to your clients. Information from the interview, along with the Application and medical records, will be used to determine their insurability.
- Let them know that the Health Interview is conducted by a health care professional (generally a Registered Nurse). Additional information about the Health Interview is contained in the brochure.
- The Interviewer will call the client to schedule a convenient time for the interview. The interview can take place wherever the client chooses such as their home, place of business, the health care professional's local office, or other location that is convenient for the client.
- The Interviewer will have an Identification Card and will be dressed in regular business clothes, not a white uniform or lab coat.
- The interview takes less than an hour to complete. It is best to schedule it at a time and place where the interview can be conducted privately and without fear of distraction. Family or friends should not be present in the same room during the interview so that the client can devote all their attention to the interview.
- The interview is not a physical exam. No disrobing, blood, or other specimens are required.
- The interview includes general health questions similar to those on the Application. It also includes questions about daily activities and the ability to do these activities independently. Some questions may seem as if the answers should be obvious to the Interviewer. Explain to the client, however, that all questions must be asked of each Applicant to insure consistency.

- Ask the client to have available the names, addresses, and phone numbers of their Primary Care Physician and any other physicians they've seen in the past five years. The Interviewer will also need to know the names, dosage, and reason for all prescription medication.

- There are two cognitive exercises in the interview. The client should be advised to pay attention during these exercises and take them seriously. One exercise is called The Delayed Word Recall (DWR). During this exercise the client is shown 10 words and asked to use each of them in a sentence. This activity helps "encode" the words into short term memory. Later in the interview, the client will be asked to recall the words. It's important that the client try and recall as many words as possible. The other exercise is called the Short Portable Mental Status Questionnaire (SPMSQ). It is comprised of basic questions related to orientation. An example of the type of question in the SPMSQ is "What state are we in?"

- At the end of the interview the client will be asked to sign and date the interview form. The client will also be asked to provide a form of pictured identification, such as a driver's license or passport, to verify the signature.

- Lastly, please advise your client that the Interviewer will not provide information or answer questions about our products. If such questions arise during the interview, the Interviewer is instructed to tell the client to call their agent.

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Glossary of Terms and Abbreviations Relating to Long-Term Care Insurance Guidelines and/or Functionality

Term	Definition
ADL	Activity of Daily Living
IADL	Instrumental Activity of Daily Living
DME	Durable Medical Equipment (e.g. walker, cane, wheelchair, oxygen, etc.)
Delayed Word Recall (DWR)	A memory exercise that was specifically designed to be used as a screening instrument for short-term memory or primary memory loss. It was designed to maximize the likelihood of poor performance in people with Alzheimer's Disease and minimize the likelihood of poor performance in normal elderly subjects.
The Short Portable Mental Status Questionnaire (SPMSQ)	The SPMSQ reviews long-term memory skills.
Comorbid	A secondary condition that affects the primary diagnosis (e.g. heart disease is a comorbid of diabetes)
Stability In Months	The specific, minimum length of time that is required from completion of any/all treatment of a condition until the time an Application can be submitted. If the disease is a chronic one, this refers to the number of months that the condition must be successfully controlled to the extent that the disease poses no threat to the Applicant's general health or need for Long-Term Care services.
Uninsurable	The condition is considered a high risk for Long-Term Care service use, and therefore an Applicant should not take the Application.
Rule Out	The illness or injury of concern must be ruled out, or not found to be present, before the Application is taken.
Underwrite For Cause	Identify the specific illness or injury causing the impairment, and use the guidelines for that condition to evaluate the risk.

Notes

Medical Abbreviations

The following is a list of the some commonly used abbreviations for medical conditions:

ABBREVIATION	MEDICAL CONDITION
AAA	Abdominal Aortic Aneurysm
Afib	Atrial Fibrillation
AIDS	Acquired Immune Deficiency Syndrome
ALS	Amyotrophic Lateral Sclerosis
ARC	AIDS Related Complex
ASHD	Arteriosclerotic Heart Disease
BCC	Basal Cell Carcinoma
BPH	Benign Prostatic Hyperplasia
BUN	Lab Value - Blood Urea Nitrogen
CABG	Coronary Artery Bypass Graft
CAD	Coronary Artery Disease
CHF	Congestive Heart Failure
CLL	Chronic Lymphocytic Leukemia
CML	Chronic Myelogenous Leukemia
CNS	Central Nervous System
COLD	Chronic Obstructive Lung Disease
COPD	Chronic Obstructive Pulmonary Disease
CPAP	Continuous Positive Air Pressure
CTS	Carpal Tunnel Syndrome
CVA	Cerebral Vascular Accident (Stroke)
DDD	Degenerative Disc Disease
DJD	Degenerative Joint Disease
DM	Diabetes Mellitus
DVT	Deep Vein Thrombosis
HBP	High Blood Pressure
HTN	Hypertension

IBS	Irritable Bowel Syndrome
IDDM	Insulin-Dependent Diabetes Mellitus
IMF	Idiopathic Myelofibrosis
MD	Muscular Dystrophy
MI	Myocardial Infarction
MS	Multiple Sclerosis
MVP	Mitral Valve Prolapse
NIDDM	Non-Insulin Dependent Diabetes Mellitus
NHL	Non-Hodgkins Lymphoma
OA	Osteoarthritis
OBS	Organic Brain Syndrome
OCD	Obsessive-Compulsive Disorder
PUD	Peptic Ulcer Disease
PTCA	Percutaneous Transluminal Coronary Angioplasty
PVD	Peripheral Vascular Disease
PMR	Polymyalgia Rheumatica
RA	Rheumatoid Arthritis
SCC	Squamous Cell Carcinoma
SLE	Systemic Lupus Erythematosus
TB	Tuberculosis
THR	Total Hip Replacement
TIA	Transient Ischemic Attack (mini stroke)
TKR	Total Knee Replacement
TMJ	Temporomandibular Joint Syndrome
UC	Ulcerative Colitis

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Medications List

Any medication taken by an Applicant is significant, and should be reported on the Application. This guide provides you with names and descriptions of some of the medications that most often result in poor risk selection. The following medications, if currently taken, indicate fairly significant health problems, which are typically declined.

DRUG	DESCRIPTION
Adriamycin	Cancer
Akineton	Parkinson's Disease
Aldesleukin	Cancer
Alkeran	Cancer
Antabuse	Alcoholism
Aricept	Cognitive Impairment
Artane	Parkinson's Disease
Asparaginase	Leukemia
A.Z.T.	HIV, AIDS
Baclofen	Multiple Sclerosis
Bethanechol	Neurogenic Bladder
BiCNU	Cancer
Blenoxane	Cancer
Busulfan	Leukemia
CeeNU	Hodgkin's Disease
Cellcept	Hepatitis
Cerubidine	Leukemia
Clozaril	Antipsychotic
Cogentin	Parkinson's Disease
Cognex	Memory Loss
Cyloserine	Alzheimer's Disease
Cytosar-U	Leukemia
Cytoxan	Cancer
Dacarbazine	Cancer
Dantrium	Multiple Sclerosis
Depo-Provera	Cancer

DES	Cancer
Ditropan	Neurogenic Bladder
Dopar	Parkinson's Disease
Doxorubicin	Cancer
Eldepryl	Parkinson's Disease
Emcyt	Prostate Cancer
Ergamisol	Cancer
Ergoloid Mesylate	Memory Loss
Estinyl	Cancer
Estrace	Cancer
Etoposide	Testicular Cancer
Eulexin	Cancer
Exelon	Alzheimer's Disease
Floxuridine	GI Cancer
Foscavir	HIV
Ganite	Cancer
Gold Therapy	Rheumatoid Arthritis
Hexalen	Cancer
Hydergine	Memory Loss
Hydrea	Cancer
Idalycin	Leukemia
Ifex	Testicular Cancer
Interferon	Leukemia
Kemadrin	Parkinson's Disease
L-Dopa	Parkinson's Disease
Lanvis	Leukemia
Laradopa	Parkinson's Disease
Leukeran	Cancer
Leukine	Cancer
Levadopa	Parkinson's Disease
Levsin	Parkinson's Disease
Loxitane	Antipsychotic
Lupron	Cancer
Lysodren	Cancer

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Matulane	Hodgkin's Disease
Megace	Cancer
Mercaptopurine	Leukemia
Mestinon	Myasthenia Gravis
Methotrexate	Cancer (other reasons require further investigation)
Moban	Antipsychotic
Moditen	Antipsychotic
Mutamycin	Cancer
Myleran	Cancer
Myochrysine	Arthritis
Navane	Antipsychotic
Neosar	Cancer
Neupogen	Cancer
Niloric	Memory Loss
Nilutamide	Metastatic Prostate Cancer
Nipent	Hairy Cell Leukemia
Novantrone	Leukemia
Oncovin	Cancer
Paraplatin	Cancer
Parlodel	Parkinson's Disease
Pentam300	HIV
Permax	Parkinson's Disease
Platinol	Cancer
Priftin	Tuberculosis
Primazine	Antipsychotic
Proleukin	Cancer
Prolixin	Antipsychotic
Prostigmin	Myasthenia Gravis
Reminyl	Alzheimer's Disease
Retrovir	HIV
Ridaura	Arthritis
Rifapentine	Tuberculosis
Risperdal	Antipsychotic
Sandostatin	Cancer

Serentil	Antipsychotic
Seroquel	Antipsychotic
Sinemet	Parkinson's Disease
Solganal	Arthritis
Sparine	Antipsychotic
Stelazine	Antipsychotic
Symmetrel	Parkinson's Disease
Tace	Cancer
Tacrine	Memory Loss
Tensilon	Myasthenia Gravis
Teslac	Cancer
Thioplex	Cancer
Thorazine	Antipsychotic
Velban	Cancer
Videx	HIV
Wellcovorin	Cancer
Zanosar	Cancer
Zofran	Cancer
Zoladex	Cancer
Zyprexa	Antipsychotic

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Medical Conditions Guidelines

The following chart lists most of the medical conditions you will encounter in taking an Application for Long-Term Care Insurance. In addition to the medical condition, a time frame (Stability Indicator) is indicated to convey the specific, minimum length of time that is required from completion of any/all treatment for that condition to the time an Application can be submitted. If the disease is a chronic one, then the Stability Indicator refers to the number of months that the condition must be successfully controlled to the extent that the disease poses no threat to the Applicant's general health or need for Long-Term Care services.

MEDICAL CONDITION	STABILITY INDICATOR	MINIMUM STABILITY/WAITING PERIOD
Acoustic Neuroma	• Post-surgical or radiation treatment, now resolved	6 months
	• Surgery anticipated	Postpone
Acute Transverse Myelitis		Uninsurable
Acquired Immune Deficiency Syndrome (AIDS)		Uninsurable
Acromegaly		Uninsurable
ADL Deficits	Anyone who requires the help of another person, for either physical or cognitive reasons, to perform any one of the following Activities of Daily Living (ADLs): Bathing, Dressing, Control of Bowel/Bladder (Continence), Using the Toilet, Transferring out of Bed/Chair, Eating, Ambulation/Mobility (inside and outside)	Uninsurable
AIDS Related Complex (ARC)		Uninsurable

Condition	Criteria	Waiting Period / Decision
Alcohol and Other Chemical Dependency, Including Drug/Chemical Dependency	• Current Use	Uninsurable
	• Treated with abstinence	36 months
Alzheimer's Disease		Uninsurable
Amputation	• Due to accident - independent in ADLs, IADLs	6 months
	• Due to disease (such as diabetes or PVD)	Uninsurable
Amyotrophic Lateral Sclerosis (ALS)		Uninsurable
Anemia	• Cause Unknown	Uninsurable
	• Hemolytic - Cause unknown, but recovered/stable - No splenectomy	12 months
	• Iron deficiency, corrected	6 months.
	• Pernicious, with B 12 injections - No neurological impairment	6 months
	• Splenectomy	60 months
Aneurysm	• Abdominal, Thoracic, Aortic - Unoperated	6 months
	- Operated, complete recovery	3 months
	• Cerebral - Unoperated	Uninsurable
	- Operated, complete recovery	12 months
Angina	• Asymptomatic, controlled with meds	6 months
	• With history of Heart Attack or Diabetes	12 months
	• Intestinal	Uninsurable
	• In combination with CHF	Uninsurable
	• Work-up in progress	Uninsurable
Angioplasty, Cardiac (Balloon Angioplasty)	• No Heart Attack	3 months
	• History of Heart Attack - Asymptomatic	6 months
	- Symptoms continue	Uninsurable
	- Treatment for Congestive Heart Failure	Uninsurable

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Condition	Guidelines
Ankylosing Spondylitis	• No pulmonary compromise .... 6 months • Major joint replacement .... 12 months
Anxiety	• Controlled with meds
	- No interference with activities ..... 6 months • Panic Attacks - No ADL or IADL limitations - No cognitive impairment .... 12 months • Chronic, severe anxiety disorder .... Uninsurable
Aortic Stenosis/ Aortic Insufficiency	(See Heart Valve Disease)
Arrythmia	• Mild - Controlled with meds .... 3 months • Atrial fibrillation/flutter - Single episode - Controlled with meds No Transient Ischemic Attack (TIA) No Cerebrovascular Accident (Stroke) .... 6 months - Chronic Atrial Fibrillation Asymptomatic, - Controlled with meds .... 12 months History of CHF or syncope .... 24 months Defibrillator, implanted .... Individual Consideration
Arteritis	(Thromboangitis Obliterans, Buerger's Disease, Temporal, Giant Cell) • No ADL or IADL limitations - No active disease .... 12 months
Arteriosclerotic Heart Disease	(ASHD) (See Coronary Heart Disease)
Arthritis	• Mild osteoarthritis - No ADL or IADL limitations - No joint deformities - No joint replacement .... 0 months • Moderate Osteoarthritis or Mild-Moderate Rheumatoid Arthritis - No ADL or IADL limitations - No joint deformities - History of Joint Replacement - History of cortisone injections ..... 6 months

Arthritis *cont'd.*	• Severe, Osteoarthritis or Rheumatoid - Requires Durable Medical Equipment - ADL or IADL limitations - Continual steroidal use - Surgery recommended .... Uninsurable
Asthma	• Mild - Controlled with meds - No ADL or IADL limitations - Stable weight - No home oxygen - No hospitalization within six months - No evidence of Congestive Heart Failure .... 12 months • Moderate - Same as above - Steroids at a dose less than 20 mg/day .... 6 months • Severe .... Uninsurable • Currently smoking .... Uninsurable
Ataxia (Unstable Gait)	.... Uninsurable
Atrioventricular (A-V) Heart Block	• Complete Block - Pacemaker inserted .... 3 months - History Transient Ischemic Attack .... 60 months
Autonomic Neuropathy	.... Uninsurable
Autonomic Insufficiency	(Shy–Drager syndrome) .... Uninsurable
Avascular Necrosis	• No ADL or IADL limitations - No pending surgery - No chronic pain .... 12 months
Azotemia	(See Renal Disease)
Back or Spine Surgery	.... 6 months
Bell's Palsy	• No ADL or IADL limitations .... 3 months
Benign Prostatic Hypertrophy	• Unoperated - Asymptomatic .... 0 months • Surgical repair - No urinary catheter .... 3 months
Berger's Disease	.... Uninsurable
Binswanger's Disease	.... Uninsurable

Condition	Rating
Blastomycosis	Uninsurable
Blindness	• Due to diabetes or with ADL loss ... Uninsurable • Successful adaptation to visual loss ... 12 months
Bone Marrow Transplant	(See Transplant, Organ)
Bronchiectasis	(See Emphysema)
Bronchitis	(See Asthma)
Cancer	• Any continuing therapy ... Uninsurable • With Metastasis (spread from original site) ... Uninsurable • Recurrent Cancer (same organ or site) ... Uninsurable • Cancer of the bone, brain, esophagus, liver, lung, ovary, pancreas, stomach, esophagus or testes ... 48 months • Cancer of other internal organs - Breast: stages 0 & I ... 12 months stage II ... 36 months stages III & IV ... Uninsurable - Colon and Rectum: stage A ... 12 months stage B ... 24 months stages C or D ... Uninsurable - Head and Neck stage I ... 12 months stage II ... 36 months stages III & IV ... Uninsurable - Kidney stages I & II ... 12 months stages III & IV ... Uninsurable - Lung ... 48 Months - Prostate stages A & B ... 12 months stage C ... 36 Months stage D ... Uninsurable - Bladder stage A ... 12 months stage B ... 48 months stages C & D ... Uninsurable - Thyroid ... 24 months

Condition	Guideline
Cancer *cont'd.*	- Skin Basal Cell .... 0 months Squamous Cell .... 0 months Melanoma in Situ, superficial, early stage .... 12 months deeper or higher stage .... 48 months
Cardiomyopathy	• No ADL or IADL limitations - No Congestive Heart Failure .... 12 months • Symptomatic or Progressive .... Uninsurable
Carotid Artery Disease	• Operated, endarterectomy .... 3 months • Unoperated - 70% Stenosis or greater .... Uninsurable - No history of TIA .... 12 months - History of TIA .... 60 months
Carpal Tunnel Syndrome	• No ADL or IADL limitations .... 3 months
Cerebral Palsy	• No ADL or IADL limitations .... 12 months
Cerebral Vascular Accident (CVA)	(See Stroke)
Chagas' Disease (Steatorrhea)	.... Uninsurable
Chromosomal Abnormalities	(including XXY, XXXY, XXXX, Trisomy 21) .... Uninsurable
Chronic Organic Brain Syndrome (OBS)	.... Uninsurable
Chronic Obstructive Lung Disease (COLD)	(See Emphysema)
Chronic Obstructive Pulmonary Disease (COPD)	(See Emphysema)
Cirrhosis of the Liver	.... Uninsurable
Claudication	(See Peripheral Vascular Disease)
Colitis	• Irritable bowel syndrome, diverticulitis .... 3 months • Crohn's or Ulcerative - Unoperated .... 12 months - Independent with ostomy .... 6 months

Condition	Criteria / Decision
Colostomy or Ileostomy	• Independent in management .... Underwrite Cause
Concussion	• No ADL or IADL limitations - No cognitive impairment .... 6 months
Confusion	.... Uninsurable
Congestive Heart Failure	• No ADL or IADL limitations - Controlled with meds .... 12 months • Multiple episodes .... Uninsurable • In combination with: Angina or Heart Attack; Angioplasty or Heart Surgery; Asthma or Chronic Bronchitis; Diabetes; Emphysema or Chronic Obstructive Pulmonary Disease; or Tuberculosis (TB) .... Uninsurable
COPD	(See Emphysema)
Coronary Bypass Grafts	• Asymptomatic .... 6 months • With history of Heart Attack, during or after surgery or with diabetes .... 12 months • History of CHF post-operative .... Uninsurable
Coronary Heart Disease (CAD, ASHD)	• With or without Heart Attack - No ADL or IADL limitations .... 6 months • With Congestive Heart Failure .... Uninsurable • With Unstable Angina .... Uninsurable
Cor Pulmonale	.... Uninsurable
Crohn's Disease	(See Colitis)
Cystic Fibrosis	.... Uninsurable
Decubitus Ulcers	.... Uninsurable
Dementia	.... Uninsurable
Demyelinating Disease	.... Uninsurable

Condition	Criteria
Depression	• Situational - No ADL or IADL limitations - No cognitive impairment .... 6 months • Chronic History - Stable medication dose - No ADL or IADL limitations .... 12 months - Any hospitalization .... 24 months
Diabetes Mellitus	• Non-insulin dependent - No circulatory, neurological, eye, or renal disease - No steroidal therapy .... 6 months • With circulatory, neurological, eye, or renal disease complications .... Uninsurable • Insulin dependent 50 units or less daily .... 12 months
Dialysis - Hemodialysis or Peritoneal	.... Uninsurable
Diverticulitis	(See Colitis)
Dizziness/Vertigo	• Acute viral labrynthitis .... 3 months • Meniere's Disease - Controlled with meds .... 6 months • Cause unknown - No neurological impairment .... 12 months • Ongoing problem .... Uninsurable
Drug/Chemical Dependency (including Drugs, Alcohol and Other Chemical Dependency)	• Treated with current abstinence .... 36 months • Current Use .... Uninsurable
Edema (Swelling)	.... Underwrite Cause
Endarterectomy (Carotid or Femoral)	.... 3 months
Endocarditis, Infectious	• Single Episode – Resolved, stable .... 6 months • More than one episode .... Uninsurable
Emphysema	• Mild - Controlled with meds - No ADL or IADL limitations - Stable weight

Emphysema *cont'd.*	- No home oxygen - No hospitalization within six months - No evidence of Congestive Heart Failure .... 6 months • Moderate - Same as above - Steroids at a dose less than 10 mg/day .... 9 months • Severe .... Uninsurable • Actively Smoking .... Uninsurable • With Congestive Heart Failure, Asthma, or Chronic Bronchitis .... Uninsurable
Encephalitis	• No cognitive impairment .... 12 months
Enteritis	(See Colitis)
Epilepsy, Seizure Disorder	• Controlled with meds - No ADL or IADL limitations - No cognitive impairment .... 12 months • Uncontrolled, unknown reason .... Uninsurable
Esophageal Varices	.... Uninsurable
Esophageal Stricture	.... 3 months
Falls	.... Underwrite Cause
Fibromyalgia	• With pulmonary compromise .... 6 months • Fatigue that limits daily function .... Uninsurable
Fractures	• Arms - No ADL or IADL limitations .... 3 months • Compression .... (See Osteoporosis) • Legs - No ADL or IADL limitations .... 6 months • Skull - No ADL or IADL limitations - No cognitive impairment .... 12 months • Vertebral - Due to Osteoporosis or Paget's Disease No ADL or IADL limitations No respiratory compromise .... 24 months - Due to accident No ADL or IADL limitations .... 6 months

Condition	Criteria
Friedreich's Ataxia	.... Uninsurable
Gastric Balloon	.... Uninsurable
Gaucher's Disease	.... Uninsurable
Giant Cell Arteritis (Active)	.... Uninsurable
Glaucoma	• No visual loss in last two years - Successful adaptation to visual loss .... 0 months • Visual loss over last year - Successful adaptation to visual loss .... 12 months
Gout	• Gouty Arthritis - No ADL or IADL limitations - No joint deformities .... 3 months
Guillian Barre	• No residual neurological impairment .... 6 months
Head Injury	• No ADL or IADL limitations - Resolved .... 24 months • With residual impairment .... Uninsurable
Hearing Loss	• Successful adaptation to hearing loss .... 3 months
Heart Attack (Myocardial Infarction)	• No ADL or IADL limitations - No Angina .... 3 months • Angina - Controlled with meds .... 6 months • In combination with CHF .... Uninsurable
Heart Valve Disease	• Aortic stenosis/aortic insufficiency, unoperated - No Congestive Heart Failure - Stable .... 6 months • Mitral valve prolapse, Mitral stenosis/insufficiency, unoperated - No Congestive Heart Failure - Stable .... 6 months
Heart Valve Replacement	• Single valve replacement .... 6 months • Double valve replacement .... Uninsurable
Hemochromatosis (Bronze Diabetes)	.... Individual Consideration

Hepatitis	• Resolved .... 6 months • Chronic, active .... Uninsurable
Herniated Intervertebral Disc	• Operated - No ADL or IADL limitations .... 3 months • Unoperated - No ADL or IADL limitations - No chronic pain .... 6 months
Herpes Zoster	• Post-acute episode - Rehabilitation complete, no pain or neuralgia .... 3 months • Neurological work-up .... 12 months
Hiatal Hernia	.... 0 months
High Blood Pressure (Hypertension)	• Controlled with meds .... 6 months • Uncontrolled readings >175/100 .... Uninsurable
Hip Replacement	(See Joint Replacement)
HIV Positive Status	.... Uninsurable
Hodgkin's Disease	• Disease free, treatment free .... 60 months
Hospitalization	• Released fully recovered .... Underwrite Cause • Currently in hospital or anticipated admission .... Uninsurable
Hunter's Syndrome	.... Uninsurable
Huntington's Chorea	.... Uninsurable
Hurler's Syndrome	.... Uninsurable
Hydrocephalus	.... Uninsurable
Hypertension	(See High Blood Pressure)
IADL Deficits	Anyone who requires the help of another person, for either physical or cognitive reasons, to perform two or more of the following Instrumental Activities of Daily Living (IADLs): Using the Telephone, Managing Finances, Taking Transportation, Shopping, Laundry, Housework,

Condition	Criteria	Rating
IADL Deficits *cont'd.*	Taking all Medications, Preparing Meals/Cooking	Uninsurable
Idiopathic Pulmonary Fibrosis, Active		Uninsurable
Ileitis, Regional, end-stage		Uninsurable
Immune System Disorders		Uninsurable
Irritable Bowel Syndrome	(See Colitis)	
Joint Replacement (Hip, Knee, Shoulder)	• Physical Therapy completed • No ADL or IADL limitations	3 months
Kaposi's Sarcoma		Uninsurable
Korsakoff's Psychosis		Uninsurable
Knee Disorder	• No ADL or IADL limitations • No surgery recommended	3 months
Knee Replacement	(See Joint Replacement)	
Lesch–Nyhan Syndrome		Uninsurable
Leukemias	• Acute, any type	Uninsurable
	• Chronic, non-lymphocytic (CML)	60 months
	• Chronic Lymphocytic (CLL) - stable and treatment free	36 months
	- stages III or IV	Uninsurable
	• Hairy Cell - stable and treatment free	24 months
Lues (Stage IV Syphilis/ Tabes Dorsalis)		Uninsurable
Lupus	• Discoid, inactive	6 months
	• Systemic Lupus	Uninsurable
Lyme Disease	• Resolved	6 months
	• Hospitalization for complications	12 months
Lymphoid Interstitial Pneumonia		Uninsurable
Lymphoma, Non-Hodgkin's	• Disease and treatment free	60 months

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Condition	Guideline
Macular Degeneration	• No ADL or IADL limitations - Stable with no further visual loss .... Underwrite Cause
Manic Depression	• No psychiatric hospitalization in five years - Controlled with medication .... 24 months
Marfan's Syndrome	.... Uninsurable
Melanoma	(See Cancer)
Mental Retardation	.... Uninsurable
Memory Loss	.... Uninsurable
Mitral Valve Prolapse, Stenosis, Insufficiency	(See Heart Valve Disease)
Mixed Connective Tissue Disease	.... Uninsurable
Mobility	• With ADL or IADL Limitations .... Uninsurable
Multiple Myeloma	.... Uninsurable
Multiple Sclerosis	.... Uninsurable
Muscular Dystrophy	.... Uninsurable
Myasthenia Gravis	• Without symptoms or complications .... 24 months • Post-surgery with full recovery and rehab complete .... 24 months • Disease process unresponsive to treatment .... Uninsurable
Myelofibrosis	• Asymptomatic .... 6 months • Abnormal Bone Marrow Exam .... 24 months • Splenectomy .... 60 months
Myocardial Infarction	(See Heart Attack)
Narcolepsy	• Asymptomatic .... 12 months • Recent onset or hospitalization .... 24 months
Nephrectomy, Unilateral	(Loss of one kidney) .... 12 months
Nephritis, Glomerulonephritis	.... 12 months
Nephrolithiasis	• Post-Lithotripsy .... 3 months

Condition	Guideline
Nervous Breakdown	• No psychiatric hospitalizations in two years - No antipsychotic medications ..... 24 months
Neurofibromatosis	..... Uninsurable
Neurogenic Arthropathy	• Post joint replacement ..... 6 months • History of compression fractures ..... 12 months
Neurogenic Bladder	..... Uninsurable
Neuropathy	• Non-progressive, mild ..... 6 months • Autonomic Neuropathy ..... Uninsurable
Organ Transplant	(See Transplant, Organ)
Organic Brain Syndrome	..... Uninsurable
Osler–Weber–Rendu Disease (Telangiectasis)	..... Uninsurable
Osteomyelitis (Bone Infection)	• Resolved ..... 12 months • Chronic, active ..... Uninsurable
Osteoporosis	• No history of fractures ..... 0 months • History of compression fractures (less than three) - No ADL or IADL limitations ..... 24 months • Three or more compression fractures ..... Uninsurable
Oxygen Use	..... Uninsurable
Pacemaker	(See Atrioventricular Block)
Paget's Disease (Osteitis Deformans)	• Asymptomatic ..... 0 months • Moderate disease - No ADL or IADL limitations ..... 12 months • Severe disease ..... Uninsurable
Pancreatitis	• Acute - No alcohol abuse in the past 36 months ..... 12 months • Chronic ..... Uninsurable
Paralysis/Paresis	• No ADL or IADL limitations ..... Underwrite Cause • Hemiplegia ..... Uninsurable • Paraplegia ..... Uninsurable • Quadriplegia ..... Uninsurable

Condition	Criteria	Decision
Parkinson's Disease		Uninsurable
Peptic Ulcer Disease	• Asymptomatic	0 months
	• History of gastrointestinal bleed	6 months
Pericarditis	• Resolved	6 months
Peripheral Vascular Disease	• No leg pain - Nonsmoker - No ADL or IADL limitations	6 months
	• Occasional leg pain - Nonsmoker - No ADL or IADL limitations	6 months
	• Weekly leg pain - Continued smoking - ADL or IADL limitations	Uninsurable
Phobias, Psychoneurosis	• Treated with antipsychotic medication	Uninsurable
Polyarteritis Nodosa		Uninsurable
Polycystic Kidney Disease	• Asymptomatic	6 months
	• Hospitalizations for renal failure or surgery	24 months
	• Transplant	60 months
Polymyalgia Rheumatica	• Resolved - No more than 10 mg Prednisone per day	12 months
	• Unresolved or > 10 mg Prednisone per day	Uninsurable
Polyps - Benign		3 months
Portal Hypertension		Underwrite Cause
Post Polio Syndrome	• No history of paralysis	0 months
	• History of paralysis - No ADL or IADL limitations - No walker or wheelchair usage	24 months
	• Any equipment usage or ADL/IADL limitations	Uninsurable
Postereo-Lateral Sclerosis		Uninsurable
Progressive Muscular Atrophy		Uninsurable

Condition	Criteria	Waiting Period / Decision
Progressive Systemic Sclerosis		Uninsurable
Prostatic Hypertrophy, Benign (BPH)	• Unoperated - Asymptomatic • Surgical repair - No urinary catheter	 0 months 3 months
Pulmonary Emboli	• Resolved - No breathing difficulty	 12 months
Pulmonary Fibrosis		Uninsurable
Renal Disease	• Mild renal insufficiency • Moderate to severe	12 months Uninsurable
Retinal Detachment and/or Hemorrhage	• Asymptomatic, stable • With diabetes	3 months Uninsurable
Sarcoidosis	• Asymptomatic	36 months
Schizophrenia		Uninsurable
Sciatica	• No ADL or IADL limitations - Asymptomatic	 6 months
Scleroderma, active		Uninsurable
Sclerosing Cholangitis		Uninsurable
Scoliosis	• No ADL or IADL limitations	0 months
Seizure Disorder	(See Epilepsy)	
Senility, All Forms		Uninsurable
Shy–Drager Syndrome		Uninsurable
Sleep Apnea	• Asymptomatic • CPAP machine without bottled oxygen • Hospitalization	3 months 6 months 12 months
Spinal Muscle Atrophy		Uninsurable
Spinal Stenosis	• No ADL or IADL limitations - No chronic pain - No narcotic medications	 6 months
Stroke (Cerebrovascular Accident- CVA)		Uninsurable

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Condition	Guideline
Surgery	If surgery is recommended, planned, or has been recently performed, do not take the Application until the surgery. Refer to the specific medical condition and Stability Indicator for time frames.
Thrombocytopenia	• Unoperated, asymptomatic .... 12 months • Post-Splenectomy, asymptomatic, stable .... 24 months • Reactive Thrombocytopenia .... Underwrite Cause
Thrombophlebitis, Superficial	.... 0 months
Thrombosis, Deep Vein	• No ADL or IADL limitations - Resolved .... 6 months
Transient Ischemic Attack (TIA or “mini-stroke”)	• Single episode - No ADL or IADL limitations - Nonsmoker .... 60 months • More than one TIA .... Uninsurable • In combination with diabetes or heart surgery .... Uninsurable
Transplant, Organ	• Corneal .... 3 months • Kidney .... 60 months • All others .... Uninsurable
Transverse Myelitis	.... Uninsurable
Tremors	• Benign, essential, or familial - No ADL or IADL limitations .... 6 months • Work-up in progress .... Uninsurable • Due to Parkinson’s Disease .... Uninsurable
Tuberculosis	• Resolved .... 12 months • Active .... Uninsurable
Tumors, Benign	• Brain, Spinal cord - No paralysis - No ADL or IADL limitations - No seizure disorder .... 60 months • Other sites .... 6 months

Condition	Criteria	Decision
Ulcers of Skin	• Resolved	24 months
	• Active or chronic	Uninsurable
	• Resulting in Amputation	Uninsurable
Ulcers, Duodenal	• Asymptomatic	0 months
	• History of Gastrointestinal Bleed	6 months
Urinary Incontinence	• Independent in care	0 months
	• Complete incontinence, dependent in ADLs	Uninsurable
	• Use of catheter	Uninsurable
Urolithiasis/Renal Calculus	• Hospitalization or surgery	6 months
Varices, Esophageal		Uninsurable
Varicose Veins (Legs)	• No ADL or IADL limitations	0 months
Vasculitis, All forms		Uninsurable
Vertebral or Spinal Disorder, Not Otherwise Classified	• No ADL or IADL limitations - No chronic pain or narcotic medications - No active ongoing therapy or recommendations for therapy - No walker or wheelchair usage	12 months
Vertigo	(See Dizziness)	
Vision Loss	(See Blindness)	
Von–Hippel–Lindau		Uninsurable
Von Recklinghausen's		Uninsurable
Waldenstrom's		Uninsurable
Walker Use		Uninsurable
Wegener's Granulomatosis		Uninsurable
Whipple's Disease		Uninsurable
Wilson's Disease		Uninsurable
Wiskott–Aldrich Syndrome		Uninsurable
Xeroderma Pigmentosa		Uninsurable

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Notes

[1] Living long has its' benefits and its' costs. San Diego Daily Transcript. September 26, 2003.

[2] "About Long-Term Care," Thomas Day. Longermcarelink.net. September, 2003. p.3

[3] Explaining Long-Term Care, Rick Edelman, Investment Advisor, January 2004. p.94

[4] The National Council on the Aging, White House Conference on Aging Listening Session. September 10, 2004, p.2

[5] Cannuscio, CC, C Jones, I Kawachi, GA Colditz, L Berkman and E Rimm, Reverberation of family illness: A longitudinal assessment of informal caregiver and mental health status in the nurses' health study. American Journal of Public Health 2002; 92:305-1311.

[6] "Living long has its' benefits and its' costs." San Diego Daily Transcript. September 26, 2003

[7] "The ABC's of LTC." On Wall Street-online, Nancy R. Mandell, July 1, 2003. p.2

[8] Prudential Financial Long-Term Care Cost Survey, January 2004.

[9] Cannuscio, CC, C Jones, I Kawachi, GA Colditz, L Berkman and E Rimm, Reverberation of family illness: A longitudinal assessment of informal caregiver and mental health status in the nurses' health study. American Journal of Public Health 2002; 92:305-1311

[10] HIAA, "Benefits of Long-Term Care Insurance: Enhanced Care for Disabled Elders. Improved Quality of Life for Caregivers and Savings to Medicare & Medicaid, September 2002, p. 7

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LTC3[SM] Long-Term Care Insurance is issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102 (800 732-0416). This coverage contains benefits, exclusions, limitations, eligibility requirements and specific terms and provisions under which the insurance coverage may be continued in force or discontinued. All insurance policies may not be available in your state. Coverage is issued under policy number GRP 113096, however policy numbers may vary by state.