KEMPER

Application for Home Health Care Indemnity Insurance

KEMPER SENIOR SOLUTIONS

Insurance Benefits Provided by Reserve National Insurance Company

APPLICANT

Full Legal Name of Proposed Insured _____

Gender ☐ Male ☐ Female **Social Security No.** ____/____/____ **Date of Birth** ____/____/____

Legal Residence Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Phone No. ____/____/____ E-mail _____

HOME HEALTH CARE INDEMNITY POLICY

HOME OFFICE USE: Policy Number(s)

UNDERWRITING

If you are applying for the Home Health Care Indemnity Policy, please answer the following:

1. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?	☐ **Yes** ☐ **No**
2. Did you have another long-term care insurance policy or certificate in force during the last 12 months?	☐ **Yes** ☐ **No**
a. If so, with which company?	☐ **Yes** ☐ **No**
b. If that policy lapsed, when did it lapse?	☐ **Yes** ☐ **No**
3. Are you covered by Medicaid?	☐ **Yes** ☐ **No**
4. Do you intend to replace any of your medical or health insurance coverage with this policy?	☐ **Yes** ☐ **No**
5. Are you currently living in a nursing home or assisted living facility or currently receiving home health care or similar-type benefits?	☐ **Yes** ☐ **No**
6. Are you physically unable to perform routine activities such as bathing, dressing, eating, toileting or transferring to or from a bed or chair?	☐ **Yes** ☐ **No**
7. Do you acknowledge receipt of an outline of coverage for this policy?	☐ **Yes** ☐ **No**

Payment Mode: ☐ Annual ☐ Monthly (Automated Bank Account Withdrawal)

Base Policy (Nonforfeiture Benefit Rider $ _____)	**** Initial Premium $*** _____
Base Policy + Extra Benefit Rider (NB Rider $_____)	**** Initial Premium $*** _____
Base Policy + Inflation Benefit Rider (NB Rider $_____)	**** Initial Premium $*** _____
Base Policy + Extra Benefit Rider + Inflation Benefit Rider (NB Rider $_____)	**** Initial Premium $*** _____

* Includes one-time policy registration fee

AGREEMENTS & SIGNATURES

IT IS REPRESENTED THAT ALL STATEMENTS AND ANSWERS CONTAINED IN THIS APPLICATION ARE FULL, COMPLETE AND CORRECTLY RECORDED AND THAT: 1. This application and any supplements thereto will be the basis for and be a part of any insurance issued, and that all statements and answers in this application and any supplements are complete and true to the best of applicant's knowledge and belief. 2. The insurance applied for in this application will not be considered in force until issued by the Company and the first premium paid during the insured's lifetime. The Company shall have 60 days from the date signed in which to consider and act upon this application which the parties agree is a reasonable time. If within such period insurance has not been received by the applicant, or if notice of rejection has not been given, then this application shall be deemed to have been declined by the Company and the Company will return any premium tendered herewith. For purposes of insurability and underwriting determinations by Reserve National Insurance Company, I hereby authorize any physician, medical practitioner, hospital, clinic, pharmacy benefit manager, pharmacy related service organization, or other medical or medically-related facility, insurance company or MIB, Inc. ("MIB"), that has any health or medical records or knowledge concerning me or any members of my family named in this application, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. I authorize the Company or its reinsurers to make a brief report of my personal health information to MIB. I, or my authorized representative, am/is entitled to receive a copy of this authorization upon request. This authorization shall remain valid for a period of 24 months from the date hereof. I understand that I may revoke this authorization at any time by mailing written notice thereof to the Company at 601 East Britton Road, Oklahoma City, OK 73114. If this application was taken over the telephone, I state that my answers were correctly recorded and I have signed this application after the telephone call.

If accepted by the Company, the applicant requests coverage to be effective: ☐ Date of Application ☐ Date of Issue ☐ Other _____	**Policy to be Delivered to:** ☐ Applicant ☐ Agent

If eligible for Medicare, I have received a "Guide to Health Insurance for People With Medicare" and the "Important Notice to Persons on Medicare."..... ☐ **Yes** ☐ **No**

I have received: ☐ Potential Rate Increase Disclosure Form ☐ Long-Term Care Insurance Personal Worksheet ☐ "A Shopper's Guide to Long-Term Care Insurance ☐ "Things You Should Know Before You Buy Long-Term Care Insurance"

Protection Against Unintentional Lapse: I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of the Home Health Care policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. ☐ I elect NOT to designate any person to receive such notice.

Name _____ Phone No. _____/_____/_____

Mailing Address _____
Street City State Zip

The sum of $ _____* , which is the ☐ **Annual** ☐ **Monthly** initial premium for the policy(ies) applied for, has been ☐ **Paid to** ☐ **Authorized as a draft on my account by** "Kemper Senior Solutions."

* This must match the Initial Premium on the front side of this application.

Caution: If your answers on this application are incorrect or untrue, Reserve National Insurance Company may have the right to deny benefits or rescind your policy.

I have reviewed the outline of coverage and the explanation of nonforfeiture benefits and ☐ Reject ☐ Accept the nonforfeiture option.

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy, with and without inflation protection. I realize that based on current health care trends, the benefits provided by a long-term care plan which does not have meaningful inflation protection may be significantly diminished in terms of real value to me, depending on the amount of time which elapses between the date I purchase the policy and the date on which I first become eligible to use them. Specifically, I have reviewed the Policy with and without inflation protection, and I ☐ Reject ☐ Accept inflation protection.

Signed at: _____ _____
City State

_____ **Date:** _____
Signature of Proposed Insured

Agent: I certify that I asked each question of the applicant personally and the answers have been accurately recorded hereon.

Agents shall list any other health insurance policies and certificates they have sold to the applicant. _____

(a) List policies and certificates sold which are still in force. _____

(b) List policies and certificates sold in the past five (5) years which are no longer in force. _____

Agents shall list any other health insurance policies or certificates the applicant has in force. _____

_____ _____ _____
Signature of Producer **Producer Number** **Date**

_____ _____
Print Producer Name **Agency Name**

BANK DRAFT AUTHORIZATION

Please complete the separate bank draft authorization form.

Note to Producer: The bank draft authorization form is available on the Kemper Senior Solutions forms portal.