



Applying for employees and their spouses is easy!

Instructions for the enrollment form and short form application

When completing an application, please fill in each section of the forms carefully, answering each question completely. If any parts are left blank, we cannot process your application. Employees and spouses should complete his or her own form. Be sure to select one daily maximum benefit, and one lifetime maximum benefit. Indicate if you want the benefit account non-forfeiture option and/or the automatic benefit increase option. Premiums for both employees and their spouses will be deducted from the employee's paycheck. Persons will be mailed certificates of coverage if they are accepted.

Newly hired employees enrolling when first eligible

1. Complete the *Enrollment Form for New Employees*. Be sure to read and sign section 4.
2. Give the form to the benefits personnel in your office. They will complete the eligibility information in section 1 before forwarding the application to CNA.

Existing employees applying at any other time

1. Complete the *Short Form Application*. Complete sections 1, 2, 3, and 5, then read and sign sections 4 and 6.
2. Give the application to the benefits personnel in your office. They will complete the eligibility information in section 3 before forwarding the application to CNA.

Spouses applying for coverage at any time

1. Complete the *Short Form Application*. Complete sections 1, 2, 3 and 5, then read and sign section 6. Be sure to include the employee's name and social security number in section 3. The employee must read and sign section 4.
2. Give the form to the benefits personnel in the employee's office. They will complete the eligibility information in section 3 before forwarding the application to CNA.

Questions?

Just call a CNA customer service representative:
1-888-653-9600





Long Term Care Insurance

Enrollment form for new employees



If any part of sections 1 through 4 is blank, we cannot process your enrollment form.

SECTION 1 – EMPLOYEE INFORMATION

Full name		Date of birth	<input type="checkbox"/> Male
			<input type="checkbox"/> Female
Employee ID	Social Security Number		
Address			
City	State	Zip	
Daytime phone	Evening phone		
To be completed by benefits personnel			
Date of benefit eligibility	Payroll location: (Select one)		
	<input type="checkbox"/> Central Payroll or <input type="checkbox"/> IBU _____		

SECTION 2 – BENEFIT SELECTIONS

Select **ONE** daily benefit:

- Option 1: \$100 daily benefit
 Option 2: \$150 daily benefit
 Option 3: \$200 daily benefit

Select **ONE** lifetime maximum:

- Choice A: 730 days x daily benefit (2 years)
 Choice B: 1250 days x daily benefit (3.4 years)
 Choice C: 1825 days x daily benefit (5 years)

Select **OPTIONAL** benefits:

For an additional cost, you may select one or both of the following optional features:

- Non-forfeiture benefit account
 Automatic benefit increase option *(Selecting this option qualifies coverage for the MN Long Term Care Partnership)*

OVER, PLEASE

SECTION 3 – OTHER INSURANCE COVERAGES

Do you currently have long-term care insurance in force or have you recently applied for such insurance? Yes No

If yes, please list all such coverages in the space provided below. Indicate if you intend to replace any medical or health insurance coverage, including health care service contract or health maintenance organization with the insurance applied for with this application.

Company name	Company address	Policy number	Is coverage to be replaced?	When
			Yes <input type="checkbox"/> No <input type="checkbox"/>	

SECTION 4 – EMPLOYEE AUTHORIZATION

To the best of my knowledge and belief, the information on this enrollment form is true and complete. I understand that the insurance I have selected for myself will begin on the Certificate Effective Date shown in my Certificate of Insurance provided that I am actively at work on that date with my employer and am eligible for benefits under the State Employees Group Insurance Program. If I am not actively at work on that date, my insurance will not take effect until the first day of the month after I return and remain actively at work. I understand that actively at work means that I am at my usual place of employment on the effective date of the coverage.

I authorize my employer to make the appropriate payroll deduction for the above-specified coverage and release other necessary information to the administrators of the program.

Signature	Date
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Long Term Care Insurance

Short Form Application for employees'
spouses and late-enrolling employees



SECTION 1 – APPLICANT INFORMATION

Full name (first, middle, last)		Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address		Social Security Number	
City	State:	Zip	
Daytime phone	Evening phone		

SECTION 2 – BENEFIT SELECTIONS

Select **ONE** daily benefit:

- Option 1: \$100 daily benefit
 Option 2: \$150 daily benefit
 Option 3: \$200 daily benefit

Select **ONE** lifetime maximum:

- Choice A: 730 days x daily benefit (2 years)
 Choice B: 1250 days x daily benefit (3.4 years)
 Choice C: 1825 days x daily benefit (5 years)

Select **OPTIONAL** benefits:

For an additional cost, you may select one or both of the following optional features:

- Non-forfeiture benefit account
 Automatic benefit increase option (*Selecting this option qualifies coverage for the MN Long Term Care Partnership*)

SECTION 3 – EMPLOYEE INFORMATION

I certify that I am an employee the spouse of an employee

Employee's full name

Employee's ID number

Employee's Social Security Number

To be completed by benefits personnel,
For employees and spouses enrolling after the May 2010 enrollment period

Date of hire	Date of benefit eligibility	Payroll location (Check ONE) <input type="checkbox"/> State of Minnesota Central Payroll <input type="checkbox"/> IBU _____
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OVER, PLEASE

SECTION 4 – PAYMENT METHOD

I authorize my employer to make payroll deductions for the above-specified coverage and release other necessary information to the administrators of this program.

Employee's signature _____ Date ____ / ____ / ____

SECTION 5 – STATEMENT OF INSURABILITY

1. Height _____ ft. _____ in. Weight _____ lbs.	
2. During the last seven years have you been diagnosed, received medical advice or been treated by a member of the medical profession for any of the following:	Yes No
a. Acquired Immune Deficiency Syndrome (AIDS) or any other immune system disorder.	<input type="checkbox"/> <input type="checkbox"/>
b. Alzheimer's Disease, dementia or change in cognitive functioning.	<input type="checkbox"/> <input type="checkbox"/>
c. Multiple Sclerosis, Huntington's Disease, Parkinson's Disease or Amyotrophic Lateral Sclerosis.	<input type="checkbox"/> <input type="checkbox"/>
d. Emphysema, chronic bronchitis or asthma.	<input type="checkbox"/> <input type="checkbox"/>
e. Internal lupus erythematosus or any other connective tissue disease or disorder.	<input type="checkbox"/> <input type="checkbox"/>
f. Cancer which has spread or metastasized.	<input type="checkbox"/> <input type="checkbox"/>
g. Heart disorder.	<input type="checkbox"/> <input type="checkbox"/>
h. Diabetes mellitus, glucose intolerance or hyperglycemia.	<input type="checkbox"/> <input type="checkbox"/>
i. Cerebral vascular accident, stroke or transient ischemic attack.	<input type="checkbox"/> <input type="checkbox"/>
j. Alcoholism or substance abuse.	<input type="checkbox"/> <input type="checkbox"/>
k. Bone or joint disease or disorder requiring prescription medication or surgery.	<input type="checkbox"/> <input type="checkbox"/>
l. Mental, emotional or nervous disease or disorder, depression, or chemical imbalance.	<input type="checkbox"/> <input type="checkbox"/>
3. Have you used any tobacco products more than once a month at any time during the last three years?	<input type="checkbox"/> <input type="checkbox"/>
4. At any time during the last two years have you needed assistance or supervision or were you limited in any way physically or cognitively from performing any of the daily activities of bathing, dressing, toileting, mobility, eating or managing medications?	<input type="checkbox"/> <input type="checkbox"/>
5. At any time in the last seven years have you applied for or received Social Security Disability benefits or Medicaid?	<input type="checkbox"/> <input type="checkbox"/>
6. Do you currently have or have you had in the past 12 months any long-term care insurance in force other than Group Long-Term Care Insurance from Continental Casualty Company or have you applied for such insurance?	<input type="checkbox"/> <input type="checkbox"/>
7. Do you intend to replace any medical or health insurance coverage including a health care service contract or health maintenance organization with insurance applied for with this application other than with M-Pel long term care insurance from Continental Casualty Company?	<input type="checkbox"/> <input type="checkbox"/>

NEXT PAGE, PLEASE

SECTION 6 – AUTHORIZATION

NOTICE: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

I understand and agree that the statements in this application are complete and true to the best of my knowledge and belief and that they will form a part of the contract of insurance. I also understand and agree that the insurance for which I am applying, if issued, shall be based on these statements.

Authorization to Obtain Information

“Information Provider” as used herein may include any physician, medical practitioner, hospital, clinic, other medical or medically related facility, clearinghouse, insurance or reinsuring company, agent, broker, service provider, Medical Information Bureau, Inc. (MIB), credit bureau or other consumer reporting agency, employer or the Veterans Administration.

“Information” received from an Information Provider may include advice, diagnosis, prognosis, treatment or care of any physical or mental condition concerning me, including information about HIV or AIDS, drug or alcohol abuse or mental illness (except psychotherapy notes) and/or financial, consumer report, or any other non-medical information concerning me.

I AUTHORIZE any Information Provider to give Continental Casualty Company (the Company) any and all Information regardless of any previous restriction or limitation on disclosure of such Information. In order to expedite my request, I further authorize an Information Provider (except MIB) to release Information to the Company’s agents, brokers, service providers, its reinsurers, or any other third party retained by the Company to collect and transmit such Information.

I UNDERSTAND that the Information obtained by use of this Authorization is at my request and will be collected by the Company to determine eligibility for insurance. I understand that this Authorization to Obtain Information shall remain valid for two years from the date shown below. I understand that if I do not sign this Authorization, the Company may not accept my application for insurance.

I UNDERSTAND that the Company may maintain or have access to personal information acquired separately through any of my previous insurance applications with the Company or its affiliates for insurance even in instances where insurance was not placed with me. I authorize the Company to use or disclose such information for consideration of my current application for insurance.

I UNDERSTAND that I may revoke this Authorization at any time by providing written notice to the Company, except: (i) to the extent that an individual has taken action in reliance upon such authorization prior to notice of the revocation, or (ii) to the extent that this authorization was provided as a condition of obtaining insurance coverage and other law provides the Company with the right to contest a claim for coverage under the policy or the insurance coverage under the policy itself.

I UNDERSTAND that Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer the responsibility of the Information Provider or protected by the privacy rule under the Health Insurance Portability and Accountability Act.

I UNDERSTAND I may request to receive a copy of this Authorization and I agree that a photographic copy of this Authorization shall be as valid as the original.

I CERTIFY that I have read, or had read to me, the completed application. All statements in this application are representations and not warranties. If this application is accepted, the insurance will take effect on the effective date shown on the schedule page attached to the certificate of coverage.

Caution Notice: If your answers on this application are incorrect or untrue, the Continental Casualty Company may have the right to deny benefits or rescind your coverage, subject to the incontestability provisions in the policy.

Applicant’s Signature _____

Date _____ / _____ / _____

Coverage is not guaranteed and is based on the information provided.