



Aetna Life Insurance Company
P.O. Box 5712
Hopkins, MN 55343

Group Long Term Care Insurance Employee Enrollment Form -- **G** Commonwealth of Virginia

- **Active Employees – Complete during a Special Enrollment period or within 60 days of hire**

Instructions

Each enrollee must complete and sign a separate form and print all responses in **BLACK** ink.

1. Please complete this Enrollment Form for Guarantee Issue if you are an eligible employee as described in one of the groups below and you are in an Eligible Class:
 - An eligible active employee*, including employees on leave of absence or disability, enrolling during a designated enrollment period; or
 - A newly hired eligible or newly eligible active employee* enrolling within 60 days of first becoming eligible.
2. Be sure to provide complete information to avoid delays in processing your request for coverage.
3. Make a copy of this completed enrollment form for your records and return the original in the envelope provided to: Aetna Life Insurance Company, Long Term Care, P.O. Box 5712, Hopkins, MN 55343.

* As an active employee, you are eligible to apply for coverage on a guarantee issue basis. However, if you are ill, injured or on a medical leave of absence and away from work on the date that coverage would otherwise become effective for you, then the effective date of your coverage will be delayed to the first of the month following the date you return to work for at least five consecutive working days and you are in an Eligible Class. Also, if your employment status changes after you submit this enrollment form, you must call us at 1-877-894-2470 for further instructions, as this may affect your eligibility for coverage.

Note: If this form is not completed in its entirety and signed, it will be returned for completion.

Part A: Employee Information

Employer – Indicate Employer Agency Name and Number <i>(This information is required for processing.)</i> <input type="checkbox"/> College of William and Mary (204) <input type="checkbox"/> University of Virginia Medical Center (209) <input type="checkbox"/> University of VA/Academic Division (207) <input type="checkbox"/> VA Polytechnic Institute & State University (208) <input type="checkbox"/> VA Military Institute (211) <input type="checkbox"/> James Madison University (216) <input type="checkbox"/> Old Dominion University (221) <input type="checkbox"/> Virginia Commonwealth University (236) <input type="checkbox"/> University of Virginia’s College at Wise (246) <input type="checkbox"/> George Mason University (247) <input type="checkbox"/> Virginia Institute of Marine Science (268) <input type="checkbox"/> Virginia Department of Economic Development Partnership (310) <input type="checkbox"/> Virginia Tourism Corporation (320)		Payment Method (Payroll Deduction Only) <input type="checkbox"/> Semi-Monthly (24x/year) <input type="checkbox"/> Other _____			
Employee Name (Last, First, Middle Initial)		Social Security Number		Hire Date (MM/DD/YYYY)	
		_ _ _ - _ - - - -		/ /	
Street Address		City		State	Zip Code
Email Address					Country
Work Phone Number () -	Date of Birth (MM/DD/YYYY)	Sex (circle one)	Marital Status		
Home Phone Number () -	/ /	M F	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
			<input type="checkbox"/> Widowed	<input type="checkbox"/> Separated	<input type="checkbox"/> Other _____

If you need assistance completing this form, contact us toll-free at 1-877-894-2470.

Part B: Daily Benefit Amount Options/Plan Options/Increase Option

Select your daily benefit amount and applicable plan option(s). Refer to the Outline of Coverage in the enrollment package for additional information.

Daily Benefit Amount Options	Select a daily benefit amount: <input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200 <input type="checkbox"/> \$250
	If you prefer, you may choose other coverage amounts between \$50 and \$300 in \$1 increments Please indicate amount: \$ _____
Plan Options	Please select your Lifetime Maximum Amount (Choose one): <input type="checkbox"/> 2 Years <input type="checkbox"/> 5 Years
Inflation Protection Increase	<input checked="" type="checkbox"/> Future Purchase Inflation
Indicate 'yes' or 'no' for the additional plan option	Yes No <input type="checkbox"/> <input type="checkbox"/> Nonforfeiture Benefit (<i>If you check no, you must sign the Rejection of Nonforfeiture Benefit below</i>) (<i>See rate pages for the additional cost of the plan option listed above</i>)
Eligibility Option	Is your spouse also applying for Long Term Care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide name: Spouse's Name (Last, First, Middle Initial) _____ Spouse's Social Security Number ____ - ____ - _____ Each person must complete a separate enrollment form. Please submit both applications together. Your rates will be reduced by 10% when both your coverage and your spouse's coverage become effective.

Rejection of Nonforfeiture Benefit: If you want to DECLINE the Nonforfeiture Benefit Option, check this box and sign below.

I have reviewed the Outline of Coverage and the explanation of Nonforfeiture Benefits described therein, and I **REJECT** the Nonforfeiture Benefit Option.



Employee's Signature

Date

Part C: Certification and Authorization

Read, sign and date where indicated. No one can sign this form except you or your legal representative.

Fraud Notice

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention District of Columbia Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an enrollment form containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Attention Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention New Jersey Residents: Any person who includes any false or misleading information on an enrollment form for an insurance policy is subject to criminal and civil penalties.

Attention Tennessee Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance.

I acknowledge that the Group Long Term Care coverage for which I am requesting enrollment is underwritten by Aetna Life Insurance Company ("Aetna").

I agree that this document is my enrollment request for Group Long Term Care Insurance. I understand that any misstatements or omissions will make any insurance based on this enrollment form void at the option of Aetna.

I authorize deductions from my earnings ("payroll deductions") for any contributions required for coverage, and I agree to make any necessary payments for coverage as required under the Group Long Term Care Policy.

I understand that in order for my coverage to take effect, I must be actively at work on the coverage effective date. I understand that if I am ill, injured or on medical leave of absence and away from work on the date coverage would otherwise become effective, coverage will not go into effect until the first day of the month following the date I return to work for at least five consecutive working days and I am in an Eligible Class.

I acknowledge that I have read the Notice to Applicant (included with the enrollment package) and Fraud Notice (shown above), and that the Group Long Term Care Policy will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the long term care coverage.

Part C: Certification and Authorization

I certify that the answers and statements on this form are complete and true to the best of my knowledge and belief and that I am eligible to request enrollment for Group Long Term Care Insurance.



Employee MUST Sign Here

Date

Part D: Protection Against Unintended Lapse

If, after your coverage takes effect, you stop paying premiums, you will receive notice that your coverage is about to lapse (terminate). You have the right to designate at least one person who, besides you, will receive notice of termination of your long term care coverage for nonpayment of premium. That person will not be responsible for payment of the premium, and you will always receive your own copy of the notice. If you want a copy of the lapse notice to be sent to another person in addition to yourself, give us that person's name and address. Notice will not be given until 30 days after a premium is due and unpaid. If you elect **NOT** to designate another person, you must sign the waiver below. Aetna is required to offer this protection against unintended lapse.

Lapse Designee Name (Last, First, Middle Initial)

Street Address

City

State

Zip Code

Waiver of protection against unintended lapse: *If you are waiving your right to designate a contact, sign below.* I understand that I have the right to designate at least one other person other than myself to receive notice of lapse or termination of this long term care insurance coverage 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 the notice.



Employee's Signature

Date

Part E: Replacement Questions

- Answer all four questions and **sign** below or we will not be able to process your enrollment request.
- If, after reviewing these questions, your decision is to replace existing coverage you may have, read the "Notice to Applicant" in the enrollment package.

1. Do you have other long term care insurance in force (including a health care service contract or health maintenance organization contract)?..... Yes No

2. Did you have other long term care insurance in force during the last twelve (12) months?..... Yes No

If "YES", with which Company?

Name of Company _____

Street Address of Company _____

City, State, Zip Code of Company _____

If that insurance lapsed, when did it lapse (Date)? _____

3. Are you covered by Medicaid (NOT Medicare)?..... Yes No

4. Do you intend for this coverage to replace your existing medical or health coverage?..... Yes No

If "YES", with what Company is your existing medical or health coverage?

Name of Company _____

Street Address of Company _____

City, State, Zip Code of Company _____

Policy Number: _____



Employee's Signature

Date

Long Term Care Insurance Personal Worksheet

INSTRUCTIONS

Employees/Spouses: Acknowledge (check the box on the last page) the *Premium Information, Aetna's Right to Increase Premiums, Rate Increase History* and the *Potential Rate Increase Disclosure Form*; then sign and return this form.

All Other Family members: You must complete two (2) areas on the last page: 1) Indicate by selecting the appropriate box whether or not you want to provide the personal financial information and 2) Acknowledge (check the box) the *Premium Information, Aetna's Right to Increase Premiums, Rate Increase History* and the *Potential Rate Increase Disclosure Form*; then sign and return this form.

This form is used for the benefit of prospective insureds. It assists Aetna Life Insurance Company (Aetna) in selling long term care insurance to people who need the coverage and who can afford it. Aetna is required to present this form to you and to offer to discuss the affordability of this insurance. Aetna is also required to fill out part of the information on this worksheet and ask you to fill out the rest to help you and Aetna decide if you should buy this insurance. However, you may choose not to discuss any or all of the information elicited by this form.

People buy long term care insurance for a variety of reasons, including:

- to *avoid spending assets* for long term care;
- to make sure there are *choices* regarding the type of care received;
- to *protect family* members from having to pay for care; or
- to *decrease* the chances of going on Medicaid.

By state law, Aetna must fill out part of the information on this worksheet and ask you to fill out the rest to help you and Aetna decide if you should buy this policy.

These are all very important reasons to keep in mind when considering the purchase of long term care insurance. Long term care insurance, however, can be expensive, and may not be appropriate for everyone. One way to help you decide if long term care insurance is right for you is to review your financial status. The following list of questions is a financial guideline to help you review your financial status. Please consider *protection of assets, freedom of choice, family* and *financial* reasons before making your decision.

Premium Information (*Please refer to the enrollment kit for the premium rate for your age and plan selection options.*)

Policy Form Numbers: Group policy # GR-700-W

(*In certain states, the group policy form number may be: GR-700; GR-700-WFQ; GR-700-WQF; or GR-700-W-NQ.*)

The premium for the coverage you are considering will be \$ _____ per _____.

Type of Policy (noncancellable/guaranteed renewable):

Coverage under the group policy is **guaranteed renewable** to each covered person, except for non-payment of any required premium.

Aetna's Right to Increase Premiums

Aetna has a **limited** right to increase premiums after you have purchased your coverage. Any increase must apply identically to all such group policies with similar rating characteristics in the plan sponsor's state such as age, rate classification and selected benefit options. *You cannot be singled out for a premium increase for any reason, including increasing age or use of long term care coverage.*

Rate Increase History

Aetna has sold long term care insurance since 1987 and has sold this policy since 1994. Aetna has never raised its rates for long term care insurance in this Commonwealth or any other state; however, rates may change at any time you elect to modify benefits for your coverage.

Questions Related to Your Income

(You are not required to answer these questions; they are intended to help you)

How will you pay each year's premium? **(Please check one)**

From my Income From my Savings/Investments My Family will Pay

Have you considered whether you could afford to keep this coverage if the premiums were raised, for example, by 20%?

What is your annual income? **(Please check one)**

Under \$10,000 \$10,000-20,000 \$20,000-30,000 \$30,000-50,000 Over \$50,000

How do you expect your income to change over the next 10 years? **(Please check one)**

No change Increase Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection if it is offered as an option under this group policy? **(Please check one)**

Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

From my Income From my Savings/Investments My Family will Pay

The national average annual cost in 2002 was \$54,900¹, but this figure varies across the country. In ten years, the national average annual cost would be about \$89,426 if costs increase 5% annually.

Please refer to the enrollment kit for the elimination period (deductible period) for the group policy you are considering. Approximate cost \$_____ for that period of care.

In order to determine the approximate cost, you will need to know costs in the area of the country where you will likely receive long term care. A good way to do this is to check nursing facility costs for that area. For example: If the elimination period were [90] days and the national average daily cost in 2002 were \$150.41¹, then the approximate cost for that period of care would be \$13,536.90.

How are you planning to pay for your care during the elimination period? **(Please check one)**

From my Income From my Savings/Investments My Family will Pay

¹ GE LTC Survey, 3/02

Questions Related to Your Savings and Investments
(You are not required to answer these questions either)

Not counting your home, about how much are all your assets (savings and investments) worth? **(Please check one)**

- Under \$20,000 \$20,000-\$30,000 \$30,000-\$50,000 Over \$50,000

How do you expect your assets to change over the next ten years? **(Please check one)**

- Stay about the same Increase Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long term care.

Disclosure Statement
(Please check one)


The answers to the questions above describe my financial situation.

OR

I choose not to complete this information. However, I have reviewed the information provided on the Personal Worksheet, and I wish to purchase this long term care insurance coverage. Please proceed with your review of my Enrollment Form/Medical Questionnaire.

(This box must be checked)

I acknowledge that I have reviewed this form including the premium, premium rate history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this group policy may increase in the future.**

Signed:  _____
(Enrollee)

Date: _____

Printed Name: _____
(Enrollee)

Plan Sponsor: Commonwealth of Virginia

Enrollee's State of Residence: _____

IN ORDER FOR US TO PROCESS YOUR ENROLLMENT REQUEST, PLEASE RETURN THIS SIGNED STATEMENT TO AETNA IN THE SELF-ADDRESSED ENVELOPE PROVIDED, ALONG WITH YOUR ENROLLMENT FORM/MEDICAL QUESTIONNAIRE.

Aetna may contact you to verify your answers.