INTRODUCTION

The purpose of this Underwriting Guide is to provide important information you will need to underwrite the Short-Term Care insurance plan from United Commercial Travelers of America ("United Commercial Travelers," "UCT," "we," or "our") in the most efficient manner possible.

Product

Based on the type of facility, the coverage provides indemnity benefits for stays in a Long Term Care Facility, Nursing Facility or Assisted Living Facility due to injury or sickness.

The following criteria must be met:

1. Being unable to perform (without Substantial Assistance from another individual) at least two of six Activities of Daily Living (ADL) (Bathing, Continence, Dressing, Eating, Toileting, and Transferring) for a period of at least 90 days due to loss of functional capacity, or
2. Requiring Substantial Supervision to protect such individual from threats to health and safety due to Severe Cognitive Impairment.

This is not a Long Term Care policy. It is a limited benefit health policy. Benefits are supplemental and are not intended to cover all medical expenses.

Issue Age: 50 – 85
Daily Benefit: $50 - $300
Maximum Benefit Period: 100 or 200 or 360 days of Covered Services
Elimination Period: 0 or 20 days
Maximum Lifetime Benefit Period: three times the Maximum Benefit Period
Available Riders: 5% Compound Inflation
Guaranteed Purchase Option
Home Health Care

Available Discounts:
Spousal Discount 10% or 5%*
Non-tobacco use 10%

• Spousal discount applies when couples apply at the same time and are both issued – 10% each. If only one is issued, the discount is 5%. 
APPLICATION

- **Effective Date**
  The effective date of coverage will be the date we receive the application (in our home office) unless a specific effective date is requested. A specific effective date may not be retroactive from the date we receive the application or more than 60 days after the signature date and we do not allow effective dates on the 29th, 30th, or 31st.

- **Member Information**
  This section has to do with the Fraternal Membership. If the applicant is a current fraternal member, the applicant should have the necessary information to complete this section. If the applicant is not currently a fraternal member, a completed Application for Membership form M-81 Rev. 0813 needs to be attached to the application.

- **Method of Premium Payment**
  The mode of premium payment may be Annual, Semi-Annual, Quarterly, or Monthly Electronic Funds Transfer (EFT). Monthly direct is not available.

- **Electronic Funds Transfer Authorization**
  A completed bank authorization form must be submitted with the payer’s personalized bank check marked “void.” If a savings account is used make sure we have the appropriate account and routing information on the bank authorization form (AUTHORITY TO HONOR PREMIUM CHECKS).

- **Initial Premium**
  Initial premium rates for the Short Term Care insurance plans will be based on “Issue Age Rates.” The applications must be accompanied by the initial premium for the mode selected unless the initial premium is to be drafted from the Applicant’s bank account. An agent should NOT submit cash, agent’s personal checks, or agency checks. When using the EFT method of payment, bank withdrawals will begin with either the initial draft or with the second month following the effective date if initial premium is collected. The check for the initial premium cannot be back-dated or post-dated. Make sure the appropriate fraternal dues are added to the modal premium, if applicable.

- **Signatures**
  The application must be signed by the Applicant. It is not permissible for anyone else to sign the Applicant's name. Signature by attorney-in-fact, guardian, or conservator is not acceptable. A policy can be considered for issue to a competent Applicant who cannot read or write provided the Applicant's signature “X” or mark is witnessed by the agent.

- **Application Date**
  The application must be dated with the actual date written and signed. Back-dating and post-dating of the application are not permitted.

- **Replacement**
  The questions dealing with existing insurance and policy replacements must be answered in all cases. If existing coverage is to be replaced, be sure to check the product availability chart to determine if replacement forms are needed. When existing insurance is being replaced, the desired effective date should be 45 - 60 days after the signature date. Existing coverage should never be terminated until the new policy has been delivered.

- **Policy Delivery**
  Any changes, corrections, or counter offers will require an amendment to the application, which must be signed by the Applicant at the time of delivery. The signed top copy of the amendment and any additional delivery requirements such as additional premium due must be returned to the Home Office before commissions are paid. The policy delivery requirement letter, enclosed with the policy, will show all requirements needed on delivery.
Submitted Applications

When reviewing applications, be sure that:

1. The Short Term Care application and all necessary forms have been completed and signed by the applicant.

2. The correct state approved application has been completed.

3. All health questions have been answered.

4. Both Agent and Applicant have initialed all changes/scratch outs on the application.

5. If premium was collected, the Applicant’s check, money order, or cashier’s check in the amount of the premium for the selected mode plus the fraternal dues (if applicable) to be submitted with the application.

6. The initial premium was collected on the day the application was written.

7. Cash, post-dated checks, third party premium checks, agent’s personal checks, or agency checks are not submitted with the application.¹

8. All applications have been submitted to the Home Office within five days after written.

9. Please keep in mind we do not save age for this product. If you are quoting the lower premium based on a younger age, please submit the application before the applicants’ birthday” to our home office. Effective dates and rates are based on the date we receive the application in our home office.

¹ Checks written by Applicant’s family members, trust fund, or family business account will be considered.

## Important Information

**Mailing address for new business:**

United Commercial Travelers of America  
1801 Watermark Drive, Suite 100  
P. O. Box 159019  
Columbus, OH 43215

**Fax number for applications:**

(800) 948-1039

**Mail Premium for faxed Applications to:**

United Commercial Travelers of America  
1801 Watermark Drive, Suite 100  
P.O. Box 159019  
Columbus, OH 43215

**Telephone Numbers:**

Office: (614) 487-9680  
Toll Free: (800) 848-0123

**Web site for online status, forms, and rates:**

www.uct.org
Underwriting Guidelines/Philosophy

UCT’s position is to compete in the marketplace on a fair and equitable basis. Individuals with progressive disorders, which may ultimately lead to medical functional dependency, are not insurable. The type of client we seek should be functionally independent, with medical problems stable and under control, and be physically and mentally active.

Upon receipt of an application, we will review it for proper completion, appropriate state required forms, premium calculation, agent appointment status, and other UCT coverage, past or present. If the underwriting requirements are not received within 45 days of an application receipt, the file is closed, and premiums are refunded. If requirements are received later, we will reevaluate the Applicant and notify the agent of our decision.

Underwriting Tools

It is important for the agent to inform their Applicant of what to expect. The following is a list of the underwriting tools used throughout the underwriting process. Please familiarize yourself with all of these.

Application: An application (Appendix-1a through k) properly completed by the agent, based on observation of the Applicant and a thorough inquiry into the details of any medical information disclosed is the basis for a sound underwriting decision. Information recorded by the agent on the application also becomes a part of the contract between United Commercial Travelers and the Applicant when it is incorporated into the policy.

This is a simplified issue product. Application is reviewed for “no” answers on health questions 1 through 8. Any “yes” answers is an automatic decline. No APS’s are ordered and decision is made based on the following criteria:

1. Answers to health questions based on application
2. Answers to health questions based on PHI (if applicable)
3. Pertinent information on IntelliScript (prescription database)

Personal History Interview (PHI): Some Applicants will receive a telephone call from a representative in the Underwriting Department. The purpose is to verify the information on the application as quickly and directly as possible. We will complete a PHI on all applicants age 70 and over. Applicants 69 and under will receive a random phone interview (1 out of every 5 applications).

Additional Tools: As stated in the application, we may also obtain information from a licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance company or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge or non-medical information concerning the Applicant.

We will check IntelliScript databases on all applicants. If medications indicate a declinable condition, we will decline. If a medication can be for multiple conditions, we will contact the applicant to obtain the reason/condition for prescription medication(s) to confirm that health questions 1 through 8 were answered accurately.

Rescission: Claims’ examiners will let Underwriting Department know if they receive claims indicating that an applicant should have answered health questions 1 through 8 on the application with a “yes.” If underwriter feels an investigation is in order, underwriter may order medical records to review the possibility that the applicant did not answer health questions 1 through 8 truthfully. If medical records prove that the applicant should have answered any of the health questions 1 through 8 with a “yes,” then the underwriter will rescind the policy and immediately return all premiums received, recover all commissions paid out and it will be as if the policy never went into effect.
Uninsurable Conditions

We will decline coverage on an Applicant if any of the following applies:

1. Applicant is currently receiving Medicaid benefits.
2. Applicant requires assistance or supervision of any kind to perform activities of daily living.
3. Applicant requires assistance with shopping, housekeeping or cooking.
4. If during the past two years, the Applicant suffered a fracture of the spine or hip.
5. If within the past two years, the Applicant has been a resident of an assisted living facility or personal care home or been confined in a nursing home or any facility providing assistance with activities of daily living.
6. If within the past two years, the Applicant has been required any assistance with mobility including the use of a walker, multipronged cane, walking aids, wheelchair or scooter.
7. If the applicant is currently bedridden, hospitalized or have been hospitalized two or more times within the past year.
8. If within the past two years the Applicant had or had been advised to have kidney dialysis or had a heart attack or stroke or heart valve surgery, been recommended to have surgery but not had such surgery.
9. If within the past two years the Applicant had or been treated for internal cancer, leukemia or malignant melanoma, Hodgkin's Disease, Parkinson's Disease, disabling arthritis, degenerative bone disease, cirrhosis of the liver, Alzheimer's Disease or alcohol or drug abuse.
10. If an applicant had or has been told by their physician they need: amputation due to disease, emphysema, chronic bronchitis, other chronic lung disease, Myasthenia Gravis, Lupus, Multiple or Amyotrophic Lateral Sclerosis, paralysis, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC).
11. Receive Federal, state or local government financial assistance in any form such as Supplemental Security Income.
12. Insulin dependent diabetic.

We will consider the following Medical Conditions after 2 years:

Heart Attack
Heart Valve Surgery
Stroke
Been recommended to have surgery but not had such surgery

We will consider the following Medical Conditions after 2 years of last treatment:

<table>
<thead>
<tr>
<th>Alcohol</th>
<th>Hodgkin's Disease</th>
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<tbody>
<tr>
<td>Alzheimer's Disease</td>
<td>Internal Cancer</td>
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<tr>
<td>Cirrhosis of the liver</td>
<td>Kidney Dialysis</td>
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<td>Degenerative Bone Disease</td>
<td>Leukemia</td>
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<tr>
<td>Disabling Arthritis</td>
<td>Malignant Melanoma</td>
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<tr>
<td>Drug Abuse</td>
<td>Parkinson's Disease</td>
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</table>
The Following Medical Conditions are Unacceptable:

- AIDS/ARC
- ALS (Lou Gehrig's Disease)
- Amputation or loss of sight due to disease
- Amyotrophic Lateral Sclerosis
- Cerebral Palsy (if paralysis is involved)
- Chronic Bronchitis
- Chronic Obstructive Lung Disease (COLD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes on insulin
- Dizziness (if chronic affecting ADL or Osteoporosis)
- Drug Addiction/Abuse
- Emphysema
- Fibromyalgia (if chronic pain affecting ADL)
- Fractures due to osteoporosis or associated with vertigo or dizziness
- Gangrene (bacterial infection requiring surgical removal of affected area)
- Kidney Failure
- Lymphoma
- Lupus
- Memory Loss
- Multiple Sclerosis
- Myasthenia Gravis
- Osteoporosis (with history of fractures)
- Paralysis
- Poliomyelitis (recurrent if paralysis involved)
- Post Polio Syndrome (if paralysis involved)
- Pulmonary Disease, requiring use of oxygen
- Rheumatoid Arthritis
- Senile Dementia
- Vertigo (if chronic affecting ADL or Osteoporosis)
Short Term Care
Reinstatement Guidelines

Grace period

Short Term Care policies have a grace period of 31 days after the premium due date. The policy will remain in force during the 31 day grace period.

Reinstatement

Owner must submit a written request for reinstatement and back premiums to pay the policy up to date. If any renewal premium is not paid within the time granted for payment, a subsequent acceptance of any premium by us or by any of our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however, that, if we or any of our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt (Appendix 2) unless we have previously notified the policyholder in writing of our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after that date. In all other respects we and the policyholder shall have the same rights thereunder as were under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

Reason for lapse

- If a policy lapses due to a company error, Evidence of Insurability is not required (even if a Certificate of Health is received by Underwriting). If there is a question regarding whether the lapse was due to company error, the case should be referred to the Client Services supervisor to review and gather all of the required paperwork before referring to Underwriting.

- If Notifications suggests a possible billing error, you can review the policy history using Transaction History.

- If a policyholder requests cancellation, then changes his/her mind and requests reinstatement, we follow the same procedures as if the policy had lapsed for nonpayment of premiums. (The grace period starts on the requested cancellation date - even if it was a future date - not on the date the cancellation request was signed.)

- The system will automatically lapse a policy on the 63rd day if the policy is not suspended or no premium has been received.
Underwriting Short Term Care Reinstatements

To reinstate a policy to a premium paying basis, we require all of the following:

1. A written request to reinstate the policy;

2. Evidence of the insured’s insurability that is satisfactory to us. This means a Certificate of Health (Appendix 3) is required and must be completed in its entirety to the best of the applicants knowledge including all necessary signatures;

3. If payment of all past due premiums is received, a conditional receipt (Appendix 2) should be sent to the insured.

Once all of the above has been received please review the following information:

1. Make sure we have a completed Certificate of Health, keeping in mind the Certificate needs to be completed with any changes in an insured’s medical history from the time of original issue to present.

   For example: A policy has an effective date of 8/1/2008 and paid to 1/1/2010 and the insured is requesting to be reinstated April 2010. If we are to consider this request and the insured sends us a Certificate of Health marked “no changes in health history” that would mean from 8/1/2008 to present the insured had not consulted a physician. A completed Certificate of Health must contain:

   a. All dates, types of treatments and physicians name and phone number.
   b. We must also have the signatures of a witness and the insured with a current date.

   In the event a Certificate of Health comes back incomplete (i.e. no dates, no doctors, or statements written in such as, “in good health”), decline the reinstatement.

2. If the information is provided, take into account why the policy lapsed and how long the policy has been lapsed. For instance, did the insured miss paying the bill because they moved or have they been ill; if the policy has been out of force for 3 months or more and the insured is now requesting reinstatement be mindful of a possible change in the insured’s medical history.

3. Review the original application in the imaging system (Laserfiche). Check the insured’s policy for:

   a. Any past health history
   b. Check any claims history

4. Run prescription data base search. Make sure you have an up-to-date authorization. Check for significant medications and prescribing physicians.
Now, with all of the information above, you can begin to determine whether or not we can consider this insured for reinstatement. If questions arise we can do one of two things:

1. Send the reinstatement request for a Personal History Interview to get additional information; or

2. If any of the information obtained for consideration is inconsistent with the Certificate of Health then the Certificate will need to be returned to the applicant with the “Additional Reinstatement Requirements” cover letter asking the insured to explain any inconsistencies.

If we need to return information to the insured for completion give the applicant 10 BUSINESS DAYS to get the needed information back to us. After 10 days, decline the reinstatement.

NOTE: If the information comes back after 10 days, the Chief Underwriter will need to approve it.

If the reinstatement is declined and the agent appeals our decision, the applicant needs to obtain their own records because the cost for obtaining medical records is not built into the cost of reinstating a policy. Generally, an insured can obtain their records at no cost. If more information is needed and there is money on the policy, return the premium along with the “Additional Reinstatement Requirements” cover letter with an explanation as to what is needed.

If the reinstatement is declined, we will process the decline and send the “Decline Reinstatement” letter located in the Underwriting Folder on the P drive. If you have a check, return the original check with the letter. PLEASE NOTE: If you do not have a check, check notifications and the Suspense field (from Quick Inquiry) to make sure there is no money on the policy.

If the reinstatement is approved, the Underwriting Assistant needs to reinstate the policy and order a reinstatement confirmation letter.
APPLICATION FOR SHORT TERM CARE INSURANCE POLICY

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<tr>
<th>APPLICANT</th>
<th>APPLICANT'S ADDRESS</th>
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<td>Last</td>
<td>First</td>
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<tr>
<td>Age</td>
<td>Date of Birth</td>
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<td>Month</td>
<td>Day</td>
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SOCIAL SECURITY NUMBER
State: __________________ Zip Code: __________________

Underwriting Risk Classification Question
Have you used any form of tobacco in the past two years? ☐ Yes ☐ No

Are you a member of The Order of United Commercial Travelers of America? ☐ Yes ☐ No

Council Name: __________________ Council Location (City & State): __________________

Is your spouse also applying for the Short Term Care Insurance Policy? ☐ Yes ☐ No
If yes, please complete:
<table>
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<th>Last Name:</th>
<th>First Name:</th>
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HEALTH QUESTIONS
IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS, YOU ARE NOT ELIGIBLE FOR COVERAGE.

1. Do you require assistance or supervision of any kind to perform activities of daily living such as walking, eating, bathing, dressing, transferring or toileting? ☐ Yes ☐ No
2. Do you require assistance with shopping, housekeeping or cooking? ☐ Yes ☐ No
3. During the past two (2) years have you:
   (a) Been a resident of an assisted living facility or personal care home or been confined to a nursing home, home for the aged, or any facility providing assistance with activities of daily living? ☐ Yes ☐ No
   (b) required any assistance with mobility including the use of a walker, multi-pronged cane, walking aids, wheelchair, or scooter? ☐ Yes ☐ No
4. Are you currently bedridden, hospitalized or have you been hospitalized two or more times within the past year? ☐ Yes ☐ No
5. Within the past two years, have you been advised to have kidney dialysis, had a heart attack, stroke or heart valve surgery, been recommended to have surgery but not had such surgery, had or been treated for internal cancer, leukemia or malignant melanoma, Hodgkin’s Disease, Parkinson’s Disease, disabling arthritis, degenerative bone disease, cirrhosis of the liver, Alzheimer’s Disease or alcohol or drug abuse? ☐ Yes ☐ No
6. Have you had or been told by your physician you needed amputation due to disease, you have emphysema, chronic bronchitis, other chronic lung disease, Myasthenia Gravis, Lupus, Multiple or Amyotrophic Lateral Sclerosis, paralysis, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
7. Do you receive Federal, state or local government financial assistance in any form, such as Supplemental Security Income or Medicaid? ☐ Yes ☐ No
8. Are you an insulin dependent diabetic? ☐ Yes ☐ No
BENEFIT OPTIONS

☐ Short Term Care Insurance Policy

Maximum Daily Benefit Amount: $ ______________________

☐ 0 Days

Elimination Period: ☐ 0 Days ☐ 20 Days

Maximum Benefit Period

☐ 100 Days ☐ 200 Days ☐ 360 Days

Optional Riders

☐ Home Health Care ☐ Compound Inflation Protection

REPLACEMENT INFORMATION (MUST BE COMPLETED)

1. Do you have another insurance policy in force (including health care service contract or health maintenance organization contract)? .................................................................................................................................................................... Yes ☐ No

2. Did you have another limited benefit policy in force during the last six (6) months? .................................................................................................................................................................... Yes ☐ No

If yes, with which company: (Name and address): __________________________________________________________________

Policy Number: _______________________________

If that policy lapsed, when did it lapse? ____________________________

Daily Benefit Amount: $ _______________________

Benefit Period _____________________

Do you intend to replace any of your medical or health insurance coverage with this policy? .................................................................................................................................................................... Yes ☐ No

If yes, please read and sign the replacement notice provided by the agent.

AUTHORIZATIONS AND SIGNATURES

I hereby apply to The Order of United Commercial Travelers of America (UCT) for a policy to be issued in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. The Order of United Commercial Travelers of America has the right to deny benefits or rescind my Policy. I understand that any change in my health prior to delivery of this policy may be used in the underwriting evaluation process. I have received an outline of coverage for the policy applied for.

WARNING: Any person who, with intent to defraud or knowing that he 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.

Signed At: ________________________

Applicant's Signature: ________________________________________

Dated (Month/Day/Year): _____________________________________

AGENT’S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_________________________________________________________________________________________________________________

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_________________________________________________________________________________________________________________

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and

2. I have given an outline of coverage for the policy applied for to the Applicant.

Agent’s Signature ________________________________________________ Date ____________________________

Agent’s Printed Name ____________________________________________ Agent No. ____________________________
AUTHORIZATION & ACKNOWLEDGEMENT

THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or other medical or medically-related facility, insurance company, MIB, Inc., consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or prescription drug usage or having any non-medical information concerning me to give The Order of United Commercial Travelers of America, or its reinsurers, any such information. I understand that I am authorizing The Order of United Commercial Travelers of America to receive my health information or prescription drug usage history and my non-medical information. I understand that when my health information is disclosed pursuant to this Authorization, my medical records and the Information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I authorize The Order of United Commercial Travelers of America, or its reinsurers, to make a brief report of my protected health information to MIB, Inc.

I understand that the information requested is necessary for evaluation of my application and underwriting of my application for the Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issuance determinations; obtain reinsurance, administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with The Order of United Commercial Travelers of America. I understand that failure to provide the authorization to The Order of United Commercial Travelers of America will result in the rejection of the Insurance Policy coverage.

I understand that I may revoke this authorization at any time by notifying The Order of United Commercial Travelers of America in writing at their Home Office: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619. I understand that such revocation will not have any effect on actions The Order of United Commercial Travelers of America took prior to their receiving the revocation notice.

I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under the policy. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative may request to receive a copy of this authorization.

Applicant’s Name: __________________________________________
Social Security Number: __________________________ Date of Birth: __________________________
Applicant’s Signature: __________________________________________ Date: __________________________

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly EFT

Short Term Care Only Premium $ ____________________
Home Health Care Rider Premium $ ____________________
Compound Inflation Protection Rider Premium $ ____________________
SUBTOTAL $ ____________________
Less Spousal Discount (If Applicable) $ ____________________
Less Non-Tobacco Discount (If Applicable) $ ____________________
TOTAL MODAL PREMIUM $ ____________________
Modal Fraternal Dues (If Applicable) $ ____________________
TOTAL MODAL AMOUNT DUE $ ____________________
TOTAL AMOUNT PAID WITH APPLICATION $ ____________________
### AUTHORITY TO HONOR PREMIUM CHECKS

<table>
<thead>
<tr>
<th>AUTHORIZATION</th>
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<tbody>
<tr>
<td><strong>IN FAVOR OF:</strong> The Order of United Commercial Travelers of America 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619</td>
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<tr>
<td>Name of Bank Customer:</td>
<td></td>
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<tr>
<td>Insured’s Name:</td>
<td></td>
</tr>
<tr>
<td>Routing Number:</td>
<td>Account Number:</td>
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<tr>
<td>To (Name of Bank):</td>
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<tr>
<td>Address of Bank:</td>
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You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

**AUTHORIZATION**

| Date: | Signature of Bank Customer: |

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

**To: Bank above:** In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

**ATTACH VOIDED CHECK HERE – Deposit Slips NOT Accepted**
Application for Membership

The Order of United Commercial Travelers of America • A Fraternal Benefit Society
1801 Watermark Drive, Suite 100, P.O. Box 189019, Columbus, Ohio 43215-8419
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 800.948.1039 • www.uct.org
Canadian Office: 901 Centre Street North, Room 300, Calgary, AB T2E 2P6
Tel: 403.277.0745 • Toll-free: 800.267-2371 • Fax: 403.277.6662

Proposed Member Information

Name of council applicant will belong to: ___________________________ Council No.: ____________

Council City: ___________________________ State/Prov.: ____________

Applicant Name, First: ___________________________ Mi: ______ Last: ___________________________

Address: ___________________________ City: ___________________________ State/Prov.: ______ Postal Code: ____________

Home Tel.: (__________) ___________ Bus. Tel.: (__________) ___________

Birthday: ___________ - ___________ - ___________ Social Security No./Social Insurance No.: ___________________________

Email Address: ____________ Sex: [ ] Male [ ] Female

Is applicant currently insured with UCT? [ ] Yes [ ] No

Has applicant ever been a member of UCT? [ ] Yes [ ] No If “Yes,” list member No.: __________________________

Is applicant’s spouse a member of UCT? [ ] Yes [ ] No If “Yes,” list member No.: __________________________

Member Dues Collected (check one)

[ ] Member Dues – when purchasing insurance $30 minimum

[ ] Fraternal Membership – no insurance purchased ($12 + $18 minimum Member Dues) $30 minimum

Please enroll me for membership in UCT. I understand UCT is a fraternal benefit society and agree to abide by the Society’s Constitution and Bylaws.

Applicant’s Signature: X ___________________________ Date: ____________

For Completion by Sponsoring Member/Agent

This is to certify that I am acquainted with the applicant and hereby recommend the applicant for membership.

Sponsoring Member/Agent’s Name (Please Print): ____________________________

Address: ___________________________ City: ___________________________ State/Prov.: ______ Postal Code: ____________

Sponsoring Member/Agent No.: ____________________________

Sponsoring Member/Agent’s Signature: X ___________________________ Date: ____________

For Completion by Council Secretary if Necessary

Council Action: [ ] Approved [ ] Disapproved

Secretary’s Signature: ___________________________ Date: ____________

M-81 Rev. 08/13 COMPLETE AND SUBMIT WITH APPLICATION
NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by The Order of United Commercial Travelers of America. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Agent, Broker or Other Representative)

Print Name and Address of Agent: __________________________________________________________

_____________________________________________________________________________________

The above “Notice to Applicant” was delivered to me on:____________________________________

(Applicant’s Signature) (Date)
SHORT TERM CARE INSURANCE POLICY

OUTLINE OF COVERAGE
POLICY FORM STC 1/09

THE POLICY PROVIDES LIMITED BENEFITS

THE POLICY IS NOT A LONG TERM CARE INSURANCE POLICY ACCORDING TO STATE INSURANCE LAWS AND REGULATIONS

READ YOUR POLICY CAREFULLY - This outline of coverage provides a very brief description of some of the important features of the policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and the Company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

LIMITED BENEFIT INSURANCE COVERAGE - The policy is designed to provide benefits for convalescent care in a facility that provides nursing care or other benefits specified in the policy.

BENEFITS

Facility Confinement Benefit
Once the Elimination Period is satisfied under the policy, we will pay the actual charges incurred up to the Maximum Daily Benefit Amount for each day you are confined in a Facility.

Bed Reservation Benefit
Once the Elimination Period is satisfied, we will pay the actual charges incurred up to the Maximum Daily Benefit Amount for fees charged to reserve a bed by a Facility when You are absent for any reason during the course of an eligible confinement. This benefit is limited to twenty-one (21) days per Period of Care. Benefits payments will count toward the Maximum Benefit Period.

Qualifying For Benefits

To receive benefits under the policy, the following requirements must be met:
1. The policy must be in force on the date Covered Services are received; and
2. A Physician must certify that:
   a) You are unable to perform at least two (2) Activities of Daily Living without Hands On Assistance or Standby Assistance; or
   b) You have a Cognitive Impairment and require Substantial Supervision.

Limitations On Benefits

Benefits under the policy will not be paid during the Elimination Period and are subject to the Lifetime Maximum Benefit Period.
Important Definitions

**Activities of Daily Living** means the basic human functions required for you to remain independent. For the purposes of the policy, Activities of Daily Living are as follows: bathing, continence, dressing, eating, toileting and transferring.

**Cognitive Impairment** means a deficiency in a person’s short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning or judgment as it relates to safety awareness. Cognitive Impairment is measured by clinical evidence and standardized tests and is based on your impairment as indicated by loss in the following areas:
1. short or long term memory; or
2. recognition of who or where You are; or time of day, month or year; or your deductive or abstract reasoning.

**Covered Services** means confinement in a Facility (as defined in the policy). Covered Services will be modified to include in Home Health Care, if the optional Home Health Care Rider is listed on the policy schedule page and the premium for the rider is paid.

**Elimination Period** means the number of Facility Confinement days (or any combination of Facility Confinement care days and Home Health Care days, if the Home Health Care Rider is elected), for which benefits are not payable under the policy. Days counted toward the Elimination Period need not be consecutive. The Elimination Period is shown on the Policy Schedule Page. The Elimination Period must be satisfied only once during the Insured’s lifetime and can only be satisfied by days on which you incur charges for which payment would be made under the policy if there were no Elimination Period.

**Facility** means a facility that provides ongoing care and related services to at least five (5) inpatients in one (1) location and meets all of the following standards:
1. it is licensed by the appropriate licensing agency, if the state in which it operates licenses such facilities; and
2. it is operated pursuant to law; and
3. it is primarily engaged in providing, in addition to room and board accommodations, nursing care (skilled, intermediate or custodial) by or under the supervision of a duly licensed Physician; and
4. it provides twenty-four (24) hour a day care and services sufficient to support needs of persons who require nursing care; and
5. it has appropriate methods and procedures for handling and administering drugs and biologicals; and
6. it maintains a daily medical record of each patient.

A Facility includes a long term care facility, a nursing home facility or an assisted living facility.

A Facility IS NOT: a hospital, Your Home, and Alzheimer's Facility, an adult foster care facility, a facility or part thereof used primarily for rest; or a home or facility for the aged or for the care and treatment of drug and alcohol abuse; or a home or facility used for the care and treatment of Mental or Nervous Disorders or educational care.

**Hands On Assistance** means the physical assistance of another person without which you would be unable to perform an Activity of Daily Living.

**Home** means your private residence, home for the retired or aged, or a place providing residential care, including an adult congregate living facility or a personal care facility.

**Lifetime Maximum Benefit Period** means the maximum number of Facility confinement days (or any combination of Facility confinement days and Home Health Care days, if the Home Health Care Rider is elected) for which benefits are payable under the policy. The Lifetime Maximum Benefit Period is shown on the Policy Schedule Page and is equal to three (3) times the Maximum Benefit Period.

**Maximum Benefit Period** means the maximum number of Facility confinement days (or any combination of Facility confinement days and Home Health Care days, if the Home Health Care Rider is elected) for which benefits are payable under the policy per Period of Care. The Maximum Benefit Period is shown on the Policy Schedule Page.

**Maximum Daily Benefit Amount** means the maximum amount payable for any one day of benefits provided under the policy. The Maximum Daily Benefit Amount is shown on the Policy Schedule Page.
Important Definitions

**Period of Care** means the first day benefits are paid for a Facility confinement (or the first day benefits are paid for either, a Facility confinement or Home Health Care, if the optional Home Health Care Rider is elected). A Period of Care ends, if for a period of 180 consecutive days:
1. You have not met the requirements for benefit eligibility; and
2. Your Physician certifies that You did not require and have not been advised to be confined in a Facility or to receive Home Health Care for the 180 day period; and
3. You have not been confined in a Facility or received Home Health Care for the 180 day period.

**Physician** means a licensed practitioner of the healing arts operating within the scope of his or her license who is other than a member of your immediate family.

**Standby Assistance** means the presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, injury to you while you are performing an Activity of Daily Living.

**Substantial Supervision** means continual supervision, which may include cueing by verbal prompting, gestures, or other demonstrations by another person that is necessary to protect You from threats to your health or safety.

**Exclusions:** We will not pay benefits for that portion of any expense which is:
1. caused by Mental or Nervous Disorder, without demonstrable organic disease *(NOTE: ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN SYNDROMES ARE COVERED BY THIS POLICY AS ANY OTHER SICKNESS)*; or
2. caused by alcoholism or drug addiction; or
3. caused by illness, treatment or medical conditions arising out of:
   a) war or act of war (whether declared or undeclared); or
   b) participation in a felony, riot or insurrection; or
   c) service in the armed forces or units auxiliary thereto; or
   d) suicide (while sane or insane), attempted suicide or intentionally self-inflicted injury; or
4. for treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers’ compensation, employer’s liability or occupational disease law, or any motor vehicle no-fault law; or
5. for services provided by a member of Your Immediate Family; or
6. for services for which no charge is normally made in the absence of insurance; or
7. for care received outside the United States or its territories.

**Guaranteed Renewable For Life - Premium Subject To Change.** The policy is renewable as long as you live, provided you continue to pay premiums when due. At no time while you continue your policy in force, may we place any restrictive riders on your coverage. We cannot cancel or refuse to renew the policy. Your premiums will not increase due to a change in your age or health. We can, however, change your premiums but only if we change premiums for all policies in the same premium class with the same policy form number in your state. We must give you at least thirty (30) days written notice before we change your premiums.
You have selected the following benefits for the Base Policy:

Maximum Daily Benefit Amount $ __________
Elimination Period _________ Days
Maximum Benefit Period _________ Days
Lifetime Maximum Benefit Period _________ Days

Check [ X ] for one of the following Base Policy Option and Optional Riders applied for:

☐ The annual premium for the Base Policy Form $ __________
☐ The annual premium for the Base Policy Form With the Compound Inflation Protection Rider $ __________
☐ The annual premium for the Base Policy Form With the Guaranteed Purchase Option Rider $ __________
☐ Home Health Care Rider $ __________

TOTAL ANNUAL PREMIUM $ __________
FOR AGENT USE ONLY

Short-Term Care Application
Submission Checklist:

☐ Complete Application

☐ Collect premium amount (Please remember to include membership dues – a minimum of $30 annually, $15 semi-annually, $7.50 quarterly, or $2.50 monthly)

☐ Complete Application for Membership (M-81 Rev. 0813)

☐ Provide client with Outline of Coverage

☐ Provide client with Receipt

☐ Complete Replacement Notice and leave copy with the applicant if necessary

PREMIUM RECEIPT
Make check payable to UCT.

Received from ________________________________ the sum of $______________.

If, for any reason, the policy is not issued, payment will be refunded in full in a timely manner. Insurance is not effective until the application is approved, the premium has been paid and the policy is issued.

Date: ____________  Licensed Resident Agent: __________________________
CONDITIONAL RECEIPT
SHORT TERM CARE

Do NOT pay cash. Do NOT make check or money order payable to the Agent or leave blank. Please make check or money order payable to: United Commercial Travelers.

Received from: ____________________________________________________________

This __________ day of __________________ the sum of $ ______________________

This receipt is not valid unless it is signed by a duly authorized representative of the Society. This receipt is not valid unless the amount paid with the reinstatement, if paid by check or money order is honored on first presentation for payment.

Signature of Agent: ________________________________________________________

IMPORTANT: This Conditional Receipt does not provide any Short Term Care insurance until all of its conditions are met. If you do not hear from the Society regarding the proposed insurance within 45 days, notify the Home Office at the address above.

1. The initial reinstatement premium
2. Any medical examination required by the Society is completed and,
3. The Society at its Home Office is satisfied that, at the time of completing the application, the Proposed Insured was insurable under the Society’s rules for insurance on the requested plan, in the amount and at the risk applied in the application.

Otherwise, coverage will not begin and the Society shall have no liability except to refund all premiums and/or fees paid.

The reinstated Policy shall cover only loss resulting from any accidental Injury as my be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date.

AUTHORITY OF REPRESENTATIVES: Neither the representative nor the medical examiner is authorized to accept risks or pass upon insurability, to make or modify contracts, or to waive any of the Society’s rights or requirements, or to extend the time for any premium payment.

TERMINATION: Any insurance that results from this receipt will immediately terminate if the Society declines the application and refunds your payment or if you have not received your contract within 60 days of this receipt, in which event your payment will be refunded.
# CERTIFICATE OF HEALTH

## APPLICATION FOR SHORT TERM CARE INSURANCE REINSTATMENT

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## NAME OF INSURED:

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## HEALTH QUESTIONS

1. Do you require assistance or supervision of any kind to perform activities of daily living such as walking, eating, bathing, dressing, transferring or toileting? □ Yes □ No
2. Do you require assistance with shopping, housekeeping or cooking? □ Yes □ No
3. During the past two (2) years have you:
   (a) Been a resident of an assisted living facility or personal care home or been confined to a nursing home, home for the aged, or any facility providing assistance with activities of daily living? □ Yes □ No
   (b) Required any assistance with mobility including the use of a walker, multi-pronged cane, walking aids, wheelchair, or scooter? □ Yes □ No
4. Are you currently bedridden, hospitalized or have you been hospitalized two or more times within the past year? □ Yes □ No
5. Within the past two years, have you been advised to have kidney dialysis, had a heart attack, stroke or heart valve surgery, been recommended to have surgery but not had such surgery, had or been treated for internal cancer, leukemia or malignant melanoma, Hodgkin’s Disease, Parkinson’s Disease, disabling arthritis, degenerative bone disease, cirrhosis of the liver, Alzheimer’s Disease or alcohol or drug abuse? □ Yes □ No
6. Have you had or been told by your physician you needed amputation due to disease, you have emphysema, chronic bronchitis, other chronic lung disease, Myasthenia Gravis, Lupus, Multiple or Amyotrophic Lateral Sclerosis, paralysis, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? □ Yes □ No
7. Do you receive Federal, state or local government financial assistance in any form, such as Supplemental Security Income or Medicaid? □ Yes □ No
8. Are you an insulin dependent diabetic? □ Yes □ No
AUTHORIZATION & ACKNOWLEDGEMENT
THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or other medical or medically-related facility, insurance company, MIB, Inc., consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or prescription drug usage or having any non-medical information concerning me to give The Order of United Commercial Travelers of America, or its reinsurers, any such information. I understand that I am authorizing The Order of United Commercial Travelers of America to receive my health information or prescription drug usage history and my non-medical information. I understand that when my health information is disclosed pursuant to this Authorization, my medical records and the Information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I authorize The Order of United Commercial Travelers of America, or its reinsurers, to make a brief report of my protected health information to MIB, Inc.

I understand that the information requested is necessary for evaluation of my application and underwriting of my application for the Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issuance determinations; obtain reinsurance, administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with The Order of United Commercial Travelers of America. I understand that failure to provide the authorization to The Order of United Commercial Travelers of America will result in the rejection of the Insurance Policy coverage.

I understand that I may revoke this authorization at any time by notifying The Order of United Commercial Travelers of America in writing at their Home Office: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619. I understand that such revocation will not have any effect on actions The Order of United Commercial Travelers of America took prior to their receiving the revocation notice.

I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under the policy. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative may request to receive a copy of this authorization.

Applicant’s Name: _______________________________________________________________________
Social Security Number: ________________________ Date of Birth: ________________________
Applicant’s Signature: _______________________________________ Date: ______________________

STC COH 12