Instructions for completing this application

This Application must be completed by the Applicant.

When the Applicant signs this application they are making a certification under penalty of perjury that all questions are true and correct to the best of their knowledge

Members, their eligible dependent spouses may apply for coverage through this Association.

All Applicants must complete all questions and sign and date where indicated.

Members must fall into one of the following categories:

1. Members of police departments or fire departments of municipal or public corporations or districts including volunteers or reserves.
2. Peace or law enforcement officers who are regular and salaried officers or employees of the state or of a single county or other political subdivision or public or municipal corporation.
3. Persons who are emergency medical services personnel and employed by a fire department of a city, county or district.
4. Persons at the time of becoming members of such associations were qualified pursuant to paragraphs 1, 2, or 3 above.
5. Spouses of qualified applicants
6. Retirees may not apply unless they are otherwise qualified in one of the above sections.

The above list of qualified applicants would generally include County DA Investigators, County Probation Officers with peace officer status, State of California Investigators with peace officer status, Correctional Officers with the Department of Corrections of the State of California, California Highway Patrol Officers, County Correctional Officers, Firefighters, and CalFire Firefighters. Others persons who may believe they qualify and are not listed above must contact the Plan Administrator to determine eligibility.

I certify under penalty of perjury that I have read the above statement and agree that I qualify under the requirements stated above.

______________________________ / ______________

Member **Date**

______________________________ / ______________

Eligible Spouse **Date**

(Note: To be signed by Member, or Spouse, whichever is applying)

NOTE: Employee and Spouse must complete a separate application.
All Incomplete Applications will be returned.

An application will be considered incomplete for any of the following reasons:

- The signature blocks are not signed.
- The medical questions are not thoroughly explained.
- The appropriate payment is not received with the application (direct billing only).
- ***Please make checks payable to NPFBA.***
- Any question or field is left blank.

All applications will be individually underwritten. If necessary, we will obtain your medical records or request a short paramedical exam to assist us in the underwriting process.

Spouses age 35 and older are required to complete a paramedical exam as part of the underwriting process.

Please mail your completed application in the postage-paid envelope provided.
If this envelope was not provided to you, please mail to:

NPFBA

Long Term Care Plan
P.O. Box 31
Martell, CA 95654-0031

Once your application is approved you will be required to sign a statement of good health before coverage will be issued.

If you have any questions about this plan or if you need assistance in completing your application, please call toll free 877-582-0003.

Our office hours are Monday through Friday 8:00 a.m. to 5:00 p.m.

OFFICE USE ONLY

Field Service Manager: ____________________ Field Service Manager #: __________________

APPLICANT INFORMATION (Please Print)

I am applying as: (check the appropriate box below)

EMPLOYEE	*SPOUSE*
☐ **Active Full Time Firefighter**	☐ **Spouse of Active Full Time Firefighter**
☐ **Active Full Time Law Enforcement Officer**	☐ **Spouse of Active Full Time Law Enforcement Officer**
☐ **Volunteer / Paid Call Firefighter**	☐ **Spouse of a Volunteer / Paid Call Firefighter**
☐ **Volunteer Law Enforcement Member**	☐ **Spouse of a Volunteer Law Enforcement Member**
☐ **Reserve Law Enforcement Officer**	☐ **Spouse of a Reserve Law Enforcement Officer**
☐ **Non-Safety Fire Dept Employee**	☐ **Spouse of a Non-Safety Fire Dept Employee**
☐ **Non-Safety Law Enforcement Dept Employee**	☐ **Spouse of a Non-Safety Law Enforcement Dept Employee**

Name of Agency that "**Employee**" is employed with: ____

Job Title of **Employee**: ________________________________

Employee Name: _____________________________________ **Employee SS#:** ____________________

Have you met or discussed this coverage with a representative of NPFBA? ☐ Yes ☐ No

Applicant's Name Last First M.I.	Height	Weight	Sex	DOB	Age Last Birthday
				/ /	

Mailing Address	City	State & Zip

Physical Address	City	State & Zip

Home Phone Number	Best Time to Call	Social Security Number	Marital Status
( )		/ /	☐ Married ☐ Single ☐ Divorced ☐ Widow
Alternate Phone Number Cell, Pager, Work, etc. ( )	**Best Time to Call**	**Email**	

PLAN OPTIONS – CHECK APPLICABLE BOX

☐ **Plan 130/70/50**
$130 /Day Nursing Home
70% Residential Care
50% Home Health Care
5% Inflation Protection per year

☐ **Plan 150/70/50**
$150 /Day Nursing Home
70% Residential Care
50% Home Health Care
5% Inflation Protection per year

☐ **Group Plan / Negotiated Benefits Plan /Modified Payment Plan, may be available.**

PAYMENT TERM – CHECK APPLICABLE BOX

☐ **20 Years** ☐ **25 Years** ☐ **30 Years** ☐ **35 Years** ☐ **40 Years**

The maximum payment term is based on your age at time of application. Please see the published cost (rate) schedule to determine the length of time that you are allowed to make payments.

BENEFICIARY

_____________________________________/______________________________

Full Name/Relationship Alternate (Contingent)

PAYMENT OPTIONS

Note: Each Applicant will be billed on an individual basis (surcharges are per applicant). Combined billing is not available.

Please select one of the following three methods of payment:

1) ☐ **Monthly Bank Draft** ($1.00 surcharge per transaction)

I hereby authorize NPFBA or its designated agent and the financial institution named below to initiate monthly withdrawals from my checking/savings account. This authority will remain in effect until I provide written notification to cancel this Plan or my affiliation with NPFBA, its designated agent or my financial institution.

I understand that if the required funds are not on deposit in my account on the day designated to execute the automatic deduction, I will be subject to the payment collection provision shown in the Evidence of Coverage and that any charges for overdraft or insufficient funds may be charged to me along with any service charges applied by NPFBA.

X____

Signature **Date**

Please deduct my monthly payment from (choose one):

☐ Checking Account Number _________________________ Routing Number _____________________

Attach VOIDED check here. We are unable to process your application without this information.

☐ Savings Account Number __________________________ Routing Number _____________________

____

Financial Institution Name Telephone

____

Financial Institution Address (City, State, Zip)

2) ☐ **Credit Card** ☐ Annual ☐ Semi-Annual ($1.00 surcharge per transaction) ☐ Lump Sum

Type of Credit Card ☐ Master Card ☐ Visa ☐ Discover Card Number_______________________________________

Expiration Date ________/______________

X____________________________________

Signature

3) ☐ **Billing** (Please direct bill me in one of the following ways):

☐ Annually ☐ Semi-Annual ($1.00 per transaction) ☐ Quarterly ($2.00 per transaction) ☐ Lump Sum

Note: One month of payment must accompany your application if billing is selected.
We are unable to process your application without the initial payment.
Please make checks payable to NPFBA.

4) ☐ **Other:** ____

Part I – MEDICAL INFORMATION

Please answer all the following questions by placing an "X" in either the "Yes" or "No" block

1. Are you employed or do you engage in hobbies, social activities, or volunteer work? *Explain*: ____ ☐ Yes ☐ No
2. Have you gained or lost more than 5 pounds in the past twelve (12) months? *If yes please explain below.* ☐ Yes ☐ No
3. a. Are you receiving any type of Disability Benefits? ☐ Yes ☐ No
   b. Are you now, or have you ever received benefits from Medi-Cal? ☐ Yes ☐ No
   c. Due to any present or past mental or physical disability, is any person or institution currently authorized to act on your behalf? ☐ Yes ☐ No
   d. Are you dependent on the use of a walker or wheelchair? ☐ Yes ☐ No
   e. Are you confined to your bed, home, hospital, or nursing home? ☐ Yes ☐ No
   f. Do you use any medical appliance such as a catheter, oxygen equipment, respirator, or a dialysis machine? ☐ Yes ☐ No
4. Do you require assistance, supervision or are you limited in any way in performing any of the following daily activities: bathing, dressing, toileting, meal preparation, eating, mobility, housekeeping or managing medications? ☐ Yes ☐ No
6. Have you been diagnosed or treated by a health care professional within the last 3 years for Transient Ischemic Attack (TIA)? ☐ Yes ☐ No
7. During the past 5 YEARS, have you been diagnosed or treated by a member of the medical profession for any of the following conditions? ☐ Yes ☐ No
   (If YES, place an X in the box next to those that apply)

☐ Acquired Immune Deficiency Syndrome (AIDS)
☐ AIDS Related Complex (ARC)
☐ Alcoholism or Drug Abuse
☐ ALS (Lou Gehrig's Disease)
☐ Alzheimer's Disease
☐ Aneurysm
☐ Arthritis treated with Steroids or Gold
☐ Cerebral Vascular Disease
☐ Cirrhosis of the Liver
☐ Congestive Heart Failure
☐ Dementia
☐ Diabetes with Insulin
☐ Emphysema or COPD
☐ Heart Attack
☐ HIV Positive
☐ Internal Lupus Erythematosis
☐ Kidney Failure
☐ Memory Loss
☐ Multiple Sclerosis
☐ Multiple Transient Ischemic Attacks (TIA's)
☐ Osteoporosis with Fractures
☐ Parkinson's Disease
☐ Stroke

☐ ***Check this box if you have had none of the conditions listed above in the last 5 years.***

If you answered yes or checked a box to any question on this page please explain below, giving full details including: Name and address of Physician, Condition, Treatment dates, and any resulting limitations (Additional room on page 11)

Item #	Description - Dates - Details – Narrative

Part II – MEDICAL HISTORY

1. Within the past **15 years** have you been diagnosed or treated by a member of the medical profession for any of the following conditions? (If YES, place an X in the block next to those that apply and explain in full detail below)

- ☐ Amputation
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Arthritis (Prescription Drugs)
- ☐ Atrial Fibrilation
- ☐ Bypass surgery or angioplasty
- ☐ Cancer (External)
- ☐ Cancer (Internal)
- ☐ Carotid Artery Disease
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema or COPD
- ☐ Fractures
- ☐ Heart Valve Impairment
- ☐ High Blood Pressure
- ☐ Hypertension
- ☐ Incontinence/Bladder or Bowel Control
- ☐ Joint Disorder or Replacement
- ☐ Macular Degeneration
- ☐ Melanoma
- ☐ Mental/Nervous Disorder
- ☐ Osteoporosis
- ☐ Peripheral Vascular Disease
- ☐ Phlebitis
- ☐ Seizure Disorder
- ☐ Single Transient Ischemic Attack (TIA)
- ☐ Sleep Apnea or Sleep Disorders
- ☐ Spine or Back Disorders

☐ ***Check this box if you have had none of the conditions listed above in the last 15 years.***

2. Within the past **5 YEARS**, have you been medically advised that you will need surgery, which has not been performed? ☐ Yes ☐ No

3. During the past **5 YEARS**, have you:
   a. Sought medical advice or treatment for any of the following conditions? ☐ Yes ☐ No

   ☐ Confusion/Disorientation ☐ Falling ☐ Tremors
   ☐ Deterioration of vision ☐ Loss of appetite ☐ Unstable gait
   ☐ Fainting ☐ Numbness

   b. Used any of the following: ☐ Yes ☐ No

   ☐ Braces ☐ Cane ☐ Wheelchair ☐ Walker ☐ Scooter
   ☐ Other: ___________________________________

4. When you walk 4 blocks at a normal pace or climb a flight of stairs, do you experience any difficulties such as shortness of breath, dizziness or leg cramps? ☐ Yes ☐ No

5. Have you ever been diagnosed, advised of, or received medical treatment by a member of the medical profession for any condition not named above (other than routine physical exams with normal findings)? ☐ Yes ☐ No

6. Do you now, or have you during the past **3 YEARS**, used any tobacco products including cigarettes, cigars, pipes, chewing tobacco, etc? ☐ Yes ☐ No

7. Do you, or anyone you know, have any concerns over your present health? ☐ Yes ☐ No

If you answered yes or checked a box to any question on this page please explain below, giving full details including: Name and address of Physician, Condition, Treatment dates, and any resulting limitations (Additional room on page 11)

Item #	Description - Dates - Details – Narrative

Part III - PRESCRIPTION MEDICATION

☐ **Check this box if you have not taken prescription medications for more than six months.**

List ALL Prescriptions you are currently using **OR** have used within the past FIVE years.

Medication	Reason

Part IV – PHYSICIAN INFORMATION

Please list the Name, Address and phone numbers of your treating physician.

Name ______________________________ Telephone # (_____) ____________________

Address ____
Street City State Zip Code

Applicant's Kaiser or HMO I.D. Number: ________________________

Have you been seen by any other physician and/or medical facility in the past two years? ☐ Yes ☐ No
Please provide physician's names and addresses and reason for visit

1. ____

2. ____

Part V – OTHER LONG TERM CARE

1. Do you now have in force, or are you applying for, any other long term care, nursing home or home health care policy, rider or certificate (including a health care service contract or a health maintenance organization contract)? ☐ Yes ☐ No

2. Other than the above, did you have a long term care policy, rider or certificate in force during the last 12 mos? ☐ Yes ☐ No

3. Have you ever had an application for Life, Health or Long Term Care insurance declined, postponed, modified or rated? *If yes please explain in the area provide on the previous page.* ☐ Yes ☐ No

Part VI – PROTECTION AGAINST UNINTENDED 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 this long-term care policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

☐ I designate the following person(s) to receive notice prior to cancellation of my policy for nonpayment of premium:

Full Name: ____

Address: ____

Telephone Number: ____

☐ I elect not to designate any person to receive such notice.

APPLICANT CERTIFICATION

I certify that I have reviewed all the information and notices contained in this application and that all information supplied on this form is true to the best of my knowledge.

I also understand and agree that the coverage for which I am applying, if issued, shall be subject to these statements and will take effect on the effective date stated on the schedule of benefits. If statements in this application are fraudulent or materially untrue, sanctions that could include rescission of my coverage or a benefit denial may be applied. If I have submitted intentionally fraudulent statements, I understand that my name may be submitted to the relevant authority for criminal prosecution.

I understand that the Plan I am applying for has been approved by the Trustees of the National Peace Officer and Fire Fighters Benefit Association (NPFBA), but does not qualify for Medi-Cal spend-down protection under the California Partnership for Long Term Care.

I understand that based on the medical information provided, I may receive a preferred, standard, or modified rating. The standard rating will have an elimination period of 90 days, while the preferred rating will have an elimination period of 60 days. A modified rating will be an elimination period agreed upon by the applicant and the Trust. Modified ratings are sometimes offered in lieu of a denial of coverage. Certain other riders and exclusions may be added to the certificate with agreement of both parties. I will have the opportunity to accept or deny the certificate if it is not issued on a preferred basis. If I deny the certificate of coverage, I will receive my full-prepaid payment within approximately 30 days of my decision.

Additionally, I understand that if I use or if I have used any tobacco products within the last 36 months, I will be issued a certificate on a standard basis and I will automatically have a 90-day elimination period.

This coverage will not be effective until the 'Statement of Continuing Good Health" has been signed and returned on a form provided by the Administrator. This Statement of Good Health confirms that all information on the initial application continues to be correct and that nothing has changed since the original application was submitted.

I have read and understand the above statements concerning information that may be fraudulent, and the probable penalty of making such statements.

X____

Signature of Applicant **Date**

This certification is made in connection with the application for Long Term Care (LTC) coverage with the National Peace Officers and Fire Fighters Benefit Association Trust.

____

Print Name as it appears on the face page of Application

______________________________ /   /

Social Security Number **Date of Birth**

Additional Information

If you answered yes or checked a box to any question on this application please explain below, giving full details including: Name and address of Physician, Condition, Treatment dates, and any resulting limitations (Please add additional pages if necessary)

Item #	Description - Dates - Details – Narrative

AUTHORIZATION FOR RELEASE OF INFORMATION – HIPAA COMPLIANT – Part 1

RECORDS SUBJECT:
Individual: _____________________________________ AKA:_______________
____
Social Security Number: _____-_____-_______ Date of Birth: ________________
_____

SERVICE PROVIDER:
Requesting Records from ____
____

REQUESTED BY:
Law Firm/Insurance Company requesting records: National Peace Officers and Firefighters Benefit Association(NPFBA)

The Service Provider is directed to make available for copying all records pertaining to the Individual. Including, but not limited to, any and all files, photographs, video and/or audio tapes and/or records for all injuries or conditions in the Service Provider's possession or under the Service Provider's control that is held for any purpose. Nothing shall be removed, deleted, altered or withheld.

If additional items are to be disclosed or not disclosed by Service Provider, you *must* check ALL appropriate boxes.

Release Records	Do **NOT** Release Records	
☐	☐	All medical records during the care and treatment, hospitalizations, evaluations, testing, examination, office visits, emergency room, lab testing. Including, but not limited to, nurse's notes, operative and pathology reports, emergency room records, surgery records, physical therapy records, inpatient and outpatient charts, MD progress notes, consults, MD orders, discharge summary, MD orders, prescriptions, EKG, and EMG, EEG.

AUTHORIZATION FOR RELEASE OF INFORMATION – HIPAA COMPLIANT – Part 2

Release Records	Do **NOT** Release Records	
☐	☐	All Original X-ray films, MRI films, CT Scans, and film reports.
☐	☐	All psychiatric, drug and/or alcohol treatment, evaluation, treatment, abuse testing, counseling, rehabilitation records. **INITIAL HERE ________**
☐	☐	All mental health information consisting of, but not limited to, all notes, records and reports of psychotherapy diagnosis, evaluation and treatment. **INITIAL HERE ________**
☐	☐	All employment records, including, but not limited to, payroll records, absenteeism or time off, benefits, applications, and claim records, applications for employment, work absentee records, time cards, incident reports, W-2's, 1099's, pre-employment exam records and employee progress records.
☐	☐	All insurance records, including correspondence, payments, photographs, underwriting and claim records. Including, but not limited to, copies of policies involved, payments made there under, medical records submitted by the company or other physicians. Any and all documents, including, but not limited to, Declarations of coverage, which evidence compliance with California Financial Responsibility Laws at the time of the accident.
☐	☐	All HIV test results or any related AIDS virus information. INITIAL HERE ________

AUTHORIZATION FOR RELEASE OF INFORMATION – HIPAA COMPLIANT – Part 3

At the request of the Individual this information will be used for the purpose of aiding the Individual and his or her attorney in establishing the liability, nature and extent of a claim for injuries and disabilities and to establish benefits, expenses, compensation and damages. The information provided may be disclosed by NPFBA to other parties and/or treating/evaluating physicians. This Authorization does not permit the Service Provider to allow the copying of records by any other copy service or business associate as defined by the Health Insurance Portability and Accountability Act (HIPAA). This Authorization does not permit disclosure of any information to any person, entity, provider or insurance company other than the copying of records by a representative of NPFBA. Any and all Authorizations signed before this Authorization are revoked.

Individual designates and authorizes NPFBA as his/her representative to pursue any and all legal remedies necessary to compel the production of records from the Provider.

A copy of this Authorization is as valid as the original; the original is not required to be shown. The Individual has the right to revoke this Authorization at any time by giving the Provider written notice of revocation of this Authorization. A copy of this signed Authorization will be given to the Individual after it has been signed. The Individual has the right to refuse to sign this Authorization.

This authorization shall expire three years from the date of execution below unless a different date is specified here ______.

Date: __________ ____

Individual's signature or Representative

Date: __________ ____

If signed by other than Individual indicate relationship (Parent, Guardian or Conservator)

This authorization was created in 14-point type in accordance with California Legislature Assembly Bill 715.