



NPFBA™



NATIONAL PEACE OFFICERS AND  
FIRE FIGHTERS BENEFIT ASSOCIATION™

*A Jointly Sponsored Long Term Care Trust of The California Law Enforcement Association® and  
The California Association of Professional Firefighters®*

# LONG TERM CARE APPLICATION

PROTECTING THOSE WHO PROTECT THE PUBLIC

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# INSTRUCTIONS FOR COMPLETING THIS APPLICATION

## **This Application must be completed by the Applicant.**

**When the Applicant signs this application he/she is making a certification under penalty of perjury that all answers are true and correct to the best of his/her knowledge.**

**NOTE:** Employee and Spouse must complete separate applications.  
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.
- 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.

**All spouses of active employees are required to complete a paramedical exam at the expense of NPFBA 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  
PO Box 31  
Martell, CA 95654-0031

Once your application is approved you may be required to sign the “Statement of Continuing 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, option #2. Our office hours are Monday through Friday 8:00 am to 5:00 pm.**

**OFFICE USE ONLY**

Field Service Manager: \_\_\_\_\_

**Employees and their eligible spouses may apply for coverage through this Association.**

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

**Applicant must be age 60 or less and must fall into one of the following categories:**

1. Member of police department or fire department of municipal or public corporation or district including volunteers or reserves.
2. Peace or law enforcement officer who is a regular and salaried officer or employee of the state or of a single county or other political subdivision or public or municipal corporation.
3. Person who is an emergency medical services personnel and employed by a fire department of a city, county or district.
4. Person who at the time of becoming a member of such associations was qualified pursuant to paragraphs 1, 2, or 3 above.
5. Spouse of qualified employee pursuant to paragraphs 1, 2, or 3 above.
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 who 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.

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**Applicant**

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**Date**

## 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  
Respite Care

**Plan 150/70/50**

\$150/Day Nursing Home  
70% Residential Care  
50% Home Health Care  
5% Inflation Protection per year  
Respite Care

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

Department/Plan: \_\_\_\_\_

## 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.*

## APPLICANT INFORMATION

### Please Print

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

#### Employee

- Active Full Time Firefighter
- Active Full Time Law Enforcement Officer
- Volunteer / Paid Call Firefighter
- Volunteer Law Enforcement Member
- Reserve Law Enforcement Officer
- Non-Safety Fire Dept. Employee
- Non-Safety Law Enforcement Dept. Employee

#### Spouse

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

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

Name of representative: \_\_\_\_\_

Name of Agency that Employee is employed with: \_\_\_\_\_

Job Title of Employee: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Employee SS#: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Last Name		First Name			M.I.
Mailing Address		City	State	Zip	
Physical Address		City	State	Zip	
Home Phone Number	Best Time to Call	Social Security #		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Alternate Phone Number	Best Time to Call	Email			
Height	Weight	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth		Age Last Birthday

## BENEFICIARY

**Please do not designate beneficiaries under the age of 18.**

**PRIMARY**

Full Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Email: \_\_\_\_\_

**ALTERNATE (CONTINGENT)**

Full Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Email: \_\_\_\_\_

## 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 methods of payment:**

**Monthly Bank Draft** (\$1.00 surcharge per transaction)

Please deduct my monthly payment from (choose one):

**Checking**       **Savings**

\_\_\_\_\_  
Account Number

\_\_\_\_\_  
Routing Number

\_\_\_\_\_  
Financial Institution Name

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Financial Institution Address including City, State & Zip

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

*I hereby authorize NPFBA or its designated agent and the financial institution named below to initiate monthly withdrawals from my checkingsavings 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.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Credit Card**

**Annual**     **Semi-Annual** (\$1.00 surcharge per transaction)     **Quarterly** (\$2.00 surcharge per transaction)

Type of Credit Card:     **Master Card**       **Visa**       **Discover**

\_\_\_\_\_  
Card Number

\_\_\_\_\_  
Expiration Date

\_\_\_\_\_  
Signature

**Group Plan/Negotiated Benefits Plan/Modified Payment Plan.**

# MEDICAL INFORMATION & HISTORY

Please answer all of the following questions. If answering "Yes" to any question, please provide details in the space provided on page 10.

1. Are you employed or do you engage in hobbies, social activities, or volunteer work?  Yes  No

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2. Have you gained or lost more than 5 pounds in the past twelve (12) months?  Yes  No

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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

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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

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5. Have you ever been diagnosed or treated by a health care professional for stroke (CVA), Transient Ischemic Attack (TIA) or cerebral aneurysm?  Yes  No

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

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7. 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

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

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9. Have you ever used restricted or controlled substances except as prescribed by a licensed physician?  Yes  No

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10. During the past 5 years, have you been counseled, treated or hospitalized for the use of alcohol or drugs?  Yes  No

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

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12. In the last 5 years, has a health professional recommended that you should have any surgeries, tests, or procedures (including diagnostic & screening procedures) that have not been performed?  Yes  No

13. Have you been diagnosed or treated by a member of the medical profession for any of the following conditions?  
(Place an X in the box next to those that apply. If you answered yes to any of the following, please provide details on Page 10)

- |   |   |
|---|---|
| <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) | <input type="checkbox"/> Hemophilia   |
| <input type="checkbox"/> AIDS Related Complex (ARC)                 | <input type="checkbox"/> Hepatitis  |
| <input type="checkbox"/> Alcoholism or Drug Abuse                   | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> ALS (Lou Gehrig's Disease)                 | <input type="checkbox"/> HIV Positive   |
| <input type="checkbox"/> Alzheimer's Disease                        | <input type="checkbox"/> Huntington's Chorea  |
| <input type="checkbox"/> Amputation                                 | <input type="checkbox"/> Hypertension   |
| <input type="checkbox"/> Anemia                                     | <input type="checkbox"/> Incontinence/Bladder or Bowel Control                        |
| <input type="checkbox"/> Aneurysm                                   | <input type="checkbox"/> Joint Disorder or Replacement                                |
| <input type="checkbox"/> Angina                                     | <input type="checkbox"/> Kidney Failure   |
| <input type="checkbox"/> Anorexia                                   | <input type="checkbox"/> Macular Degeneration   |
| <input type="checkbox"/> Anxiety                                    | <input type="checkbox"/> Melanoma   |
| <input type="checkbox"/> Arrhythmia                                 | <input type="checkbox"/> Memory Loss  |
| <input type="checkbox"/> Arthritis (Prescription Drugs)             | <input type="checkbox"/> Meniere's Disease  |
| <input type="checkbox"/> Arthritis Treated with Steroids or Gold    | <input type="checkbox"/> Mental/Nervous Disorder                                      |
| <input type="checkbox"/> Atrial Fibrillation                        | <input type="checkbox"/> Multiple Sclerosis   |
| <input type="checkbox"/> Asthma                                     | <input type="checkbox"/> Muscular Dystrophy   |
| <input type="checkbox"/> Auto-Immune Disease                        | <input type="checkbox"/> Obesity  |
| <input type="checkbox"/> Blood Disease                              | <input type="checkbox"/> Organ Transplants  |
| <input type="checkbox"/> Bulimia                                    | <input type="checkbox"/> Organic Brain Syndrome                                       |
| <input type="checkbox"/> Bypass Surgery                             | <input type="checkbox"/> Osteoporosis   |
| <input type="checkbox"/> Cancer (External)                          | <input type="checkbox"/> Osteoporosis with Fractures                                  |
| <input type="checkbox"/> Cancer (Internal)                          | <input type="checkbox"/> Paralysis  |
| <input type="checkbox"/> Carotid Artery Disease                     | <input type="checkbox"/> Parkinson's Disease  |
| <input type="checkbox"/> Cerebral Vascular Disease                  | <input type="checkbox"/> Peripheral Vascular Disease                                  |
| <input type="checkbox"/> Cirrhosis of the Liver                     | <input type="checkbox"/> Phlebitis  |
| <input type="checkbox"/> Clotting Disorder                          | <input type="checkbox"/> Psychiatric Disorder<br>(Depression, Bipolar Disorder, etc.) |
| <input type="checkbox"/> Colitis                                    | <input type="checkbox"/> Retinitis Pigmentosa   |
| <input type="checkbox"/> Congestive Heart Failure                   | <input type="checkbox"/> Rheumatoid Arthritis   |
| <input type="checkbox"/> Dementia                                   | <input type="checkbox"/> Schizophrenia  |
| <input type="checkbox"/> Depression                                 | <input type="checkbox"/> Scleroderma  |
| <input type="checkbox"/> Diabetes                                   | <input type="checkbox"/> Seizure Disorder   |
| <input type="checkbox"/> Diabetes with Insulin                      | <input type="checkbox"/> Single/Multiple Transient Ischemic Attack (TIA)              |
| <input type="checkbox"/> Dizziness                                  | <input type="checkbox"/> Sleep Apnea or Sleep Disorders                               |
| <input type="checkbox"/> Eating Disorders                           | <input type="checkbox"/> Spine or Back Disorders                                      |
| <input type="checkbox"/> Emphysema, COPD or Chronic Lung Disease    | <input type="checkbox"/> Stroke   |
| <input type="checkbox"/> Fractures                                  | <input type="checkbox"/> Systemic Lupus Erythematosus                                 |
| <input type="checkbox"/> Glaucoma                                   | <input type="checkbox"/> Tremor   |
| <input type="checkbox"/> Heart Attack or Angioplasty                |   |
| <input type="checkbox"/> Heart Valve Impairment                     |   |

**Check this box if you have not been diagnosed or treated for any of the conditions listed above.**





## PHYSICIAN INFORMATION

Please provide information for primary physician and any additional treating physicians.

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Applicant's Kaiser or HMO I.D. Number: \_\_\_\_\_

Have you been seen by any other physician and/or medical facility in the past 2 YEARS?  Yes  No

Please provide physician's name, address, phone number and reason for visit. *Additional space on page 10.*

1. \_\_\_\_\_

2. \_\_\_\_\_

## 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

*Please provide company names for the purpose of benefit coordination:*

\_\_\_\_\_

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

3. Have you ever had an application for Life, Health or Long Term Care insurance declined, postponed, modified or rated?  Yes  No

*If yes, please explain:* \_\_\_\_\_

## 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 coverage for nonpayment of dues. I understand that notice will not be given until thirty (30) days after dues is due and unpaid.

- I designate the following person(s) to receive notice prior to cancellation of my coverage for nonpayment of dues:**

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

- 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 application 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 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.

**No coverage will be provided for any job related injury or an injury caused by a third party where a cash settlement was provided in lieu of future medical coverage. Keep this in mind whenever you are offered cash in lieu of future medical coverage. This is particularly important in workers' compensation claims.**

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

**Under the terms of the Plan, any dispute not resolved through the Plan's claim procedure will be resolved by binding arbitration with the American Arbitration Association.**

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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.**

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Print Name as it appears in Applicant Information of Application

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Social Security Number

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Date of Birth

# AUTHORIZATION FOR RELEASE OF INFORMATION – HIPAA COMPLIANT – PART 1

## Records Subject:

Individual: \_\_\_\_\_

AKA: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Service Provider:

Requesting Records from:

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## 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.**

**Do NOT**  
**Release Records**      **Release Records**

All medical records during the care and treatment, hospitalizations, evaluations, testing, examination, office visits, emergency room, or lab testing. Including, but not limited to, nurse's notes, operative and pathology reports, emergency room records, surgery records, physical therapy records, in-patient 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

- | <b>Release Records</b>   | <b>Do NOT<br/>Release Records</b> |   |
|--------------------------|-----------------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/>          | All Original X-ray films, MRI films, CT Scans, and film reports.  |
| <input type="checkbox"/> | <input type="checkbox"/>          | All psychiatric, drug and/or alcohol treatment, evaluation, treatment, abuse testing, counseling, rehabilitation records.<br><br><b>INITIAL HERE</b> _____  |
| <input type="checkbox"/> | <input type="checkbox"/>          | All mental health information consisting of, but not limited to, all notes, records and reports of psychotherapy diagnosis, evaluation and treatment.<br><br><b>INITIAL HERE</b> _____  |
| <input type="checkbox"/> | <input type="checkbox"/>          | 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-2s, 1099s, pre-employment exam records and employee progress records.   |
| <input type="checkbox"/> | <input type="checkbox"/>          | 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. |
| <input type="checkbox"/> | <input type="checkbox"/>          | All HIV test results or any related AIDS virus information.<br><br><b>INITIAL HERE</b> _____  |

# 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 \_\_\_\_\_.**

\_\_\_\_\_  
Individual's Signature or Representative

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

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



**NPFBA™**



NATIONAL PEACE OFFICERS AND  
FIRE FIGHTERS BENEFIT ASSOCIATION™

**1-877-582-0003, Option #2 • Fax (209) 223-2966**

**PO Box 31 • Martell, CA 95654-0031**