Penn Treaty Network America Insurance Company℠
3440 Lehigh Street, Allentown, PA 18103

I. AGENT INFORMATION:

Agent Name: Kenneth Wheeler Agent Number: 60484 Date: / /

APPLICANT INFORMATION:

Name _____
(First) (Middle) (Last)

Mailing Address _____
(Street) (City) (State) (Zip)

Billing Address (complete only if different from Mailing Address)
_____
(Street) (City) (State) (Zip)

How long at current address _____

Telephone ( ) _____ E-Mail _____

Soc. Sec. No. _____ Birth Date / /

Sex ❑ Female ❑ Male Height _____ Weight _____ Age _____ Marital Status ❑ Single ❑ Married ❑ Widow(er)

❑ Iowa Long Term Care Partnership Lifetime Inflation Plan Form No. _____

Maximum Daily Benefit $_____
Max. Lifetime Benefit/Benefit Period _____
Elimination Period _____days

ALTERNATIVE PAYMENT OPTIONS:
❑ One ❑ Two ❑ Five ❑ Ten
❑ Up to 65 ❑ Pay as you go

PREMIUM MODE:
❑ Annual ❑ Semi-Annual ❑ Quarterly
❑ Monthly ❑ ACH (When selecting ACH, two (2) months premium & a copy of a voided check is needed.)

OPTIONAL RIDER:
❑ Nonforfeiture Premium Benefit Rider
❑ Christian Science Facility Rider
Form No. _____

UNDERWRITING CLASS:
❑ Preferred ❑ Premier ❑ Select
❑ Standard ❑ Other _____

This policy qualifies under the Iowa Long Term Care Insurance Program for Medicaid Asset Protection. This policy may provide benefits in excess of the Asset Protection provided in the Iowa Long Term Care Asset Preservation Program.

PREMIUM CALCULATION:

Annual Premium	$
Application Fee	$
Marital Discount (deduct 10%)	$
Premium Submitted	$

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a felony of the third degree, (as determined by a court of competent jurisdiction).

II. Medical Information

Applicant's Name (necessary only if application is faxed) _____

1.	Do you need or receive assistance or supervision in performing everyday living activities such as walking, bathing, dressing, eating, transferring or toileting?	Yes ❑	No ❑
2.	Are you currently confined to a hospital, Long Term Care facility or are you receiving any type of care or assistance in your home ?	Yes ❑	No ❑
3.	Have you ever been diagnosed with or treated for Alzheimer's Disease, Dementia, Senility or any other type of Organic Brain Syndrome?	Yes ❑	No ❑
4.	Have you ever been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), or Aids Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)?	Yes ❑	No ❑

NOTE: If any of the above questions are answered "Yes", the applicant is NOT ELIGIBLE for coverage and the application should not be submitted.

5.	Within the past five (5) years:		
	a) have you been hospitalized or been advised to be hospitalized?	Yes ❑	No ❑
	b) have you had any surgical procedures performed or been advised to undergo surgery?	Yes ❑	No ❑
	c) have you been confined to a nursing home or assisted living facility or been advised to be confined to a nursing home or assisted living facility?	Yes ❑	No ❑
	d) have you received care in your home or been advised to receive care in your home?	Yes ❑	No ❑
6.	Within the past two (2) years, have you received assistance with shopping, cleaning, cooking, laundry or transportation?	Yes ❑	No ❑
7.	Within the past two (2) years, have you used a cane, walker or wheelchair?	Yes ❑	No ❑
8.	Have you ever had an application for life or health insurance (including Long Term Care insurance) declined, rated, modified or postponed?	Yes ❑	No ❑
9.	Have you ever received disability benefits of any type?	Yes ❑	No ❑
10.	Are you currently covered by a Power-of-Attorney (POA) agreement?	Yes ❑	No ❑
11.	Within the past five (5) years, have you smoked or used any tobacco products ?	Yes ❑	No ❑
12.	Within the past five (5) years, have you sought and/or received any medical or surgical advice, examination or treatment for:		
	a) Cancer, Leukemia or Hodgkin's Disease?	Yes ❑	No ❑
	b) Stroke,TIA (Trans-Ischemic Attack), Epilepsy or Seizures?	Yes ❑	No ❑
	c) Parkinson's Disease or any other Central Nervous System Disease or Disorder?	Yes ❑	No ❑
	d) Memory Loss, Forgetfulness or Confusion?	Yes ❑	No ❑
	e) Depression, Psychosis or any other Mental, Nervous, Emotional or Brain Disorder?	Yes ❑	No ❑
	f) Nephritis, Kidney Failure, Incontinence, Cirrhosis of the Liver or Diabetes ?	Yes ❑	No ❑
	g) Osteoporosis, Arthritis or any other Bone, Joint or Muscle Disease or Disorder?	Yes ❑	No ❑
	h) Heart Disease or Disorder, Hypertension or any other Circulatory Disorder?	Yes ❑	No ❑
	i) Cystic Fibrosis, Emphysema or any other Lung Disease?	Yes ❑	No ❑
	j) Drug or Alcohol Abuse?	Yes ❑	No ❑
13.	Within the past five (5) years, have you sought and/or received any medical or surgical advice, examination, or treatment for any health condition or symptoms not included in the above medical/health questions?	Yes ❑	No ❑

If any question is answered "Yes", please list the complete details. Include name(s), address(es) and dates of all physicians consulted, hospitalizations and treatment of any form received.

If more space is needed, attach a sheet signed by the applicant and check this box. ☐ (check only if additional sheet is submitted)

III. Medications

Applicant's Name (necessary only if application is faxed) _____

Please list all medications currently being taken.					
Medication	Condition	Dosage	Medication	Condition	Dosage

If more space is needed, attach a sheet signed by the applicant and check this box. ☐ (check only if additional sheet is submitted)

IV. Family Physician

Physician's Name: _____ Telephone: ( )

Address: _____

V. Additional Information

1. Do you now, or did you within the last twelve (12) months, have another Long Term Care, Nursing Home and/or Home Health Care insurance policy or certificate (including health service contract or health maintenance organization contract) in force? .. Yes ❑ No ❑
   a) If "Yes", with what company? _____
   b) If the policy or certificate has lapsed, when did it lapse? ..... ____/____/____
2. Do you intend to replace **any** of your medical or health insurance with this policy? ..... Yes ❑ No ❑
   If "Yes", a completed Replacement Form MUST be submitted with the Application.
3. Are you covered by Medicaid? (If you are eligible for or covered by Medicaid, you should reconsider your decision to purchase a policy as it may not be financially suitable)..... Yes ❑ No ❑
4. Agent to list all policies he or she has sold to the applicant in the last five (5) years. (Use additional **signed** sheet if necessary.)

Company	Policy/Certificate Number	Type of Coverage	Effective Date of Coverage	Currently in Force?	If Lapsed, Give Date
				❑ Yes ❑ No	
				❑ Yes ❑ No	
				❑ Yes ❑ No	
				❑ Yes ❑ No	
				❑ Yes ❑ No	

VI. Nonforfeiture Protection

I have reviewed the Outline of Coverage and the explanation of the Nonforfeiture Option. I realize that the rider provides me with the right to maintain a portion of my maximum lifetime benefits / benefit period in the event the policy lapses after having been continuously in force for at least three (3) years. Specifically, I have reviewed the Nonforfeiture Rider and I :

❑ accept Nonforfeiture Protection ❑ reject Nonforfeiture Protection.

VII. Third Party Designation - Protection Against Unintended Lapse

I understand that I have the right to designate at least one (1) person other than myself to receive notice of the cancellation of this Long Term Care insurance policy for nonpayment of premium. I understand that notice to my designee will not be given until thirty (30) days after a premium is due and unpaid.

❑ I elect to designate this person to receive such notice:

Name: _____

Address: _____

Telephone: ( )

❑ I elect not to designate any person to receive such notice at this time.

Applicant's Name (necessary only if application is faxed)

VIII. Acknowledgments/Release of Medical Information

I hereby declare that all statements, answers and elections as recorded herein are full, complete and true. It is understood and agreed that: a copy of this application shall be attached to and form a part of any policy issued; no insurance hereby applied for shall take effect unless a policy has been delivered to me and the initial term premium is paid in full; and, if issued, coverage will begin in force as of the effective date shown in the policy schedule. I hereby affirm that I have read, or had read to me, the completed application. I realize that any missing and/or inaccurate information or fraudulent statement in the application may result in loss of coverage under the policy, subject to its Time Limit on Certain Defenses. I realize no agent shall have the right or authority to make, alter, modify or discharge any contract or policy issued on the basis of this application.

I hereby authorize any licensed physician, medical practitioner, medically-related facility or insurance company that has any records of my health to give Penn Treaty Network America Insurance Company℠ such information in the event that Penn Treaty Network America finds it necessary in order to evaluate my application for insurance. A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for six (6) months from the date this authorization is signed and I understand that I, or my authorized representative may obtain a copy of this authorization upon request.

I have read the Outline of Coverage for the policy applied for. If I am age 65 or older, I have also received the "Guide to Health Insurance for People with Medicare" and the required Medicare Disclosure Statement, if applicable.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, PENN TREATY NETWORK AMERICA INSURANCE COMPANY℠ MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR POLICY.

Dated: / / at _____ _____

State Signed | Signature of Applicant

IX. Release of Records

I hereby agree to the release of my insurance records pertaining to this Long Term Care Insurance policy by Penn Treaty Network America to the State of Iowa for the purpose of documenting a claim for Asset Protection under the Iowa Medicaid Program, evaluating the Iowa Asset Preservation Program for Long Term Care, and meeting Medicaid audit requirements. I understand that my records will be used for no purpose other than those stated above, and will be kept strictly confidential by the State of Iowa.

_____ / /

Applicant's Signature | Date

XI. Agent's Report (must be completed and signed)

1. Did you personally interview the applicant and witness his/her signature? ❑ Yes ❑ No
2. Was anyone else present? ❑ Yes ❑ No If yes, who? _____
3. Did you observe any physical or mental impairments with regard to memory, walking or speaking, or any form of tremor? ❑ Yes ❑ No If yes, explain. _____
4. Does the applicant live alone? ❑ Yes ❑ No If no, with whom does the applicant reside? _____
5. If there is a spouse, is he/she applying? ❑ Yes ❑ No
6. If the spouse is not applying, please explain the reason(s). _____
7. Type of Dwelling: ❑ Private Home ❑ Apartment ❑ Mobile Home ❑ Retirement Home ❑ Nursing Facility ❑ Adult Congregate Living Facility ❑ Other _____
8. Did you review the current accident and health insurance coverage of the applicant and find that additional coverage of the type and amount applied for is appropriate for the applicant's needs? ❑ Yes ❑ No

I verify that this application has been read by, or read to, the above named applicant and I have truly and accurately recorded on this application the information supplied by the applicant.

❑ I am a certified agent to sell Asset Preservation Program policies.

_____ / / 60484

Signature of Licensed Resident Agent | Date | State License I.D. No.

Kenneth Wheeler