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| Applicant Name: | Applicant Social Security Number |
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Are you (applicant) presently working? Yes No
 If yes, list occupation:

| | | |
|-------------------|-------------------|---|
| Applicant Height: | Applicant Weight: | Have you (applicant) used tobacco products in the last 12 months (chew or smoke - circle applicable activity)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|-------------------|-------------------|---|

| | | |
|---|--|---------------------------|
| Have you (applicant) had any change in weight in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Gain _____ lbs. <input type="checkbox"/> Loss _____ lbs. | Reason for Weight Change: |
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|---------------------------|---|
| Primary Physician's Name: | Date Last Consulted Month ____ / Year ____ |
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| Primary Physician's Address: Street: | Date of Last Physical Exam Month ____ / Year ____ |
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| Primary Physician's Address: City, State, Zip Code: | Primary Physician's Telephone Number: () |
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I. Insurability Profile

As the Applicant, or person applying for this coverage, you are required to answer the following questions:

- A. Yes No Do you use mechanical devices, such as: a wheelchair, walker, quad cane, crutches, hospital bed, dialysis machine, oxygen, or stairlift?
- B. Yes No Do you currently need or receive help in doing any of the following: bathing; eating; dressing; toileting; transferring; maintaining continence?
- C. Yes No Do you currently have, or have you in the past 10 years had a diagnosis for or symptoms of: Alzheimer's disease, dementia, loss of memory, or organic brain syndrome?
- D. Yes No Do you currently have, or have you in the past 10 years had a diagnosis for or symptoms of: Multiple Sclerosis, Muscular Dystrophy, ALS (Lou Gehrig's Disease) or Parkinson's Disease?
- E. Yes No Have you been diagnosed and/or treated by a member of the medical profession for HIV+?
- F. Yes No Have you developed symptoms of the disease AIDS?
- G. Yes No Have you been diagnosed and/or treated by a member of the medical profession for AIDS?

STOP HERE! If you answered "Yes" to any part of questions A through G above, DO NOT SUBMIT THIS APPLICATION. Otherwise, please continue.

II. Medical Profile

A. Do you have symptoms of, or within the last five (5) years have you received medical advice, been diagnosed, treated or consulted with a member of the medical profession or other health care professional for any of the following conditions? **Please circle condition(s) for all "YES" answers.**

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. High blood pressure, irregular heart beat, atrial fibrillation, coronary artery disease, or other diseases or disorders of the heart or circulatory system, blood or blood vessels. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Polyp, benign tumor, leukemia, lymphoma, cancer, melanoma, or a disorder of the immune system. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Diabetes, thyroid problems, or any glandular disease or disorder. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Intestines, liver or disease or disorder of the stomach or digestive system. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Bowel, rectum, kidney, bladder, prostate, urinary tract, or reproductive system. |

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|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Mental disorder, depression, bulimia, anorexia or other eating disorder, alcohol abuse, drug addiction or any psychological or emotional condition or disorder; or been advised to limit, reduce or discontinue the use of alcohol; been arrested in connection with use of alcohol or drugs; or been advised to seek or receive counseling for alcoholism or drug abuse. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Arthritis, osteoporosis, any chronic pain condition, or chronic fatigue or any other disease or disorder of the back, spine, joints, muscles or neck. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Lung disorder, shortness of breath, or any disease or disorder of the respiratory system. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Falls, dizziness, imbalance, or any disease or disorder of the eyes or ears. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Seizures, tremors, stroke, transient ischemic attack (TIA), paralysis or any other disease or disorder of the brain or nervous system. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Any other conditions or diseases not mentioned above? Please describe in this area _____ |

If you answered "Yes" to any of the questions in section IIA, please indicate question number from IIA and provide full details on the condition, treatment dates and the name, address and telephone number of your medical advisor.

| Ques No. | Date of Last Visit (mm/dd/yyyy) | Reason/ Name of Condition | Treatment Given | Medical Advisor's Full Name, Address & Telephone Number |
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| B. <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you taken any prescription/non-prescription medications in the past 24 months, including all prescription/non-prescription medications you are currently taking? Please list the medication and details. |
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| Date Last Taken (mm/dd/yyyy) | Name of Medication | Dosage/ Frequency | Reason/Name of Condition | Prescribing Physician |
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C. Yes No Have you been hospitalized, been advised to have, or had surgery, medical care, EKG, x-ray, diagnostic test or been confined to any facility in the last five (5) years? If yes, provide details.

| Test(s) Performed | Date (mm/dd/yyyy) | Reason | Results | Name, Address & Telephone Number of Medical Advisor Requesting Test(s) |
|-------------------|-------------------|--------|---------|--|
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D. Yes No Do you live alone? If no, who lives with you?

E. Yes No Do you drive? If no, why?

F. Please describe your daily routine, i.e. work, exercise, travel, socializing, physical/recreational activities, etc.:

III. Insurance History

A. Yes No Are you covered by Medicaid? (If yes, details.)

B. Yes No Are you receiving any disability benefits? (If yes, provide details including health condition(s))

C. Yes No Have you had another long-term care insurance policy or certificate in force during the last 12 months? If yes — Name of Company: _____
If it lapsed, when did it lapse? (mm/dd/yyyy) _____

D. Yes No Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract?) If yes —
Name of Company: _____ Policy Number: _____ Type and Amount of Benefits: _____

E. Yes No Do you intend to replace any of your long term care, medical or health coverage with the coverage applied for? If yes —
Name of Company: _____ Policy Number: _____ Type and Amount of Benefits: _____

F. Yes No Have you been denied coverage for medical insurance, disability insurance, long-term care insurance, nursing home insurance, life insurance or received substandard coverage? If yes —
Name of Company: _____ Coverage: _____
Date Denied: (mm/dd/yyyy) _____ Reason for Denial? _____

G. Yes No Have you signed and activated a Power of Attorney authorizing another individual to manage your personal affairs? If yes, please provide the date _____ and reason _____

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IV. Acknowledgement

I have received the Potential Rate Increase Disclosure Form and Personal Worksheet.

V. Applicant's Signature

I agree that payment of premium is my responsibility. If any other person or entity collects, pays or forwards any part of the premium for this coverage, the person or entity acts as my agent and not an agent of Unum Life Insurance Company of America.

Payroll Deduction: If applicable, I authorize my employer to deduct the premiums for this insurance from my earnings.

I have read this application and I understand that: Unum Life Insurance Company of America will rely on the information provided in this application and any medical exams or tests and other questionnaires including a face to face assessment, if required, to determine whether to provide the coverage I have requested. All these documents shall form a part of my certificate of insurance and any coverage based on such information is contestable in accordance with the provisions of the Policy.

The statements I have made on this application are true to the best of my knowledge and belief.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, UNUM LIFE INSURANCE COMPANY OF AMERICA MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR INSURANCE.

Notice: 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, may be prosecuted for insurance fraud.

X _____
Applicant's Signature

Date: _____
(mm/dd/yyyy)

Signed at (City/State)

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Printed Name of Applicant: _____
(First Name) (MI) (Last Name)

Social Security Number: _____

Policy Number: _____

NOTE: The Health Insurance Portability and Accountability Act (HIPAA) requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or process your application. Please sign and return this authorization to: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory or other medically related facility or service; insurance company; insurance service provider; third party administrator; producer; and employer that has information about my health; employment; or other insurance coverage, claims and benefits to disclose any and all of this information to persons who evaluate and process applications for Unum, Unum Life Insurance Company of America, and duly authorized representatives ("Unum"). Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information Unum obtains pursuant to this authorization will be used for evaluating and processing my application for coverage. I further understand that the information is subject to redisclosure and might not be protected by HIPAA.

This authorization is valid for two (2) years from the date below. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Unum has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Unum may not be able to evaluate or process my application and this may be the basis for denying my application. I may revoke this authorization by sending written notice to: Group Long Term Care Client Service Center, 2211 Congress Street, Portland, ME 04122.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or process my application and this may be the basis for denying my application.

(Applicant Signature)

(Date Signed (mm/dd/yyyy))

I, _____, signed on behalf of the applicant as the applicant's Personal Representative. Please circle the type of Personal Representative: Power of Attorney Designee, Guardian, Conservator; and attach a copy of the document granting authority.

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