

Figure: 28 TAC §3.3829(b)(8)(H)

**Long-Term Care Insurance
Personal Worksheet**

FOR THE STATE OF TEXAS

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [\$ ____ per month, or \$____ per year,]
[a one-time single premium of \$ ____ .]

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums: _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.]

Instructions to Company: Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.

Rate Increase History

We have sold long-term care insurance since [year] and have sold this [policy/rider], Form No. [____] since (year). [We have never raised rates for any long-term care (policy/rider) sold in this state or any other state.] [We have not raised rates for this (policy/rider) or a similar (policy/rider) in this state or any other state in the last ten years.] [We have raised rates on this (policy/rider) or a similar (policy/rider) in the last ten years. Following is a summary of the rate increases:]

Instructions to Company: A company may use the first bracketed sentence above only if it has never increased rates under any prior individual or group policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar individual or group policy forms in this state or any other state during the last 10 years. The list shall specify the individual or group policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.

Questions Related to Your Income

How will you pay each year's premium?

- From my Income From my Savings/Investments My Family will Pay

[Have you considered whether you could afford to keep this policy if the premiums went up, for example by 20%?]

Instructions to Company: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one)

- Under \$10,000 \$[10-20,000] \$[20-30,000] \$[30-50,000] Over \$50,000

Instructions to Company: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

- No change Increase Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

- From my Income From my Savings/Investments My Family will Pay

The national average annual cost of care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.

Instructions to Company: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering?

Number of days _____ Approximate cost \$ _____ for that period of care

How are you planning to pay for your care during the elimination period? (check one)

- From my Income From my Savings/Investments My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

- Under \$20,000 \$20,000-\$30,000 \$30,000-\$50,000 Over \$50,000

How do you expect your assets to change over the next 10 years? (check one)

- No change Increase Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

Questions Related to Your Needs

You must be diagnosed with cognitive impairment or be unable to perform two (2) of the following six (6) activities of daily living (ADLs) - bathing, continence, dressing, eating, toileting, and transferring - prior to your long-term care benefits being triggered. Do you understand this policy limitation?

- Yes No

What type of long-term care service do you anticipate utilizing? (check all that apply)

- Nursing home care Assisted living care Home health care Adult day care
 Hospice Care Respite care other services

Disclosure Statement

- The answers to the questions above describe my financial situation.

OR

- I choose not to complete this information.

(Check one.)

I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations use the following: I acknowledge that I have reviewed this form

- including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**

Instructions to Company: This box must be checked.

Signed: _____

(Applicant)

(Date)

[I explained to the applicant the importance of completing this information.

Signed: _____
(Agent) (Date)

Agent's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____
(Applicant) (Date)]

Instructions to Company: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

Instructions to Company: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.