The **Federal** Long Term Care Insurance Program™

FLTCIP Claims Initiation Form

This form is used to initiate the claims process. Please provide accurate and complete information to the best of your knowledge and ability. Any failure to do so could jeopardize your claim. **Note: Form completion does not guarantee claim approval and/or benefit reimbursement.**

Personal information

☐ Mr. ☐ Mrs. ☐ Ms.

First name | M.I. | Last name

Address line 1

Address line 2

City | State/Territory

Country | Zip/Foreign postal code

Gender

☐ Male ☐ Female

Home phone

___ – ___ – ____

Date of birth

__ / __ / ____

Month Day Year

Work phone

___ – ___ – ____ Extension ____

Email

Social Security number

___ – __ – ____

Please call us at the number below if you do not have a Social Security number (SSN). We use SSNs to obtain health information during the claims process.

Select your current status:

☐ Assistance is needed

☐ Receiving support services for activities of daily living (ADL)

☐ Recovered; received ADL support services prior to recovery

☐ Deceased; received ADL support services prior to death

Date of death

__ / __ / ____

Month Day Year

For assistance, call 1-800-LTC-FEDS (1-800-582-3337) TTY 1-800-843-3557.

Personal information

Select your living accommodations:

☐ Home ☐ Assisted living facility ☐ Nursing home

Facility's name (if applicable)

Address line 1

Address line 2

City

State/Territory

Country

Zip/Foreign postal code

Married?
☐ Yes ☐ No

Is your spouse in claim or opening a claim?
☐ Yes ☐ No

Are interpreter services required?
☐ Yes ☐ No

Is the claimant hearing or vision impaired?
☐ Hearing ☐ Vision

Who is the contact for this claim? ☐ Insured ☐ Other

If you selected "insured," where should we send claims correspondence? ☐ Primary address ☐ Facility address

If you selected "other," please complete the contact information below:

Contact's name

First name M.I. Last name

Relationship to the insured

Contact's street address

City State Zip code

Contact's preferred phone

___–___–____

You, the insured, are required to complete and sign all claims forms. However, if you wish to authorize someone to make decisions on your behalf, the designated person must be named on a copy of your durable financial power of attorney or guardianship papers. Once we process this legal documentation, your representative will then have the right to complete forms related to your claim.

Claim information

1. **Briefly explain why a claim is being filed.**

2. **Are you currently in need of assistance with at least two of the following activities: bathing, continence, dressing, eating, toileting, or transferring?** ☐ Yes ☐ No

   If yes, what is the approximate date the assistance began? ☐☐/☐☐/☐☐
   Month Day Year

   If yes, what type of assistance do you need?

   ☐ getting into or out of a tub or shower ☐ washing your body or hair

   ☐ putting on and taking off all clothing items and any necessary braces, fasteners, or artificial limbs

   ☐ getting into and out of bed ☐ getting into or out of chair ☐ getting into or out of wheelchair

   ☐ getting on and off the toilet ☐ performing the associated personal hygiene

   ☐ maintaining control of bladder function ☐ maintaining control of bowel

   ☐ when unable to control bowel or bladder, performing associated personal hygiene, including caring for a catheter or colostomy bag

   ☐ feeding yourself by getting food into your mouth from a container (such as a plate or cup) or by a feeding tube or intravenously

3. **Is this claim being opened because you need substantial supervision due to a severe cognitive impairment, such as Alzheimer's disease or dementia?** ☐ Yes ☐ No

   If yes, what is the approximate date assistance began? ☐☐/☐☐/☐☐
   Month Day Year

   Please note that in this case a legal representative will be required.

4. **Is this claim being opened for any of the following reasons:**

   Result of injuries sustained due to a motor vehicle accident? ☐ Yes ☐ No

   Result of a work-related injury? ☐ Yes ☐ No

   Hospice services? ☐ Yes ☐ No

   (If you receive hospice services, please list this information in the Provider Information section.)

5. **If you are currently in a skilled nursing facility, please provide the expected discharge date (if known):**

   ☐☐/☐☐/☐☐
   Month Day Year

Insurance information

Please provide the name of any medical insurance you have, including Medicare or TRICARE For Life:

Medical insurance carrier's name

If you are covered by another long term care insurance policy, please provide the following information:

Phone

Long term care insurance carrier's name

☐ Individual policy ☐ Group policy

Policy ID number

Policy effective date ___/___/___
Month Day Year

Residence information

Who is currently living with you in your home?

Name

Relationship

How long have they been living with you? _____

Name

Relationship

How long have they been living with you? _____

Name

Relationship

How long have they been living with you? _____

Medical information

Please provide the requested information for all physicians (including your primary care physician) that you may have seen in the last 12 months, as well as any hospitals or rehabilitation facilities you may have visited that relate to your need for long term care assistance.

Name

Street address

City State Zip code

Phone Fax

Start of care date ___/___/___
Month Day Year

Date of last visit ___/___/___
Month Day Year

Reason for last visit

Medical information

Name

Street address

City | State | Zip code

Phone | Fax

Start of care date ___/___/___ (Month / Day / Year) | Date of last visit ___/___/___ (Month / Day / Year)

Reason for last visit

Name

Street address

City | State | Zip code

Phone | Fax

Start of care date ___/___/___ (Month / Day / Year) | Date of last visit ___/___/___ (Month / Day / Year)

Reason for last visit

Name

Street address

City | State | Zip code

Phone | Fax

Start of care date ___/___/___ (Month / Day / Year) | Date of last visit ___/___/___ (Month / Day / Year)

Reason for last visit

Provider information

Please share information regarding any care you have received in the past 12 months. The provider may be an individual or an organization. Be sure that information for each provider is complete and accurate in order to help avoid processing delays.

Name

Street address

City | State | Zip code

Phone | Fax

Start of care date ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

End of care date (if applicable) ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

Are you currently receiving ADL services? ☐ Yes ☐ No **If yes, are hospice services included?** ☐ Yes ☐ No

Type of provider

In your home		In a facility
Informal caregivers	**Formal caregivers**	☐ Adult day care center
☐ Friend	☐ Home care agency	☐ Assisted living facility
☐ Family member	☐ Home health agency	☐ Nursing home
☐ Private caregiver	☐ Visiting nurse association	
	☐ Hospice agency	

Are services paid? ☐ Yes ☐ No

Name

Street address

City | State | Zip code

Phone | Fax

Start of care date ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

End of care date (if applicable) ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

Are you currently receiving ADL services? ☐ Yes ☐ No **If yes, are hospice services included?** ☐ Yes ☐ No

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Informal caregivers	**Formal caregivers**	☐ Adult day care center
☐ Friend	☐ Home care agency	☐ Assisted living facility
☐ Family member	☐ Home health agency	☐ Nursing home
☐ Private caregiver	☐ Visiting nurse association	
	☐ Hospice agency	

Are services paid? ☐ Yes ■ No

Provider information

Name

Street address

City | State | Zip code

Phone | Fax

Start of care date ___/___/___ (Month / Day / Year)

End of care date (if applicable) ___/___/___ (Month / Day / Year)

Are you currently receiving ADL services? ☐ Yes ☐ No **If yes, are hospice services included?** ☐ Yes ☐ No

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☐ Private caregiver	☐ Visiting nurse association	
	☐ Hospice agency	

Are services paid? ☐ Yes ☐ No

Name

Street address

City | State | Zip code

Phone | Fax

Start of care date ___/___/___ (Month / Day / Year)

End of care date (if applicable) ___/___/___ (Month / Day / Year)

Are you currently receiving ADL services? ☐ Yes ☐ No **If yes, are hospice services included?** ☐ Yes ☐ No

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☐ Family member	☐ Home health agency	☐ Nursing home
☐ Private caregiver	☐ Visiting nurse association	
	☐ Hospice agency	

Are services paid? ☐ Yes ☐ No

If you need additional space, please enclose a separate list.

Enclosed list ☐ Physician ☐ Provider

Agreement and Acknowledgment

I am requesting a determination for benefit eligibility under the FLTCIP. All of the answers and explanations I have provided are accurate and complete to the best of my knowledge and ability. I understand that medical records or answers to any questions that a care coordinator may have will also be considered.

If there are any changes to my health, treatment, or provider, I agree to immediately notify Long Term Care Partners, LLC, P.O. Box 797, Greenland, NH 03840-0797, in writing.

Caution: If you are approved for benefit eligibility, but you should not have been because one or more of your answers or explanations are incorrect or untrue, or fails to include all material information requested, we may have the right to deny a claim. Any person who, with an intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to criminal and civil penalties.

Before we can process your claim, you must certify by signing below that the information you have provided on this form is accurate and complete to the best of your knowledge and ability.

☐ I wish to open a claim for FLTCIP benefits.

Signature (insured or legal representative) _____

Date signed _____ / _____ / _____
(Required: mm/dd/yy)

Print name _____

Note: If any form is signed by the durable power of attorney designee, guardian, or executor, please submit the appropriate documents with this claims initiation form. If the Medical Release is signed by someone other than the insured, a copy of the durable financial power of attorney, or guardianship papers, may be required.

Remember to complete and sign:

- Medical Release
- Form W-9 Request for Taxpayer Identification Number and Certificate

These forms are required to process this claims initiation. In order for us to discuss your coverage with another person designated by you (including your spouse), who is not your durable power of attorney designee or guardian, please complete the Authorization for Disclosure attached at the end of this form.

Please return your completed form by fax to **1-866-513-2674** or by mail to **Long Term Care Partners, LLC, P.O. Box 797, Greenland, NH 03840-0797.**

The Federal Long Term Care Insurance Program is sponsored by the U.S. Office of Personnel Management, insured by John Hancock Life & Health Insurance Company, under a group long term care insurance policy, and administered by Long Term Care Partners, LLC.

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