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

Claims Initiation Kit

Thank you for your participation in the Federal Long Term Care Insurance Program (FLTCIP). Long Term Care Partners, LLC, administers the FLTCIP. This Claims Initiation Kit contains the forms you, the insured, or your legal representative, must complete and return to us before we can process your claim. It accompanies the *Beginning the Claims Process* brochure, which explains the key steps in the claims process, such as determining your eligibility for benefits and educating you on what to expect if you are approved.

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

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:

Long term care insurance carrier's name Phone ___-___-____

Policy ID number ☐ Individual policy ☐ Group policy

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

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

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

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

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

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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Medical Release

Insured's name

First name | M.I. | Last name

Date of birth ___ / ___ / ___
Month Day Year

For claims-related purposes of the Federal Long Term Care Insurance Program, including determining eligibility for benefits, care coordination, claims decision-making, coordinating benefits with other insurance companies or payers, claims payment, claims appeals, and claims management activities, I authorize any licensed health care practitioner, medical facility, employer, insurance company, or any other entity or person that has any health information about me to give that health information to Long Term Care Partners (LTCP), LLC, John Hancock Life & Health Insurance Company (John Hancock), their reinsurers, and their subcontractors who need to know health information to provide contracted services.

The health information I am permitting to be disclosed and used for the Federal Long Term Care Insurance Program includes any information on my medical history, and the diagnosis, prognosis, and treatment of any physical or mental condition, whether such history is in electronic or paper form. It includes the disclosure of any medical care or surgery, psychiatric or psychological care or examinations, and information about alcohol or drug use (including any information otherwise protected by Federal Regulations 42 CFR Part 2 or other applicable laws). I understand that this authorization includes my consent to use and disclose medical information that relates to mental illness, HIV, AIDS, HIV-related illness, and sexually transmitted diseases or other serious communicable diseases, but only in accordance with any law or regulation that applies to any such disclosure of this information about me.

I understand that:

- If I do not sign this authorization, any claim for long term care insurance benefits may be denied.
- I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on it before my revocation.
- To revoke this authorization, I must notify **Long Term Care Partners, LLC, P.O. Box 797, Greenland, NH 03840-0797**, in writing.
- If I do revoke this authorization, I understand that my application for long term care insurance may not be processed and any claim for long term care insurance benefits may be denied. LTCP or John Hancock has a right to contest my long term care insurance claim or coverage.
- If I do not revoke this authorization, it will be valid until the coverage terminates.
- My health information may be redisclosed and no longer protected by applicable law, including federal health information privacy regulations. This can occur only if such redisclosure is required or allowed by law (e.g., in response to a subpoena).
- A copy of this authorization is as valid as the original.

Insured's signature _____ (Required) **Date signed** ___ / ___ / ___ (Required: mm/dd/yy)

If the insured is unable to sign for him- or herself, please include a copy of the durable financial power of attorney or guardianship papers, if not already submitted.

Legal representative's signature _____ (Required) **Date signed** ___ / ___ / ___ (Required: mm/dd/yy)

Note: Handwritten signatures are required.

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**.

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Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ► **Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

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

FLTCIP Authorization for Disclosure of Information

Insured's name

First name | M.I. | Last name

Address

City | State/Territory

Country | Zip/Foreign postal code

Date of birth Month / Day / Year

I, the insured named above, authorize Long Term Care Partners, LLC (LTCP), to disclose information about my insurance coverage and benefits under the Federal Long Term Care Insurance Program (FLTCIP), including demographic information, billing and payment information, claim and related medical information, and other information related to the FLTCIP, to the person(s) listed below. This will allow that person(s) to assist me in matters related to my coverage under the FLTCIP.

Name | Relationship | Phone number

Name | Relationship | Phone number

I understand that this authorization is voluntary. Unless I revoke the authorization, I understand that it is valid until the later of 1) one year from the date this form is signed (if I do not yet have coverage nor become insured) or 2) one year from the date I no longer have coverage under the applicable account (if I am insured or become insured), at which time it will expire. I understand that I may revoke this authorization at any time by notifying LTCP in writing at: **Long Term Care Partners, LLC, Attn: HIPAA Privacy Office, P.O. Box 797, Greenland, NH 03840-0797**. Revoking this authorization will have no effect on any information released in reliance on this authorization before LTCP received the revocation. I further understand that LTCP will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I understand that the individual(s) listed above may redisclose any information received. Once information is disclosed to the individual(s), I understand that the information may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) regulations and other applicable privacy laws.

Signature (insured or legal representative) _____

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

Note: A handwritten signature is required. If signed by a personal representative of the insured, please describe the authority under which the personal representative is authorized to act and enclose any related documentation (e.g., copy of your durable financial power of attorney):

_____

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**.

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