

Application & Outline of Coverage

for one or two applicants

Long Term Care Insurance

***Underwritten by
General Electric Capital Assurance Company***



GE Financial
We bring good things to life.

This Application can be used for:

- ♦ one applicant applying for one policy — (USE INDIVIDUAL BENEFIT COVERAGE SELECTION PAGE)
- ♦ a couple applying for separate policies — (USE INDIVIDUAL BENEFIT COVERAGE SELECTION PAGE)

You may want to complete section **B** before sections **I** and **A**. (Any applicant answering 'YES' to any part of Section **B** is uninsurable.)

Be sure all sections of the application are *fully* completed. Incomplete applications cause delays and may be returned.

APPLICATION INSTRUCTIONS

I COVERAGE SELECTION

Preferred Health Discount of 10% is given if applicant accurately answers NO to questions 1 through 10.

Couples Discount: Applicants who are married are eligible for a 25% discount. Also eligible are partners or family members who live together and share basic living expenses and who are not married to each other or anyone else and do not belong to different generations of the same family. "Requirements to Access Special (Spousal) Benefits" form must be submitted.

Applications must be submitted together or within 12 months of each other.

If eligible for both Couples and Preferred Health Discounts, take 35% off the total premium.

Full Modal Premium: Full premium for the Premium Payment Mode selected must be submitted with application or both application and premium will be returned; unless EFT is chosen then a minimum of 3 month's premium must be submitted.

A APPLICANT INFORMATION

Print complete applicant's name as it should appear on the policy, and provide *all* other requested information.

B INSURABILITY PROFILE

Many applicants confuse Medicaid and Medicare. Ask if they have a Medicaid card. We cannot insure those covered by Medicaid.

C MEDICAL PROFILE

If you need more room to write, use section **II "Additional Notes"** on page **A-b** for *Individual Benefit*.

D PERSONAL PROFILE

To help us gain a perspective on the general health and activity level of the applicant, please provide as much information as possible.

F AUTHORIZATIONS

Please ensure applicant(s) read and understand these statements, check appropriate selections, and sign and date.

G AGENT'S REPORT

This information is needed to process the application. It is **not** part of the application that is included with the issued policy.

61231L

UNDERWRITING REQUIREMENTS

Agent: Your assistance is needed in requesting these items.

| AGE | Medical Records (MRR) | Telephone Interview | In-Person Health Interview | Physician's visit within last 2 years* |
|--|-----------------------|---------------------|----------------------------|--|
| < 54 and eligible for health discount. Only the application is required. | | | | |
| < 54 | ● | | | |
| 55-64 and eligible for health discount. | | ● | | |
| 55-71 | ● | | | |
| 72-79 | ● | | ● | |
| 80-84 | ● | | ● | ●* |

* Do not take an application from individuals 80 to 84 years of age who have not had a physician's visit in the last two years.

Note: Additional requirements may be requested at the underwriter's discretion.

MEDICAL RECORDS REQUEST (MRR) FORM

- Complete a separate MRR for the applicant's primary physician (if seen in the last two years).
- **Do not** order MRRs for: specialists, dentists, optometrists, chiropractors, ophthalmologists, dermatologists, podiatrists, or allergists.
- Obtain required applicant signature.
- Make sure all information is complete and legible.
- Fax immediately to PMSI: **1-800-876-8329**. (☑ Check 'fax box' on MRR)
- Submit original with application.

TELEPHONE AND IN-PERSON INTERVIEWS

For applicants who require either interview, you will need to:

- Complete the *Family Caring Network* Interview Assessment Request
- Fax to: **1-800-233-3783**. (☑ Check 'fax box' on request form)
- Submit original with application.

Please advise applicants of the importance of these interviews, what is required, and who will be contacting them. Separate brochures explain both interviews in detail.

In-Person Health Interview:

- Interviews are paid for by GE Capital Assurance.

Telephone Interview:

- This is a shortened version of the In-Person Interview.
- Includes a brief cognitive exercise.
- Takes approximately 15 minutes.

61229

SUBMIT TO HOME OFFICE

Use this checklist to help ensure that you send in all necessary information.

- | | | |
|--|---|---|
| <input type="checkbox"/> Application — <i>fully completed</i> | <input type="checkbox"/> A Check for Full Modal Premium | <input type="checkbox"/> Suitability form (when required) |
| <input type="checkbox"/> Medical Records Request (MRR) | <input type="checkbox"/> Replacement Notice (when required) | <input type="checkbox"/> State specific forms (when required) |
| <input type="checkbox"/> Requirements to Access Special (Spousal) Benefits form (for Individual Benefit Coverage only) | | |

61217

INDIVIDUAL BENEFIT

1 COVERAGE SELECTION

Applicant A

Printed name and age: _____ Age _____

Applicant B

Printed name and age: _____ Age _____

| | | | |
|--|---|---|--|
| Daily Payment Maximum \$ _____ | | Benefit Multiplier <input type="checkbox"/> Unlimited <input type="checkbox"/> 2190 <input type="checkbox"/> 1460 <input type="checkbox"/> 1095 <input type="checkbox"/> 730 | |
| Elimination Period <input type="checkbox"/> 50 days <input type="checkbox"/> 100 days | Nonforfeiture Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No | Restoration of Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | | |
|--|---|---|--|
| Daily Payment Maximum \$ _____ | | Benefit Multiplier <input type="checkbox"/> Unlimited <input type="checkbox"/> 2190 <input type="checkbox"/> 1460 <input type="checkbox"/> 1095 <input type="checkbox"/> 730 | |
| Elimination Period <input type="checkbox"/> 50 days <input type="checkbox"/> 100 days | Nonforfeiture Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No | Restoration of Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Inflation Protection / Benefit Increases
 5% Compound Increases 5% Equal Increases No Increases

Inflation Protection / Benefit Increases
 5% Compound Increases 5% Equal Increases No Increases

Eligible for Preferred Health Discount Must accurately answer NO to all of questions 1 through 10.
 Yes No

If the medical history of the applicant is found to be inconsistent with the answers to the application questions referred to in this section, the company reserves the right to adjust the premium accordingly.

Eligible for Preferred Health Discount Must accurately answer NO to all of questions 1 through 10.
 Yes No

If the medical history of the applicant is found to be inconsistent with the answers to the application questions referred to in this section, the company reserves the right to adjust the premium accordingly.

Eligible for Couples Discount Criteria must be met. See Instructions.
 Yes No

If YES and second applicant is applying on this application, no further information is needed. If second applicant is not applying on this application, please provide the following.

Eligible for Couples Discount Criteria must be met. See Instructions.
 Yes No

If YES and second applicant is applying on this application, no further information is needed. If second applicant is not applying on this application, please provide the following.

Name: _____

Name: _____

Social Security Number: _____ - _____ - _____

Social Security Number: _____ - _____ - _____

Existing Policy Number: _____

Existing Policy Number: _____

Premium Payment Mode
 Annual Semi-Annual Quarterly Monthly *
 * Automatic draft of checking account required. Must complete EFT section.

Premium Payment Mode
 Annual Semi-Annual Quarterly Monthly *
 * Automatic draft of checking account required. Must complete EFT section.

Submitted Full Modal Premium **Replacement**
 \$ _____ Is this to replace an existing policy with us?
 Yes No

Submitted Full Modal Premium **Replacement**
 \$ _____ Is this to replace an existing policy with us?
 Yes No

| | | | | | | | | | | | | | |
|-------------------|--|--|--|--|--|--|--|--|--|--|--|---|---|
| Agent Name: _____ | Agent Producer Code (Required): <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> | | | | | | | | | | | State in which application is signed: _____ | For Internal Use Cell Code: _____ LTCI-49165 |
| | | | | | | | | | | | | | |

Request for an Effective Date later than the Date of Application: I hereby request that, if my application is approved, no insurance will take effect until the date set by the Company following its approval of my application. I understand that the Company's underwriting decision will consider any changes in my health status that take place after the Date of Application and that the Initial Premium will be applied as of the Effective Date set by the Company.

Signature of Applicant **A** _____ Signature of Applicant **B** _____

ELECTRONIC FUNDS TRANSFER AUTHORIZATION (EFT) Enclose a blank voided check (not a deposit slip) for the account from which deductions will be made, and a valid check for one month's premium.

I AUTHORIZE General Electric Capital Assurance Company to make deductions from my bank account for payment of premiums. I understand that: (1) General Electric Capital Assurance Company shall not incur any liability on a draft returned by the bank; (2) amounts not clearing after their initial deposit shall constitute non-payment of premium and coverage under the contract shall lapse subject to its provisions; and (3) each monthly deduction will occur on or after the date which coincides with the policy effective date.

| | |
|--|--|
| Applicant A / Bank Account Holder's Name | Applicant B / Bank Account Holder's Name |
| X Applicant A / Bank Account Holder's Signature | X Applicant B / Bank Account Holder's Signature |
| _____ | _____ |
| Date | Date |

INDIVIDUAL BENEFIT

Use this page only if you need more room to provide information requested in the Medical Profile.

II ADDITIONAL NOTES

Print Name of Applicant A _____ Print Name of Applicant B _____

Signature of Applicant A _____ Signature of Applicant B _____

Date: _____ Date: _____

DETAILS for YES answers. Provide condition, reason consulted/treated, dates from/to, and name, address and phone # of Health Care Professional/Facility. For medications, please provide only the name and reason for taking.

Details for Applicant A
Ques.#

Details for Applicant B
Ques.#

Form with horizontal lines for writing details for Applicant A and Applicant B.

If you need more room to write, use a separate signed and dated sheet, and check here:

General Electric Capital Assurance Company

Administrative Office: 1650 Los Gamos Dr., San Rafael, CA 94903

APPLICATION For Insurance

A APPLICANT A INFORMATION * Print Clearly - Use Black Ink

APPLICANT B INFORMATION

Mr. Mrs. Miss Ms. Other Title: _____
 Married Single Widowed

Mr. Mrs. Miss Ms. Other Title: _____
 Married Single Widowed

Name _____
(as it should appear on your policy)

Name _____
(as it should appear on your policy)

Social Security Number _____

Social Security Number _____

Birthdate ____/____/____ Age _____ Birthplace (state) _____

Birthdate ____/____/____ Age _____ Birthplace (state) _____

Sex: Male Female Height: ft. ____ in. ____ Weight: lbs. _____

Sex: Male Female Height: ft. ____ in. ____ Weight: lbs. _____

Daytime Phone (_____) _____

Daytime Phone (_____) _____

Evening Phone (_____) _____

Evening Phone (_____) _____

Best time to call _____ a.m. p.m.

Best time to call _____ a.m. p.m.

Street Address _____
(No P.O. Box please)

City _____ State _____ Zip _____

B INSURABILITY PROFILE

| Applicant A | | | Applicant B | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|
| YES | NO | | YES | NO |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Are you covered by Medicaid (not Medicare)? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you use a Walker or Wheelchair; Oxygen; Respirator; or Kidney Dialysis; or need assistance or supervision by another person in performing any of the following: Moving in/out of bed or chair; Bathing; Dressing; Eating; Toileting; Bowel/Bladder control; Walking? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Have you had, do you currently have, or in the past 7 years have you ever been medically diagnosed as having any of the following: | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <ul style="list-style-type: none"> • Acquired Immune Deficiency Syndrome (AIDS) • AIDS Related Complex (ARC) • ALS (Lou Gehrig's Disease) • Alzheimer's Disease • Congestive Heart Failure (CHF) <i>in combination</i> with any of the following: Heart Attack or Angina; Emphysema/Chronic Obstructive Pulmonary Disease (COPD); Angioplasty or Heart Surgery; Asthma or Chronic Bronchitis; Diabetes; or Tuberculosis (TB) • Cirrhosis of the Liver • Dementia • Diabetes under treatment with Insulin • Emphysema/COPD <i>in combination</i> with any of the following: current smoking, Congestive Heart Failure (CHF), Asthma, or Chronic Bronchitis • Frequent or persistent Forgetfulness • Memory Loss • Metastatic Cancer (spread from original site/location) • Multiple Sclerosis (MS) • Muscular Dystrophy • Organic Brain Syndrome • Parkinson's Disease • Positive HIV test • Senility • Stroke • Transient Ischemic Attack (TIA) within the past 5 years • TIA <i>in combination</i> with Diabetes or Heart Surgery • TIA two or more times | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. In the past 6 months have you had: Open Heart Surgery; Back or Spine Surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. In the past 4 years have you had Cancer of the: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas, Stomach, or Testes? | <input type="checkbox"/> | <input type="checkbox"/> |

Do NOT complete the application for any applicant answering "YES" to any part of questions 1 through 5.

14. Who is the primary care doctor with most of your medical records?

Applicant A

Applicant B

| | |
|---------------------------------------|---------------------------------------|
| Doctor's Name _____ | Doctor's Name _____ |
| Address _____ | Address _____ |
| City, State, Zip _____ | City, State, Zip _____ |
| (_____) _____ | (_____) _____ |
| Phone No. _____ | Phone No. _____ |
| Date last seen (month/day/year) _____ | Date last seen (month/day/year) _____ |
| Reason last seen _____ | Reason last seen _____ |

① PERSONAL PROFILE

| Applicant A | | | Applicant B | |
|--|--------------------------|---|--------------------------|--------------------------|
| YES | NO | | YES | NO |
| <input type="checkbox"/> | <input type="checkbox"/> | A. Do you work 20 or more hours a week outside your home? If YES, list occupation. | <input type="checkbox"/> | <input type="checkbox"/> |
| Applicant A: _____ | | Applicant B: _____ | | |
| Employer: NOT REQUIRED | | Employer: NOT REQUIRED | | |
| <input type="checkbox"/> | <input type="checkbox"/> | B. Do you perform volunteer work? If YES, list type of work and if full-time or part-time. | <input type="checkbox"/> | <input type="checkbox"/> |
| Applicant A: _____ <input type="checkbox"/> full <input type="checkbox"/> part | | Applicant B: _____ <input type="checkbox"/> full <input type="checkbox"/> part | | |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Do you have any hobbies, interests, or participate in any outside activities on a regular basis? If YES, please describe. | <input type="checkbox"/> | <input type="checkbox"/> |
| Applicant A: _____ | | Applicant B: _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you drive an automobile? If YES, provide approximate annual mileage: | <input type="checkbox"/> | <input type="checkbox"/> |
| Applicant A: _____ | | Applicant B: _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Are you receiving disability income, worker's compensation or any state or Social Security Disability Benefits? If YES, explain type and cause: | <input type="checkbox"/> | <input type="checkbox"/> |
| Applicant A: _____ | | Applicant B: _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Do you live in some form of a residential retirement community? If YES, list the specific services that you receive (e.g., housekeeping, laundry, meals): | <input type="checkbox"/> | <input type="checkbox"/> |
| Applicant A: _____ | | Applicant B: _____ | | |

② OTHER COVERAGE AND REPLACEMENT

| | | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 19A. Do you have any accident and sickness or Long Term Care insurance policy or certificate (including health care service contract, health maintenance organization contract, or life insurance based Long Term Care coverage) in force or applied for? If YES, give details below. Applicant A _____ Applicant B _____ Company: _____ Company: _____ Long Term Care? <input type="checkbox"/> No <input type="checkbox"/> Yes – Daily Benefit: \$ _____ Long Term Care? <input type="checkbox"/> No <input type="checkbox"/> Yes – Daily Benefit: \$ _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| | | B. If you have Long Term Care coverage with us, please list policy/certificate number(s): Applicant A _____ Applicant B _____ Policy/certificate number(s): _____ Policy/certificate number(s): _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Did you have another Long Term Care insurance policy/certificate in force during the last 12 months? If YES, with which company? Applicant A _____ Applicant B _____ Company: _____ Company: _____ If that insurance lapsed, when did it lapse? Applicant A _____ Applicant B _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | D. Did you have another Long Term Care application denied during the last 12 months? If YES, with which company? ... Applicant A _____ Applicant B _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Print Name of Applicant A _____ Print Name of Applicant B _____

| | | |
|--|---|--|
| Applicant A YES NO <input type="checkbox"/> <input type="checkbox"/> | <input checked="" type="checkbox"/> Do you intend to replace <i>any</i> of your long term care, medical, or health insurance coverage with this policy? If YES, name insurer being replaced: | Applicant B YES NO <input type="checkbox"/> <input type="checkbox"/> |
|--|---|--|

Applicant A _____ Applicant B _____

Agent: If YES, be sure to fill out the Replacement Notice. Leave one copy with applicant; send one copy with application.

Ⓢ AUTHORIZATIONS

PROTECTION AGAINST UNINTENTIONAL LAPSE: I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Check only one box. If selecting this option, we recommend designating someone other than a spouse or agent.

Applicant A

Use for Individual Applications

I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:
Mr. Mrs. Miss Ms. Other Title: _____

Full Name _____ Relationship _____

Home Address _____

City, State, Zip _____ Phone:(_____) _____

I elect NOT to designate any person to receive such notice.

Applicant B

Use for Individual Applications only

I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:
Mr. Mrs. Miss Ms. Other Title: _____

Full Name _____ Relationship _____

Home Address _____

City, State, Zip _____ Phone:(_____) _____

I elect NOT to designate any person to receive such notice.

REJECTION OF COMPOUND INFLATION PROTECTION: *Check box only if you have selected no, or equal, benefit increases.*

Applicant A

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed plans offering compound, equal and no increases, and I reject compound inflation protection.

Applicant B

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed plans offering compound, equal and no increases, and I reject compound inflation protection.

BENEFITS AND COSTS EXPLAINED: I have been informed of my rights to designate a person to receive any notice of lapse or termination; to purchase Inflation Protection, Home Care Benefits, and the Nonforfeiture Benefit. The Benefits and Costs of each of these options have been fully explained to me.

X _____
Signature of Applicant A

X _____
Signature of Applicant B

No agent is authorized to: change, waive, or alter the terms and conditions of this application; accept risks; pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements.

AUTHORIZATION: I authorize General Electric Capital Assurance Company, its insurance support organizations (such as PMSI), affiliates, and any reinsurers, to obtain information as to the diagnosis, treatment or prognosis of my physical and mental condition, other coverage and any other information needed to evaluate my application for insurance. Upon presentation of this authorization, or copy of it, they may obtain such information or records thereof from any physician, health professional, hospital, clinic, Veterans Administration or other medical or medically related facility, care provider or evaluator, insurance company, consumer reporting agency or insurance support organization or other person or organization which has such information. The Company and its reinsurers may also obtain such information from the Medical Information Bureau. This authorization includes information about drugs, alcoholism, and mental illness. I understand and agree that the Company or its representatives may conduct a phone or in-person interview as part of the underwriting process. I agree that this authorization will be valid for 24 months from the date signed, and know that I or my authorized representative may have a photocopy of it.

RECEIPT: I have received and read the Privacy Notice. When I applied for insurance under this policy to be issued by General Electric Capital Assurance Company, I also received the Outline of Coverage and the applicable Shopper's or Buyer's Guide.

AGREEMENT: I agree that: 1) the answers contained herein are full, complete and true to the best of my knowledge and belief; and 2) this application will be part of the policy for which I am applying; and 3) no insurance will take effect under the policy for which I am applying: (a) until this application is approved by the Company; (b) unless the first premium is paid; (c) prior to the effective date which is established by the Company; and (d) if an answer given to any numbered question on this application changes materially after the date this application is signed but prior to the date this application is approved by the Company.

CAUTION: If your answers on this application are incorrect or untrue, General Electric Capital Assurance Company may have the right to deny benefits or rescind your insurance.

X _____
Signature of Applicant A

Date Signed

X _____
Signature of Applicant B

Date Signed

X _____
Signature of Licensed and Appointed Agent

G AGENT'S REPORT

To ensure against delays in processing please provide complete details.

| | |
|--------------------------|--------------------------|
| Applicant A | |
| YES | NO |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

| | |
|--------------------------|--------------------------|
| Applicant B | |
| YES | NO |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

1. Did you personally interview the applicant face to face and witness his or her signature? If NO, give details:
 Applicant A: _____ Applicant B: _____
2. Did you observe any physical or mental impairments with walking or talking, or any form of tremor? If YES, please explain.
 Applicant A: _____ Applicant B: _____

3. List other health insurance policies sold by you to the applicant:
 Applicant A: _____ Applicant B: _____

4. List health insurance policies sold by you to the applicant in the last five years that are no longer in force:
 Applicant A: _____ Applicant B: _____

AGENT INFORMATION

Name of Licensed and Appointed Insurance Producer (Please print)

Street Address

Social Security No. or Tax ID of Licensed and Insurance Producer

City, State, Zip

X

Signature of Licensed and Insurance Producer

()

Phone No.

()

Fax No.

Email Address of Licensed and Insurance Producer

**NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT AND
SICKNESS OR LONG TERM CARE INSURANCE**

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE. According to your application, you intend to lapse or otherwise terminate existing long term care or health insurance and replace it with an individual long term care insurance policy issued by General Electric Capital Assurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care insurance coverage is a wise decision.

STATEMENT TO APPLICANT(S) BY AGENT: (Use additional sheets as necessary) I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. The policy has no exclusion for pre-existing conditions. This means that health conditions which you may presently have are fully and immediately covered under the new policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. The policy you are applying for has no such pre-existing conditions or probationary periods.
3. If you are replacing existing long-term care insurance, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after you have thought about it, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

| | |
|---|---|
| Signature of Insurance Producer, Broker, or other Representative <input checked="" type="checkbox"/> | Type Name and Address of Insurance Producer, or other Representative or Broker. |
|---|---|

| | | |
|--|---|---------------|
| Signature of Applicant A <input checked="" type="checkbox"/> | The above "Notice to Applicant" was delivered to me on: | Date / / |
|--|---|---------------|

| | | |
|--|---|---------------|
| Signature of Applicant B <input checked="" type="checkbox"/> | The above "Notice to Applicant" was delivered to me on: | Date / / |
|--|---|---------------|

General Electric Capital Assurance Company

Administrative Office:

1650 Los Gatos Drive

San Rafael, California 94903-1899

**NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT AND
SICKNESS OR LONG TERM CARE INSURANCE**

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE. According to your application, you intend to lapse or otherwise terminate existing long term care or health insurance and replace it with an individual long term care insurance policy issued by General Electric Capital Assurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care insurance coverage is a wise decision.

STATEMENT TO APPLICANT(S) BY AGENT: (Use additional sheets as necessary) I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. The policy has no exclusion for pre-existing conditions. This means that health conditions which you may presently have are fully and immediately covered under the new policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. The policy you are applying for has no such pre-existing conditions or probationary periods.
3. If you are replacing existing long-term care insurance, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after you have thought about it, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

| | |
|---|---|
| Signature of Insurance Producer, Broker, or other Representative <input checked="" type="checkbox"/> | Type Name and Address of Insurance Producer, or other Representative or Broker. |
|---|---|

| | | |
|--|---|------------------|
| Signature of Applicant A <input checked="" type="checkbox"/> | The above "Notice to Applicant" was delivered to me on: | Date / / |
|--|---|------------------|

| | | |
|--|---|------------------|
| Signature of Applicant B <input checked="" type="checkbox"/> | The above "Notice to Applicant" was delivered to me on: | Date / / |
|--|---|------------------|

1 PREMIUM RECEIPT AND CONDITIONAL INSURANCE AGREEMENT

General Electric Capital Assurance Company

Administrative Office: P.O. Box 2080, San Rafael, CA 94903

(Herein called "We", "Us", and "Our")

RECEIPT FOR INITIAL PREMIUM: This acknowledges receipt of the initial premium to be applied in connection with your application to Us for long term care insurance. We will return your premium payment if we do not approve your application. This receipt will be void and of no effect if your check is not payable to GE Capital Assurance or is not paid upon presentation.

Make check payable to GE Capital Assurance. Do not pay cash or leave the payee blank.

| | | | |
|---|------------------|---|------------------|
| Print Name of Applicant A | Application Date | Print Name of Applicant B | Application Date |
| Initial Premium (Minimum 3 months premium) | \$ _____ | Initial Premium (Minimum 3 months premium) | \$ _____ |
| Printed Name of Insurance Producer | | Insurance Producer's Business Address & Phone Number (please print) | |
| Signature of Insurance Producer | Date Signed | | |
| X | | | |

If you requested an Effective Date that is later than your Application Date, the following Agreement will not apply and Our underwriting will consider any changes in your health status which occur after the Application Date.

AGREEMENT: This Agreement applies only if all of the following requirements have been satisfied:

1. You submit your check payable to GE Capital Assurance for the Initial Premium set forth above; and
2. You did not request in writing, an Effective Date that is later than your Application Date; and
3. You accurately answered NO to all parts of questions #1 through #5 in the application; and
4. The answers in the application accurately indicate that:
 - A. Within the past 5 years you HAD NOT: received medical advice or treatment, been medically diagnosed, or consulted with a health professional for any of the following: Brain Disorders, Convulsions, Seizures, Fainting Spells, Black Outs, Mental Illness, or Paralysis.
 - B. Within the past 3 years you HAD NOT: been medically advised to have surgery that has not been performed; or received home health care; or been medically advised to enter or been confined to a nursing home, assisted care facility, or other long term care facility.
- 5 NO material misrepresentation or misstatement was made in the application.

When all of these requirements are satisfied, you and We agree that:

1. In underwriting your application We may conduct a telephone or personal interview to determine your health status as of the Application Date. We will not disapprove your application based on any change in your health status that occurs after the Application Date.
2. If We approve your application, We will provide insurance under the policy for which application was made, and the Policy will be Effective as of the Application Date.

No applicant, insurance producer or representative has any power or authority to change any of the provisions of this Agreement.

61232L

1 PRIVACY NOTICE

Although your application is our initial source of information, we also collect information pertaining to your health history through copies of your medical records and may conduct telephone or in-person interviews.

Information regarding your insurability will be treated as confidential. General Electric Capital Assurance Company, its affiliates or its reinsurer(s) may collect information from the Medical Information Bureau, a non-profit organization of life insurance companies, which provides an information exchange for its members. If you apply for coverage or file a claim with another Bureau member company, the Bureau, upon request, will supply the company with information in its file. At your request, the Bureau will arrange disclosure to you of the information in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of the information, you may seek a correction in accordance with the Federal Fair Credit Reporting Act, and by contacting the

Bureau at: P.O. Box 105, Essex Station, Boston, MA 02112, (617) 426-3660.

The company, its affiliates, or its reinsurer(s) may also release information in its file to other insurance companies to whom you submit a claim, provided you have authorized them to obtain such information. Upon your written request, we will provide you with information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. Should you wish to request correction, amendment or deletion of any information in our file which you believe is inaccurate, please contact us and we will advise you of the necessary procedures.

For more information about any of the above, please write to:

General Electric Capital Assurance Company
Administrative Office
P.O. Box 2080 / 1650 Los Gatos Drive
San Rafael, California 94903

61221

General Electric Capital Assurance Company

A GE Financial Assurance company
Administrative Office: 1650 Los Gamos Drive
San Rafael, California 94903-1899
Phone 1-800-456-7766

LONG TERM CARE INSURANCE OUTLINE OF COVERAGE For Policy Form 7035AT

Complete and Retain
for Your Records

NOTICE TO BUYER: The policy may not cover all costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

CAUTION: The issuance of this long term care insurance policy is based upon your responses to the questions on your application. A copy of your application will be attached to your issued policy. If your answers are incorrect or untrue, the company may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address:

1650 Los Gamos Drive, San Rafael, California 94903-1899.

1. POLICY DESIGNATION

This is an individual policy of insurance.

2. PURPOSE OF OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY (OR CERTIFICATE) CAREFULLY.**

3. FEDERAL TAX CONSEQUENCES

The policy is intended to be a qualified long term care insurance contract under Section 7702B (b) of the Internal Revenue Code of 1986, as amended.

4. TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of the policy, to continue this policy as long as you pay your premiums on time. General Electric Capital Assurance Company cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

As described in the Waiver of Premium Benefit, the policy includes a waiver for premiums that become due while continuing benefits are payable under: (a) the Long Term Care Facility Benefit; or (b) the Home Care Benefit after a qualifying period has been satisfied; or (c) the Home Care Benefit under a Plan of Care from a Privileged Care Coordinator.

Premiums can be changed based on premium class; but only if they are changed for all similar policies issued in your state on the same policy form.

5. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED

If you are not satisfied with the policy, you have 30 days to return it to the company. All premiums paid will be returned within 30 days after return of the policy or denial of the application. The policy contains a provision for the refund of unearned premium in the event of termination due to death. It also provides for refund of unearned premium upon surrender or cancellation of the policy.

6. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

It is not designed to fill the 'gaps' of Medicare. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the insurance company. Neither General Electric Capital Assurance Company nor its insurance producers represent Medicare, the federal government or any state government.

7. LONG TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as a nursing home, in the community or in the home.

This policy reimburses you for covered long term care expenses incurred by the Insured Person. It is subject to limitations, elimination periods, coinsurance and other requirements.

8. BENEFITS PROVIDED BY THIS POLICY

Applicant(s) _____

| | | |
|-------------------------|--|--|
| Daily Payment | | |
| Maximum | \$ _____ | \$ _____ |
| Benefit Multiplier | _____ | _____ |
| Lifetime Payment | _____ | _____ |
| Maximum | _____ | _____ |
| Elimination Period | _____ Days | _____ Days |
| | (Only for the Long Term Care Facility Benefit) | |
| Benefit Increases | _____ | _____ |
| Nonforfeiture Benefit | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Restoration of Benefits | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | _____ | _____ |
| | _____ | _____ |

BENEFIT ELIGIBILITY: For the Insured Person to be eligible for Benefits provided by the policy, we must receive ongoing proof, including a Current Eligibility Certification, which demonstrates,

based on information from care providers, personal physicians and other Licensed Health Care Practitioners, that the covered care is needed due to the Insured Person being a chronically ill individual which means that he or she continually:

- is unable to perform, without Substantial Assistance (either standby assistance or hands-on assistance) from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity. In addition, this loss of functional capacity must, at first, be expected to exist for a period of at least 90 days; or
- requires Substantial Supervision to protect oneself from threats to health and safety due to Severe Cognitive Impairment.

A "Current Eligibility Certification" is a Licensed Health Care Practitioner's written certification, made within the preceding 12 month period, that the Insured Person meets the above requirements.

"Activities of Daily Living" are bathing, dressing, eating (taking nourishment), continence (control of bowel and bladder functions), toileting and transferring (moving in and out of a bed, chair or wheelchair).

"Substantial Assistance" is either:

- "Hands-on Assistance" which means the physical assistance (minimal, moderate or maximal) of another person without which the Insured Person would be unable to perform the Activity of Daily Living; or
- "Standby Assistance" which means the presence of another person within arm's reach of the Insured Person that is necessary to prevent, by physical intervention, injury to the Insured Person while he or she is performing the Activity of Daily Living.

"Severe Cognitive Impairment" means a loss or deterioration in intellectual capacity that:

- is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and
- is measured by clinical evidence and standardized tests that reliably measure impairment in the person's: short-term or long-term memory; orientation as to people, places, or time; and deductive or abstract reasoning.

"Substantial Supervision" means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired person from threats to his or her health or safety (such as may result from wandering).

CONDITIONS: Benefits will be paid only as reimbursement for expenses the Insured Person incurs for care and services that:

- meet the requirements for payment in accordance with the Benefits and other provisions of the policy; and
- are received pursuant to his or her Plan of Care as prescribed by a Licensed Health Care Practitioner; and
- are received while his or her insurance is in force or while covered in accordance with the Extension of Benefits provision.

Benefit payments are subject to: the Elimination Period requirements; the applicable Daily Payment Maximum and Lifetime Payment Maximum; and all other provisions of the policy.

The "Daily Payment Maximum" is the daily limit on the combined total for all benefit payments provided the Insured Person under: the Respite Care Benefit; the Long Term Care

Facility Benefit; and the Bed Reservation Benefit. It is also used to determine other Benefit limits. This amount increases over time in accordance with any Benefit Increases that apply.

The "Elimination Period" is the number of days for which the Insured Person must incur expenses that qualify for payments under the Long Term Care Facility Benefit; but for which we will NOT pay benefits. It can be satisfied either by:

- days for which payment would otherwise be made under the Long Term Care Facility Benefit (including Bed Reservation Benefit days); or
- days the Insured Person receives services covered under the Home Care Benefit in accordance with a Privileged Care Coordinator's Plan of Care.

Days used to satisfy the Elimination Period do not need to be consecutive. Once the Insured Person has satisfied this requirement, he or she will never have to satisfy a new Elimination Period for the policy.

The "Lifetime Payment Maximum" is the combined total amount we will pay as Benefits under the policy. It is determined by multiplying the Daily Payment Maximum by the applicable Benefit Multiplier. When Benefit Increases apply, this increases over time.

A "Licensed Health Care Practitioner" is any of the following who is not a family member: a physician (as described in section 1861(r)(1) of the Social Security Act); a registered professional nurse; a licensed social worker; or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

A "Nurse" is a licensed Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN).

A "Plan of Care" is a written, up-to-date, individualized plan for care and support services for a person that:

- Has been developed as a result of an assessment and incorporates any information provided by his or her personal physician; and
- Has been prescribed by a Licensed Health Care Practitioner; and
- Fairly, accurately and appropriately addresses his or her long term care and support service needs; and
- Specifies: the type, frequency and duration of all services required to meet those needs; the providers appropriate to furnish those services; and an estimate of the cost of such services.

PRIVILEGED CARE COORDINATION SERVICES: This is an option the Insured Person may choose to use. These services are intended to help identify care needs and community resources available to deliver that care.

We will pay for the services described herein when a Privileged Care Coordinator provides them to the Insured Person while his or her insurance is in force under the policy. This payment will be at our expense; and will NOT count against any policy maximum.

When the Insured Person chooses to use these services, the Privileged Care Coordinator will:

- Meet with the Insured Person in his or her home to obtain a full understanding of the person's unique situation and condition. Based on that information the Privileged Care Coordinator will develop and prescribe a Plan of Care appropriate for the Insured Person's needs. This includes care in the home and in the community.
- Provide the initial and ongoing Current Eligibility Certifications.

- Suggest a variety of formal and informal care and support service providers. This may include negotiating service and care provider rates for the Insured Person; and identifying other financial resources available to meet the needs specified in the Plan of Care.
- Help with the completion of claims forms required to obtain payment under the policy.
- Assist with implementing the Plan of Care by scheduling and coordinating the care and support service providers chosen by the Insured Person.
- Monitor the care and support services being received. This will include periodic re-assessments to determine revisions to the Plan of Care warranted by changing needs.

A “Privileged Care Coordinator” is a Licensed Health Care Practitioner designated by us to assist the Insured Person in identifying his or her long term care needs and how to match those needs with the available care and service providers and resources. Privileged Care Coordinators are professionals whose duties are: to gather objective information specific to each person’s circumstances; to use the information gathered to customize that person’s Plan of Care; and to make recommendations for providers that can deliver the needed care and services.

Privileged Care Coordinators are familiar with the care and service providers available in your area. Those providers vary greatly from skilled professionals to lay caregivers, based on the degree and type of assistance needed. Privileged Care Coordinators will help identify qualified caregivers that are acceptable to the Insured Person and his or her family. In all cases, the Insured Person is responsible for choosing the actual care and service providers to be used. If for any reason the Insured Person is not satisfied with a care or service provider, he or she may request that the Privileged Care Coordinator identify other providers from which to choose.

Additional Feature: When the Insured Person uses a Privileged Care Coordinator’s Plan of Care, the Elimination Period for the Long Term Care Facility Benefit is reduced by the number of days for which Home Care Benefits are paid; and the monthly Waiver of Premium Benefit is activated.

HOME CARE BENEFIT: We will pay the Prevailing Expenses the Insured Person incurs for the following care and support services that are consistent with his or her Plan of Care and are received other than while he or she is in a Long Term Care Facility:

Licensed providers

- Health care services provided by a Nurse, or a licensed physical, occupational, respiratory or speech therapist.

Other personnel

- Home Health Aide and Personal Care Attendant Services. This is assistance with tasks necessary to, or consistent with, the Insured Person’s ability to remain safely at home. It may include: simple health care tasks; personal hygiene; help in performing Activities of Daily Living; managing medications; and other related supportive tasks. Providers of these services may be independent and do not need to be affiliated with a home health care agency.
- Homemaker Services. This is assistance with managing and maintaining a household when the Insured Person is no longer capable of those activities. This may include: preparing meals; doing laundry; and doing incidental household tasks.

- Chore Services. This is assistance a person provides with light work or household tasks the Insured Person would normally perform. This is limited to assistance provided when: the Insured Person is no longer capable of performing the work or tasks (because of his or her need for assistance); and they are necessary to or consistent with the Insured Person’s ability to remain safely at home. This may include such activities as: simple household repairs; taking out the garbage; and related tasks that do not require the services of a trained aide or attendant.

Community Care

- Adult Day Care. This is a program providing social and health related services provided during the day in a community group setting outside the home.
- Covered Hospice Care. The following items of Hospice Care not otherwise covered by other benefits in the policy and provided in accordance with a Hospice Care Program:
 - 30 days of inpatient care (this is a lifetime limit);
 - part-time nursing care by or supervised by a registered graduate nurse;
 - counseling, including dietary counseling, for the Terminally Ill insured;
 - family counseling for the immediate family (spouse, parents, siblings, grandparents, and children of the Terminally Ill insured) and the family caregiver (a relative by blood, marriage or adoption who lives with or is the primary caregiver of the Terminally Ill insured) before the death of the Terminally Ill insured;
 - Respite Care subject to a 5 consecutive day limit for each inpatient stay and a Policy Year maximum of 14 days; and
 - medical supplies, equipment and medication required to maintain the comfort and manage the pain of the Terminally Ill insured.

“Hospice Care Program” is a coordinated, inter-disciplinary program of hospice care and services for meeting the special physical, psychological, spiritual and social needs of Terminally Ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement prior to your death and meets all of the following criteria: part-time nursing care by or supervised by a Registered Graduate Nurse (RN); counseling, including dietary counseling for you; family counseling; and medical supplies, equipment and medication required to maintain the comfort and manage the pain of the Terminally Ill insured.

“Terminally Ill” is having a medical prognosis given by a physician that the Insured Person’s life expectancy is 6 months or less.

We will pay this Benefit on a monthly basis. The total amount we will pay for all such expenses which are incurred during a calendar month will not exceed 31 times the Daily Payment Maximum.

The payment of this Benefit is not subject to the Elimination Period. However, days the Insured Person receives services covered under this Benefit in accordance with a Privileged Care Coordinator’s Plan of Care will be used to satisfy his or her Elimination Period for the Long Term Care Facility Benefit.

RESPITE CARE BENEFIT: Subject to the Daily Payment Maximum, we will pay the Prevailing Expenses an Insured Person incurs for the first 21 days of Respite Care he or she receives during a

Policy Year. Respite Care is short term care provided in order to relieve the Insured Person's primary informal (unpaid) caregiver in the Insured Person's home. It can be furnished: in an institution; in the Insured Person's home; in the home of the primary caregiver; or at a community-based program. The payment of this Benefit is not subject to, nor will it satisfy, any Elimination Period.

CAREGIVER TRAINING BENEFIT: We will pay the Prevailing Expenses the Insured Person incurs for training an informal (unpaid) caregiver to care for the Insured Person in his or her home. All of the following conditions apply to such payment:

- We will not pay for training provided to someone who will be paid to care for the Insured Person.
- The training cannot be received while the Insured Person is confined in a hospital or Long Term Care Facility; unless it is reasonably expected that the training will make it possible for the Insured Person to go home where he or she can be cared for by the person receiving the training.

This Benefit is not subject to a daily or monthly payment maximum; but the lifetime maximum total amount we will pay with respect to an Insured Person under this Benefit is an amount equal to five (5) times his or her Daily Payment Maximum.

EQUIPMENT BENEFIT: We will pay the Prevailing Expenses the Insured Person incurs for the purchase or rental of Supportive Equipment if: (1) the equipment is intended to assist the Insured Person in living at home or in other residential housing by relieving his or her need for direct physical assistance; and (2) as stated in the Plan of Care, it is expected that the equipment will enable the Insured Person to remain at home or in other residential housing for at least 90 days after the date of purchase or first rental.

"Supportive Equipment" items are: pumps and other devices for intravenous injection; ramps to permit movement from one level of a residence to another; grab bars to assist in toileting; and other mechanical aids. They do not include either: equipment that will, other than incidentally, increase the value of the residence in which it is installed; or artificial limbs, teeth, medical supplies, or equipment placed in the Insured Person's body, temporarily or permanently.

This Benefit is not subject to a daily or monthly payment maximum; but the lifetime maximum total amount we will pay with respect to the Insured Person under this Benefit is an amount equal to 50 times his or her Daily Payment Maximum.

LONG TERM CARE FACILITY BENEFIT: Subject to the Daily Payment Maximum, we will pay the expenses the Insured Person incurs for care and support services (including room and board) provided by a Long Term Care Facility. This includes expenses the Insured Person incurs for private duty nursing care provided in such a facility by a Nurse who is not employed by the facility. The expenses must be consistent with the level of charges normally made for other inpatients receiving similar care in that facility. He or she must be confined in the Long Term Care Facility as a resident inpatient.

A "Long Term Care Facility" is an institution (such as a nursing home, assisted care facility or Alzheimer's facility) which is licensed by the appropriate federal or state agency to engage primarily in providing care and services sufficient to support needs resulting from inability to perform Activities of Daily Living or Severe Cognitive Impairment.

It must also: (a) provide such care and services on a twenty-four hour a day basis; (b) have a trained and ready to respond employee on duty at all times to provide such care and services; (c) provide 3 meals a day and accommodate special dietary needs; (d) have the appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications; (e) have arrangements with a duly licensed physician or Nurse to furnish medical care in case of an emergency; and (f) have accommodations for at least five resident inpatients in one location, unless it has been determined by us, based on information from our Privileged Care Coordinator, that it has the services and facilities required to appropriately address the Insured Person's needs as described in his or her Plan of Care (even with accommodations for less than five resident inpatients).

A Long Term Care Facility is NOT: a hospital or clinic; a subacute care or rehabilitation hospital or unit; a place which operates primarily for the treatment of alcoholism, drug addiction or mental illness; your primary place of residence in an area used principally for independent residential living (including, but not limited to, boarding homes and adult foster care facilities); or a substantially similar establishment.

Note: Medications are included in Covered Hospice Care provided in the Home Care Benefit.

BED RESERVATION BENEFIT: When the Insured Person becomes temporarily absent during a covered Long Term Care Facility stay and is charged to reserve his or her accommodations, we will give the same Elimination Period credit and pay the same benefits you would have received if you had stayed in the Long Term Care Facility.

We will do this for a total of not more than the first 50 days (continuous or not) of such absence during a Policy Year.

SUPPLEMENTARY CARE BENEFIT: (For expenses not otherwise covered; upon approval by us.)

We will pay the Prevailing Expenses the Insured Person incurs for care, treatment, services, supplies or other items not otherwise covered by the policy when:

- they are clearly specified in his or her Plan of Care; and
- the Insured Person, his or her personal physician and we mutually agree that they are cost-effective alternatives to Benefits available under the policy. The agreement to using these alternatives will not waive any of the rights the Insured Person or we have under the policy; and it may be discontinued at any time without affecting the Insured Person's right to the Benefits otherwise available under the policy.

Benefits are not payable for any expenses that:

- are not for qualified long term care services as defined in Section 7702B(c) of the Internal Revenue Code; or
- are incurred prior to the date of mutual agreement; or
- are incurred after the Lifetime Payment Maximum has been reached.

Examples: Examples include, but are not limited to:

- In-home safety devices.
- Home delivered meals.
- Stays in types of facilities not otherwise covered by the policy.
- Additional equipment benefits.
- Rental or lease of emergency medical response devices.
- Other services designed to help the Insured Person remain at home.

WAIVER OF PREMIUM BENEFIT: We will waive premium payments for each coverage month that begins while the Insured Person is receiving either:

- Long Term Care Facility Benefits (after satisfying the Elimination Period); or
- Home Care Benefits after satisfying a qualifying period. The qualifying period is equal, in number, to the number of days in the Elimination Period. The qualifying period will be satisfied by: (a) days used to satisfy the Elimination Period; or (b) days for which Home Care Benefits are received; or (c) any combination of (a) and (b); or
- Home Care Benefits in accordance with a Privileged Care Coordinator's Plan of Care without completing any qualifying period.

This waiver applies to premium payments for the policy and all attached forms. It stops when the Insured Person ceases to receive continuing benefits under the Long Term Care Facility Benefit or the Home Care Benefit. When the waiver stops, we will give credit for any premium paid for periods during which the waiver applied against future premiums then due. You will then be required to pay the pro rata premium needed to return the policy to its previous premium payment mode and continue to pay future premiums as they become due.

SURVIVORSHIP BENEFIT: When the Insured Person's spouse dies after the policy has been in force for at least ten years, no further premium payments will be required for the policy if:

- Both the Insured Person and such spouse continuously had long term care insurance coverage in force with us, other than under a Nonforfeiture Benefit, on the date of death of the spouse and for at least the prior ten year period; and
- Such spouse's coverage included a similar Survivorship Benefit; and
- No long term care benefits were paid or payable by us for the Insured Person or spouse during the first ten years of such concurrent coverage.

OPTIONAL NONFORFEITURE BENEFIT: This is an optional Benefit for which an additional premium is charged. It provides continued coverage in the event the policy terminates (lapses) due to a default in the payment of any premium after it has been in force for at least 5 years. If the lapse occurs while this Benefit is in force, the policy will be continued (without further premium payments) with a reduced Lifetime Payment Maximum. The reduced maximum will be based on: your issue age; the number of years your coverage was in force; and the unused portion of your Lifetime Payment Maximum. This amount will not be reduced by any benefits payable for expenses incurred prior to the lapse.

OPTIONAL RESTORATION OF BENEFITS RIDER: This is an optional rider for which an additional premium is charged. It will restore the policy's Lifetime Payment Maximum to the amount that would have applied if no benefits had been paid under the policy. This applies whenever a period of 180 consecutive days elapses during which the policy was in force and at no time during that period did the Insured Person require, or receive, either: (a) Substantial Supervision to protect himself or herself from threats to health or safety due to Severe Cognitive Impairment; or (b) Substantial Assistance necessary to meet the policy's Benefit Eligibility requirements due to a loss of functional capacity.

9. LIMITATIONS AND EXCLUSIONS

Pre-existing conditions are NOT excluded.

Non-eligible Facilities/Providers: If an institution has multiple licenses or purposes, a portion, ward, wing or unit thereof will qualify as a Long Term Care Facility only if it meets the criteria in the definition of such a facility; is authorized by its license, to the extent that licensing is required by law, to provide such care to inpatients; and is engaged principally in providing not only room and board, but also care and services which meet all of those criteria.

Non-eligible Levels of Care: Coverage is not based on the specific level of care; but is for care furnished, for a specific covered reason, by or through the covered facilities and providers. Care from family members is not covered. "Prevailing Expenses" are expenses, fees or charges actually incurred by the Insured Person which do not exceed the level of charges normally made for similar care, service or other items provided to persons with comparable medical conditions or impairments in the locality where they are received. An expense, fee or charge is considered to be incurred on the day on which the care, service or other item forming the basis for it is received.

Exclusions/Exceptions and Limitations: Benefits are not payable for care, stays, or other items: (a) provided by a family member; (b) when no charge is normally made in the absence of insurance, but this exclusion does not apply to charges made under Medicaid; (c) provided outside of the U.S.A. or its territories or possessions; (d) provided by or in a Veterans Administration or federal government facility, unless a valid charge is made to the Insured Person or such person's estate; (e) resulting from war or act of war; (f) resulting from an attempted suicide or an intentionally self-inflicted injury; (g) provided for alcohol or drug addiction, unless the drug addiction results from administration of those substances in accordance with the advice and written instructions of a duly licensed physician; or (h) for which payment is prohibited by Section 1-302 of the Maryland Health Occupations Article because they are provided by a health care entity as a result of a referral made by a health care practitioner who has (or whose immediate family has) established beneficial interest in or compensation arrangements with the health care entity.

Non-Duplication: Benefits will be paid only for covered expenses that are in excess of the amount paid or payable under Medicare and any other federal, state or other governmental health care plan or law (except Medicaid).

We will consider, for the purposes of satisfying an Elimination Period, days on which the Insured Person incurs expenses that would otherwise qualify as satisfying his or her Elimination Period, but are excluded from coverage because benefits are paid or payable under governmental health care plans or laws as stated above.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

10. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the cost of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. You may choose from two options at the time of application that will increase your benefits every year.

Equal Increases means the daily and lifetime limits will increase by 5% of their original amounts; and *Compound Increases* means the daily and lifetime limits will increase by 5% of the most recent amounts. These increases are not affected by any benefit payments.

Increases will occur on each anniversary of the policy's effective date. Increased amounts will apply to each day benefits are payable on or after the date of the increase. If you do not purchase such a Benefit Increases option, you will need to provide satisfactory evidence of insurability to later increase coverage.

If you elect a Benefit Increase, premiums will be higher; but they will not increase due to a change in age or the automatic benefit increases. Below is a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. A similar graphic comparison illustrates premiums for those types of policies.

11. ALZHEIMER'S DISEASE AND OTHER BRAIN DISORDERS

Once insurance goes into force, coverage is provided if you are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses and meet the Benefit Eligibility requirements.

12. PREMIUM

The following shows: the annual premium for the base policy and any chosen benefit options; your premium payment mode; and the corresponding modal premium.

| | | | |
|----------------------------------|----------|---------------------------------|--|
| Name of Applicant(s) _____ | | Annual Premium | |
| Base Policy | | | |
| (with any automatic increases) | \$ _____ | \$ _____ | |
| Optional Nonforfeiture Benefit | \$ _____ | \$ _____ | |
| Optional Restoration of Benefits | \$ _____ | \$ _____ | |
| Other - _____ | \$ _____ | \$ _____ | |
| _____ | \$ _____ | \$ _____ | |
| Total Annual Premium | \$ _____ | \$ _____ | |
| Your modal premium will be | \$ _____ | \$ _____ | |
| | | to be paid on a/an _____ basis. | |

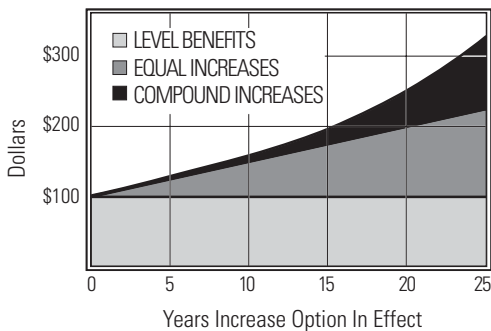
13. ADDITIONAL FEATURES

Applications are subject to medical underwriting; and are approved only if we are provided evidence of insurability which is satisfactory and acceptable to the company. Insurance is not available to those who are 85 years of age or older when applying.

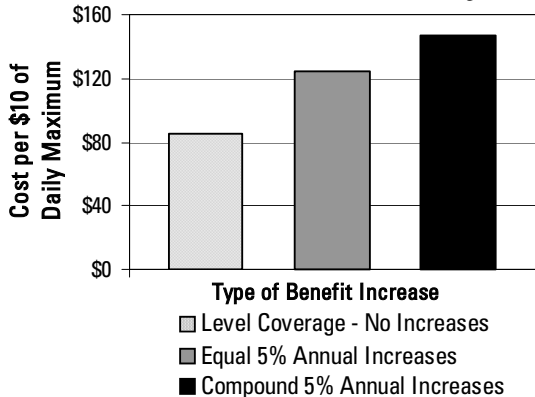
Continuation for Lapse Due to Alzheimer's Disease and Other Forms of Cognitive or Functional Impairment:

We will provide a retroactive continuation of coverage if the policy terminates due to nonpayment of premiums (lapse) and within 7 months after termination we are given proof that the Insured Person met the Benefit Eligibility requirements for any other reason. We must receive proof of his or her impairment or incapacity and all past due premiums within that 7 month period. Any benefits for which the Insured Person qualified during the continuation period will be paid to the same extent they would have been paid if the policy and its riders had remained in force from the date of termination.

Growth of Payment Maximums Over Time



Relative Premium Cost - Issue Age 65



General Electric Capital Assurance Company

Long Term Care Division

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