

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

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 services? Yes No If yes, are hospice services included? Yes No

Type of provider

In your home		In a facility
Informal caregivers <input type="checkbox"/> Friend <input type="checkbox"/> Family member <input type="checkbox"/> Private caregiver	Formal caregivers <input type="checkbox"/> Home care agency <input type="checkbox"/> Home health agency <input type="checkbox"/> Visiting nurse association <input type="checkbox"/> Hospice agency	<input type="checkbox"/> Adult day care center <input type="checkbox"/> Assisted living facility <input type="checkbox"/> Nursing home

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

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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 services? Yes No

If yes, are hospice services included? Yes No

Type of provider

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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

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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 FLTCIP, Attn: FedPoint, 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 they are 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/yyyy)

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 **FLTCIP, Attn: FedPoint, P.O. Box 797, Greenland, NH 03840-0797.**