ALASKACARE
Retiree Health Plan

Long-Term Care Health Questionnaire

FOR OFFICE USE ONLY

Toll-Free: 1-800-821-2251
doa.alaska.gov/drb

Division of Retirement and Benefits
PO Box 110203
Juneau, Alaska 99811-0203

Juneau: 465-8600
TDD: (907) 465-2805
Fax: (907) 465-4668

Instructions

- Print, completing all sections as directed below
- Provide complete dates and details for all "Yes" answers
- Make a copy of this application form for your records
- Return your completed form (with your enrollment form) in the envelope provided to the address above.

Failure to provide complete information or sign your application will delay processing.

Fraud Notice

Any person who, with intent to defraud or knowing that he/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.

Part A: Prescreen—To be completed by all new enrollees.

Please answer "Yes" or "No" by checking the box at left.

If you check "Yes" to any of the items below, please do not submit this form. These conditions and circumstances will result in a denial of coverage. They are not intended to be a complete list of conditions for which we deny coverage.

If you do **not** have any of these conditions and you **do** complete the form, you should not assume coverage will be approved. The claims administrator will review the information you provide regarding your health status and decide whether to approve your request for enrollment or increased coverage.

Check "Yes" if you have ever experienced or been specifically diagnosed, treated for, or told that you have any of the following conditions. Check "No" if you have not. If you have any doubt about your answers, ask your doctor.

❒ **Yes** ❒ **No** Alzheimer's Disease, dementia, or chronic permanent memory loss?

❒ **Yes** ❒ **No** Parkinson's Disease, Muscular Dystrophy, Multiple Sclerosis, Huntington's Chorea, Myasthenia Gravis, Amyotrophic Lateral Sclerosis (ALS), Post Polio Syndrome, Multiple Strokes, Multiple Transient Ischemic Attacks (TIAs)?

❒ **Yes** ❒ **No** AIDS or AIDS Related Complex (ARC)

Do you currently, and on a permanent basis:

❒ **Yes** ❒ **No** Require supervision or assistance from another person for personal care activities, such as bathing, dressing, mobility, or homemaking activities, such as taking medications, laundry, shopping, or preparing meals?

❒ **Yes** ❒ **No** Require a walker, wheelchair, oxygen, catheter, or kidney dialysis?

❒ **Yes** ❒ **No** Are you currently confined, or been recommended to be confined in the past 12 months, to:

- Nursing Home Care (in a nursing home or in an extended care unit of a hospital)
- Home Health Care (visiting nurse, therapist, or health aide visits)
- Adult Day Care Center

Part B: Applicant Information

Applicant Name (Last, First, M.I.)		Applicant Social Security Number	
Retiree Name (if applicant is spouse)		Retiree Social Security Number	
Street Address	City	State	ZIP+4
Daytime Telephone Number ( )	Birthdate (Mo/Day/Yr)	Sex ❒ Male ❒ Female	
Height Ft. In.	Weight Lbs.		
Additional Contact Name	Contact Telephone Number		

CONDITIONS	CHECK ONE	Please provide complete details (dates, diagnosis, treatments, medications, recovery date) to any *YES* answer. For additional space, attach a separate sheet.
In the PAST 5 YEARS have you been diagnosed for or treated for any of the following conditions?		
Heart Attack or other heart problems, high blood pressure, circulatory problems such as stroke or TIA (mini-stroke).	❒ Yes ❒ No	
Neurological paralysis, senility or any mental or other disorder of the brain, depression, memory loss, confusion, forgetfulness, anxiety, or drug or alcohol abuse.	❒ Yes ❒ No	
Liver disease.	❒ Yes ❒ No	
Parkinson's disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis, myopathies-neuropathies, Scleroderma or other connective tissue disorders, Huntington's Chorea or Lupus Erythematosus.	❒ Yes ❒ No	
Known or active cancer, tumor or other growth (other than minor skin cancer)	❒ Yes ❒ No	
Muscle, bone, or joint disorder, such as Osteoarthritis or Rheumatoid arthritis.	❒ Yes ❒ No	
Diseases of the kidney (including dialysis)	❒ Yes ❒ No	
Diabetes—insulin or noninsulin dependent. Chronic obstructive pulmonary disease or any lung problems.	❒ Yes ❒ No	
Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related disorder.	❒ Yes ❒ No	
In the PAST 5 YEARS have you been hospitalized two or more times or have you been confined to a nursing home for more than	❒ Yes ❒ No	

Part C: *continued*

Please list all medications currently prescribed. Note drug name, dosage, and the condition for which the medication was prescribed.

Medication	Dosage	Condition

Part D: Certification/Authorization

Certification

I certify that the answers and statements on this form are complete and true to the best of my knowledge and belief. I understand coverage will be effective only if and when the claims administrator gives its written consent, and that any misstatements or omissions will make any insurance based upon this application void at the option of the State of Alaska. I understand I may be contacted in person or by telephone by a representative of the claims administrator as part of the underwriting process.

Authorization

To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital service and prepaid health plans, and employers: You are authorized to provide the claims administrator and any insurance agent acting on their behalf with information concerning health care, advice, treatment or supplies (including those related to mental illness and/or AIDS/HIV) provided to me or any members of my family for whom coverage has been requested. This information will be used for the purpose of determining eligibility for long-term care group insurance coverage. This authorization will be valid for 90 days from the date of this application.

I acknowledge that I have read the Privacy Notice on page 4 and the Fraud Notice on page 1 and know that I have a right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization is as valid as the original.

Signature	**Date**

Part D: continued

Privacy Notice

In evaluating your insurability, we rely primarily on the health information you furnish to us in this application. However, we may request additional medical information about you from any of the sources specified in the authorization on page 3 or you may be contacted for a telephone interview or a home visit.

Disclosure of Information to Others

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access and Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding) and to request correction of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your attending physician. If you wish to exercise this right, or if you wish to have a more detailed explanation of our information practices, please contact the State of Alaska at the address listed on this form.