Combined Insurance Company of America

Administrative Office: P. O. Box 506 • Keene, New Hampshire 03431-0506

Supplement to Group Enrollment Form

Insured Name: _____
Please Print

Applicant SSN: _____

This Supplement to the Group Enrollment Form for Life Insurance is required to be completed when an applicant or spouse applies for the Accelerated Benefit for Long Term Care Rider

	Applicant		Spouse	
	Yes	**No**	**Yes**	**No**
1. Does the Applicant or Spouse have any other long term care insurance in force (including health care service contract, health maintenance organization contract)? *(If Yes, give details below.)*	☐	☐	☐	☐
2. Did the Applicant or Spouse have any long term care insurance policy or certificate lapse during the last 12 months? *(If Yes, provide date of Lapse:_____).*	☐	☐	☐	☐
3. Are you covered by Medicaid?	☐	☐	☐	☐
4. Do you intend to replace any of your medical or health insurance coverage with this Certificate? *(If Yes, give details below.)*	☐	☐	☐	☐

Applicant or Spouse	Name of Company	Face Amount	Month/Year Issued	To be Replaced?
				☐ Yes ☐ No
				☐ Yes ☐ No

SECONDARY ADDRESSEE:

As required by State law, an insurer issuing Long Term Care Coverage is required to notify the applicant of the right to designate at least one additional person to receive notification of a possible lapse or termination in coverage. Notice will be provided to any secondary addressee 30 days after a premium is due and unpaid. This constitutes our notification to you of your right to designate such an addressee. If you wish to designate a secondary addressee, please do so by complete the following:

Designation of Secondary Addressee:

Secondary Addressee(Give Full Legal Name): _____

Mailing Address: _____
Street City State Zip

Signature:_____ Date_____