THE STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

FILED

In the Matter of ABILITY INSURANCE COMPANY, An Authorized Insurer and Respondent	Docket Nos. 11-0088 and 11-0089 THIRD DECLARATION OF ALAN MICHAEL SINGER

2011 JUL 29 P 4: 00
Hearings Unit, OIC
Patricia D. Petersen
Chief Hearing Officer

I, Alan Michael Singer, state and declare as follows:

My name is Alan Michael Singer. I make this Declaration based on personal knowledge. I am over the age of eighteen (18) years. I am competent and authorized to testify to the matters set forth herein.

1. Attached as "**Exhibit 1**" is a true and correct copy of the insurance policy, schedule, and endorsements issued to Gladys White in this matter.

2. Attached as "**Exhibit 2**" is a true and correct copy of Ability Insurance Company CAPS entries produced by Ability Insurance Company in discovery.

3. Attached as "**Exhibit 3**" is a true and correct copy of a copy of the 8/9/10 "Ask Mike" emailed inquiry from Jack White, with OIC staff Bianca Stoner's acknowledgement of receipt of the same.

4. Attached as "**Exhibit 4**" are true and correct copies of a 7/10/07 Medico record regarding Gladys White by Dr. Mihali, and a 3/21/11 letter of Dr. Mihali.

5. Attached as "**Exhibit 5**" is a true and correct copy of a 10/24/07 Ability Insurance Company record of facsimile with attachments from Cheryl Silvernail to Medico.

6. Attached as "**Exhibit 6**" is a true and correct copy of an 8/27/07 Medico letter to Gladys White.

7. Attached as "**Exhibit 7**" is a true and correct copy of a Medico letter dated 3/20/09 to Cheryl Silvernail.

8. Attached as "**Exhibit 8**" is a true and correct copy of a 8/6/09 facsimile with

attachments from Cheryl Silvernail to Ability Insurance Company claims department.

9. Attached as "**Exhibit 9**" is a true and correct copy of an Ability Insurance Company letter to Gladys White received 10/9/09.

10. Attached as "**Exhibit 10**" is a true and correct copy of an Ability Insurance Company letter to Gladys White dated 8/31/09.

11. Attached as "**Exhibit 11**" is a true and correct copy of a 9/8/09 facsimile with attachments from Cheryl Silvernail to Ability Insurance Company claims department.

12. Attached as "**Exhibit 12**" is a true and correct copy of a 9/11/09 letter from Cheryl Silvernail to Ability Insurance Company claims department.

13. Attached as "**Exhibit 13**" is a true and correct copy of an Ability Insurance Company note (undated).

14. Attached as "**Exhibit 14**" is a true and correct copy of a 9/30/09 facsimile with attachments from Cheryl Silvernail to Ability Insurance Company "Sharon" in claims department.

15. Attached as "**Exhibit 15**" is a true and correct copy of a 11/5/09 Donald Lawler letter to Cheryl Silvernail.

16. Attached as "**Exhibit 16**" is a true and correct copy of a 11/30/09 letter from Cheryl Silvernail to Don Lawler.

17. Attached as "**Exhibit 17**" is a true and correct copy of a 12/4/09 Donald Lawler letter to Cheryl Silvernail.

18. Attached as "**Exhibit 18**" is a true and correct copy of a 1/13/10 Donald Lawler letter to Cheryl Silvernail, with returned premium check.

19. Attached as "**Exhibit 19**" is a true and correct copy of an 8/12/10 OIC Bianca Stoner letter to Ability Insurance Company with copy of 8/9/10 "Ask Mike" emailed inquiry from Jack White, with Bianca Stoner's acknowledgement of receipt of the same.

20. Attached as "**Exhibit 20**" is a true and correct copy of an 8/23/10 Donald Lawler letter

to Bianca Stoner with enclosures.

21. Attached as "**Exhibit 21**" is a true and correct copy of an 8/30/10 Bianca Stoner letter to Donald Lawler.

22. Attached as "**Exhibit 22**" is a true and correct copy of a 9/8/10 Donald Lawler letter to Bianca Stoner with enclosures.

23. Attached as "**Exhibit 23**" is a true and correct copy of a 9/24/10 Bianca Stoner letter to Donald Lawler.

24. Attached as "**Exhibit 24**" is a true and correct copy of a 10/4/10 Donald Lawler letter to Bianca Stoner.

25. Attached as "**Exhibit 25**" is a true and correct copy of a 10/21/10 Bianca Stoner letter to Donald Lawler.

26. Attached as "**Exhibit 26**" is a true and correct copy of an 11/1/10 Donald Lawler letter to Bianca Stoner.

27. Attached as "**Exhibit 27**" is a true and correct copy of a 12/1/10 Alan Singer letter to Donald Lawler.

28. Attached as "**Exhibit 28**" is a true and correct copy of a 12/16/10 Donald Lawler letter to Alan Singer.

29. Attached as "**Exhibit 29**" is a true and correct copy of a 5/27/99 filed unpublished decision, *Hanson v. Mut. of Enumclaw Ins. Co.* (with page highlighted).

30. Attached as "**Exhibit 30**" is a true and correct copy of a 12/7/10 Donald Lawler email to Alan Singer (with Alan Singer questions in black and Donald Lawler answers in red).

31. Attached as "**Exhibit 31**" is a true and correct copy of a 12/7/10 Donald Lawler email to Alan Singer (with attached correspondence), responding to attached 12/6/10 email of Alan Singer to Donald Lawler (with attached correspondence).

32. Attached as "**Exhibit 32**" is a true and correct copy of a 12/30/10 Donald Lawler email to Alan Singer (with Alan Singer questions in blue and Donald Lawler answers in red,

and with attachments).

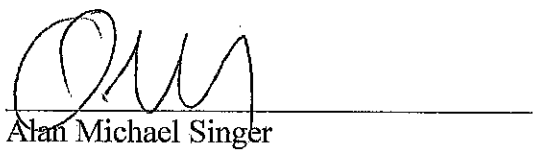
33. Attached as "**Exhibit 33**" is a true and correct copy of a 12/30/10 Donald Lawler email to Alan Singer (with Alan Singer questions in black and Donald Lawler answers in red, and with attachments).

34. Attached as "**Exhibit 34**" is a true and correct copy of a 3/10/11 Donald Lawler email to Alan Singer (with attachments).

35. Attached as "**Exhibit 35**" is a true and correct copy of the "Unintentional lapse" section of the NAIC model long term care regulation included as a letter attachment in the OIC rulemaking folder from WAC 284-54-253.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

EXECUTED this 29 day of July, 2011 at Dumwater, Washington.



Alan Michael Singer

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DUPLICATE

MUTUAL PROTECTIVE INSURANCE COMPANY

1515 SOUTH 75TH STREET • OMAHA, NEBRASKA 68124

A Mutual Company

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 is attached to the policy. If your answers are incorrect or untrue, the Company has 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 the address shown above.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company.

Insuring Clause: We agree to provide the benefits set out in this policy for any insured loss. This agreement is subject to all of the provisions of the policy. A "loss" is an expense you incur for care or services this policy covers and that you receive after the Policy Date and while the policy is in force.

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.** Also, read the copy of your application and the policy Schedule. If there is any error or omission, tell us. We will make any needed change.

The first premium you, the Insured, paid before the Policy Date (and the copy of your application, attached hereto), put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

PART A **PLEASE READ — 30-DAY RIGHT TO RETURN**

Please read your policy. If you are not satisfied, send it back to us, or to the agent who sold it to you, within 30 days after you receive it. We will return your money. That will mean your policy was never in force. We will pay a 10% penalty if the requested premium refund is not made within 30 days of our receipt of the returned policy.

PART B **GUARANTEED RENEWABLE FOR LIFE**
SUBJECT TO OUR LIMITED RIGHT TO CHANGE PREMIUMS

We guarantee to renew your policy for life, subject to the Lifetime Maximum Benefits provision, as long as the premium is paid within the allowable time; but, we do have the right to change your premium as stated below.

We can change your premium only if we do the same to all policies of this form and any similar form issued to persons of your class in your state. If a change is made, it will not be based on any physical impairment you might have or any claims you have incurred under this policy, and it will be consistent with the Rate Guarantee provision on page 2. If it is necessary to change the premium for your policy, we will send you notice at least 30 days before your premium is due.

NOTICE TO BUYER: This policy may not cover all of the 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.

A QUALIFIED LONG-TERM CARE POLICY FOR FEDERAL TAX PURPOSES

Rate Guarantee: The premium we charge for this policy is based on the benefit amounts shown in the policy Schedule and the disclosures made in your application. That premium rate is guaranteed for at least a three year period measured from the Policy Date. If subsequent rate increases are needed after that initial three year period, each new rate will be guaranteed for an additional two year period.

ALPHABETICAL GUIDE TO YOUR POLICY

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PART C — EXCEPTIONS

We will NOT pay benefits for:

(1) loss that occurs while this policy is not in force;
(2) intentional, self-inflicted injury or attempted suicide;
(3) alcoholism or drug addiction, unless addiction resulted from narcotics prescribed by a Physician;
(4) care provided by a member of your immediate family;
(5) services for which you are not liable or for which no charge normally is made in the absence of insurance; and
(6) loss that occurs outside the United States.

Non-Duplication: This contract will not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance. But it will pay benefits for covered expenses you incur that exceed the amount paid or payable by such governmental plans or laws.

PART D — LIFETIME MAXIMUM BENEFITS

The maximum dollar amount for all covered care that we will pay during the lifetime of the policy is shown in the Schedule. That lifetime dollar maximum is determined by multiplying the Daily Benefit amount by the benefit day option, both of which are shown in the Schedule. The lifetime dollar maximum may be greater than the amount shown in the Schedule if the optional inflation shield rider is in force. Coverage under this policy automatically ends after we have paid out the lifetime dollar maximum.

If the Schedule shows your lifetime dollar maximum as Unlimited/Lifetime, there is no lifetime dollar maximum for this policy.

PART E

DEFINITIONS

When we use the following words in this policy or in any optional rider, this is what we mean:

Activities of Daily Living: (a) eating; (b) dressing; (c) toileting; (d) transferring; (e) continence and (f) bathing. You are considered to need assistance for each of these activities when:

Eating: You cannot, without the aid of another person, maintain an adequate food and fluid intake consistent with your dietary needs.

Dressing: You cannot, without the aid of another person, put on and take off all necessary items of clothing, including medically necessary braces and artificial limbs.

Toileting: You cannot, without the aid of another person, get to and from the toilet, get on and off the toilet and maintain a reasonable level of associated personal hygiene.

Transferring: You cannot, without the aid of another person, walk or get in or out of a chair, wheelchair, bed, or other stationary position.

Continence: You cannot, without the aid of another person, voluntarily control bowel and bladder functions or use an external catheter or other equipment.

Bathing: You cannot, without the aid of another person, wash yourself by sponge bath in either a tub or shower, including getting into or out of the tub or shower.

Adult Day Health Care: A program of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Adult Day Health Care Center: (a) a facility licensed or certified by the state in which it is located to provide Adult Day Health Care; or (b) if licensing/certification is not required, a part of a facility (or center operated by a facility) that is licensed or certified as a hospital or any type of nursing home by the state in which it is located; or (c) a facility that is approved for Medicaid.

Anniversary Date: The same day and month as the Policy Date in each later year.

Assisted Living Care Facility: A facility that is licensed or certified as an Assisted Living Care Facility in accordance with any applicable state or local laws, with the primary purpose of providing care and services to support needs resulting from Cognitive Impairment or loss of functional capacity. The facility must have a trained employee available at all times to provide that care, and the facility must have established procedures for overseeing the administration of medications. The specific section or unit of the facility where you receive assisted living care must meet all of the above stated requirements.

Benefit Period: A period of covered care for the same or related Conditions, that is not separated by at least 180 days during which you are free of such care.

Case Coordinator: A licensed health care professional, from an agency we will choose, whose training includes managing and arranging for the type of care and services covered under this policy. This person can be a Doctor, Nurse, social worker or other similarly trained and licensed professional. Your Case Coordinator will provide a comprehensive evaluation of your status and will be responsible for developing, implementing and coordinating your Plan of Care. This person will further be responsible for assisting in the selection of providers, making arrangements to initiate services, providing ongoing care monitoring, and revising the Plan of Care as circumstances dictate. The Case Coordinator will work in consultation with your Physician.

Chronically Ill Individual: Any individual who has been certified within the preceding twelve (12) month period by a Licensed Health Care Practitioner as: being unable to perform (without Substantial Assistance from another individual) at least two (2) Activities of Daily Living for a period of at least ninety (90) days due to a loss of functional capacity; having a similar level of disability; or requiring substantial supervision to protect such individual from threats to health and safety due to severe Cognitive Impairment.

Cognitive Impairment: Deterioration of or loss in your intellectual capacity due to organic brain disease or disorder, which requires supervision to protect yourself or others, as measured by clinical evidence and standardized tests that measure your impairment in the following areas:

(a) Your short or long-term memory;

(b) Your orientation as to person (such as who you are), place (such as where you are) and time (such as day, date and year);

(c) Your deductive or abstract reasoning.

Such loss in intellectual capacity can result from Alzheimer's Disease or related degenerative and dementing illnesses.

Condition: Sickness, disease or injury. These include Mental or Nervous Disorders that cause Cognitive Impairment.

Elimination Period: The number of days for which no benefit is payable. The Elimination Period, if any, starts on the date that benefits would otherwise begin and is in effect for the number of days shown in the Schedule. Only one Elimination Period will be applied to any one Benefit Period.

Home Health Agency: An entity that provides home care services and is: (a) certified for participation in the Medicare program; or (b) licensed or certified as a Home Health Agency where required by the state; or (c) is otherwise acceptable to us if licensing or certification is not required. The Home Health Agency must keep records of nursing reports and the Plan of Care. These records must be available to us upon authorized request.

Home Health Aide Services: Assistance with simple health care tasks, personal hygiene, Activities of Daily Living, managing medications, and other related services provided by a Home Health Agency.

Home Health Professional Services: One or more of the following services for your care and treatment that are provided by a Home Health Agency in a noninstitutional setting, under the direction of a Nurse and according to a written diagnosis and Plan of Care:

(a) nursing services;
(b) physical therapy;
(c) speech therapy;
(d) respiratory therapy;
(e) occupational therapy; and
(f) nutritional services provided by a licensed dietician.

Homemaker Services: Assistance provided by a Home Health Agency with managing and maintaining a household, when you can no longer manage those activities and an informal caregiver is not available. This may include preparing meals, doing laundry and incidental household tasks.

Hospice Care: Services (not drugs or other supplies) provided by a Hospice Facility or a Home Health Agency that are designed to provide you with palliative care or to alleviate discomfort during the last phases of life. To be eligible for Hospice Care you must be diagnosed by your Doctor as having no more than 6 months to live.

Hospice Facility: A facility that is primarily engaged in providing care for terminally ill patients whose life expectancy is six months or less. It must be licensed, certified or registered as may be required by the state.

Injury: Accidental bodily Injury that results in loss independent of Sickness and other causes.

Licensed Health Care Practitioner: Any Physician and any registered professional Nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

Maintenance or Personal Care Services: Any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a Chronically Ill Individual (including the protection from threats to health and safety due to severe Cognitive Impairment).

Mental or Nervous Disorder: A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder.

Nurse: A person duly licensed as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Nursing Home: A health care facility that is licensed as a Nursing Home by the state in which it is located and that provides, as its main function, Skilled Nursing Care, Intermediate Nursing Care or Custodial Care. The facility must: (a) provide this care on a continuing inpatient basis as prescribed by a Plan of Care; (b) supervise the care through a nursing staff; (c) maintain clinical records for all patients; (d) maintain control and records of medications given; and (e) have arrangements for the services of a Doctor to furnish medical care in case of an emergency. The specific section or unit of the facility where you receive Nursing Home Care must meet the above described licensing requirements and also must provide, as the main function of that section or unit, care that meets all of the other requirements above. (Items (c) and (d) need not apply when you receive only Custodial Care.)

A Nursing Home is NOT a facility for the treatment of alcoholism, drug addiction or chemical dependency.

Nursing Home Care: Skilled Nursing Care, Intermediate Nursing Care or Custodial Care provided in a Nursing Home.

(a) **Skilled Nursing Care or Intermediate Nursing Care** must be prescribed in your Plan of Care. This care uses professional nursing methods and procedures that are administered by licensed or certified health care personnel. It includes posthospital care, rehabilitation nursing care, maintenance therapy, administration of medication, injections and catheterization.

(b) **Custodial Care** means care that is given to residents of a Nursing Home who, not needing daily nursing care, cannot properly care for themselves due to age or a covered Condition. This care must be prescribed in your Plan of Care.

Physician or Doctor: A licensed practitioner of the healing arts acting within the scope of his/her license.

Plan of Care: A written document prescribing individualized treatment or services that your Condition requires. The plan must be prepared by your Case Coordinator and approved by your Doctor. If case coordination is not used, the plan must be prepared by a Doctor or other licensed medical professional, and must be approved by your Doctor. The Plan of Care must be updated or recertified at least once every 90 days, and the updated or recertified plan must be approved by your Doctor.

Policy Date: The date on which this policy first became effective. That date is shown on the Schedule.

Qualified Long-Term Care Services: Any necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are required by a Chronically Ill Individual or are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Reasonable and Customary Charge: An amount measured by comparing it with charges normally made for similar services and supplies to individuals of similar medical Condition in the locality where the charge is made. All covered charges for which this policy provides benefits are based on the Reasonable and Customary Charges for covered services.

Schedule: Is attached to and is a part of this policy.

Sickness: An illness or disease that you have or acquire.

Substantial Assistance: Physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the Activities of Daily Living.

We, Us or Our: Mutual Protective Insurance Company.

You or Your: The Insured named in the Schedule.

PART F GENERAL BENEFIT INFORMATION

(1) **The Schedule Shows:**

(a) The Daily Benefit which is the basis for our payment of the services we cover. (That amount may be greater if the optional inflation shield rider is in force.)
(b) The Elimination Period that applies to the Benefit Period; and
(c) The dollar maximum for all covered care that we will pay during the lifetime of the policy. (That amount may be greater if the optional inflation shield rider is in force.)

If the Schedule shows your lifetime dollar maximum as Unlimited/Lifetime, there is no lifetime dollar maximum for this policy.

(2) **Receipt of Multiple Covered Services on the Same Day:** If you receive more than one type of covered service on the same day, we will pay the Reasonable and Customary Charge for each service, but in no event shall the total amount paid exceed the Daily Benefit. This is subject to the weekly benefit option under Part K, Care Coordination Benefit.

PART G ELIGIBILITY FOR THE PAYMENT OF BENEFITS

To be eligible for any type of benefit under this policy, your Doctor must show that you are chronically ill. A chronically ill person has been certified by a Licensed Health Care Practitioner as:

(1) Being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to loss of functional capacity;

(2) Having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (1); or

(3) Requiring substantial supervision to protect such individual from threats to health and safety due to severe Cognitive Impairment.

Independent Evaluation: We may, at our expense, have you examined or evaluated by independent medical experts. The studies they perform will be for the purpose of assessing and confirming that you are eligible for care as shown above, and the treatment or services prescribed in the Plan of Care meet all of the requirements of this policy.

PART H NURSING HOME CARE BENEFITS

Limitations or Conditions on Eligibility for Benefits: All of the following conditions apply to receipt of Nursing Home Care benefits.

(1) You must qualify under one of the eligibility requirements set out in Part G.

(2) You must receive Nursing Home Care in a Nursing Home, as defined.

(3) The care received must be prescribed in your Plan of Care.

(4) Your Plan of Care must be updated or recertified at least once every 90 days.

(5) You must receive covered care in excess of the number of days shown in the Schedule as the Elimination Period that applies to each Benefit Period.

Benefit: When you are eligible for and receive Nursing Home Care covered by this policy, we will pay a benefit. That benefit will be the Reasonable and Customary Charges made by the Nursing Home, not to exceed the amount of the Daily Benefit shown in the Schedule or in effect at the time you receive care. It will be paid for each day you receive care in a Nursing Home. This benefit is subject to your lifetime dollar maximum.

PART I HOME CARE BENEFITS

Limitations or Conditions on Eligibility for Benefits: All of the following conditions apply to receipt of home care benefits: (Home care benefits consist of Home Health Professional Services, Home Health Aide Services and Homemaker Services.)

(1) You must qualify under one of the eligibility requirements set out in Part G.

(2) You must receive Home Health Professional Services, Home Health Aide Services or Homemaker Services, as defined.

(3) The care received must be prescribed in your Plan of Care.

(4) Your Plan of Care must be updated or recertified at least once every 90 days.

(5) You must receive covered care in excess of the number of days shown in the Schedule as the Elimination Period that applies to each Benefit Period.

Benefit: When you are eligible for and receive Home Health Professional Services, Home Health Aide Services or Homemaker Services in your home, we will pay a benefit. That benefit will be the Reasonable and Customary Charges for each day of Home Health Professional Services, and 80% of the Reasonable and Customary Charges for each day of Home Health Aide Services or Homemaker Services, not to exceed the amount of the Daily Benefit shown in the Schedule or in effect at the time you receive care. Benefits are subject to your lifetime dollar maximum.

Additional Home Care Benefits: We will also pay a benefit for the following items, which can serve as cost-effective alternatives that allow you to remain in your own home. These benefits are not subject to the Elimination Period, and will not satisfy it. These benefits (except respite care) are not subject to the Daily Benefit, but will count toward your lifetime dollar maximum. These benefits are subject to all other conditions that apply to home care benefits.

(1) **Caregiver Training Benefit:** We will pay a lifetime benefit of up to 5 times the amount of your original Daily Benefit for the reasonable and customary cost of training a friend or family member to help you at home. We will not pay this benefit for anyone who will be paid to care for you.

(2) **Equipment Benefit:** We will pay a lifetime benefit of up to 50 times the amount of your original Daily Benefit for the purchase or rental of supportive equipment or in-home safety devices that allow you to stay in your home for at least 90 days. Such equipment or devices may include ramps, grab bars, a special bed, or an emergency medical alert system.

(3) **Respite Care Benefit:** We will pay the Reasonable and Customary Charge of temporary care in your home, an institution, or community-based program in order to give your primary in-home caregiver a rest. This benefit is subject to the amount of the Daily Benefit for all covered care shown in the Schedule or in effect at the time you receive care, and is further subject to a 21-day maximum per calendar year.

PART J COMMUNITY CARE BENEFITS

Limitations or Conditions on Eligibility for Benefits: All of the following conditions apply to the receipt of community care benefits: (Community care benefits consist of Adult Day Health Care and Hospice Care.)

(1) You must qualify under one of the eligibility requirements set out in Part G.

(2) You must receive Adult Day Health Care or Hospice Care, as defined. Adult Day Health Care must be received in an Adult Day Health Care Center. Hospice Care must be provided by a Hospice Facility or a Home Health Agency.

(3) The care received must be prescribed in your Plan of Care.

(4) Your Plan of Care must be updated or recertified at least once every 90 days.

(5) You must receive covered care in excess of the number of days shown in the Schedule as the Elimination Period that applies to each Benefit Period.

Benefit: When you are eligible for and receive Adult Day Health Care or Hospice Care, we will pay a benefit. That benefit will be the Reasonable and Customary Charges made for each day of Adult Day Health Care or Hospice Care, not to exceed 50% of the Daily Benefit shown in the Schedule or in effect at the time you receive care. Benefits are subject to your lifetime dollar maximum.

PART K CARE COORDINATION BENEFIT

Additional benefits are available under this policy when you agree to and receive coordination of care through a Case Coordinator. When you agree to coordination of care, we will pay for all expenses associated with the services of your Case Coordinator, as well as the following benefits:

(1) **Elimination Period Waiver:** You will receive benefits for the first day of care for any type of care covered under this policy. The policy Elimination Period will not apply.

(2) **Weekly Benefit:** Instead of a Daily Benefit, you will receive a Weekly Benefit. The Weekly Benefit will consist of a weekly (Monday through Sunday) maximum of up to 7 times your Daily Benefit for the Reasonable and Customary Charges for care received during the week. This benefit is subject to your lifetime dollar maximum. The added flexibility of this benefit is valuable because the amount and kind of care you need could exceed your Daily Benefit on any given day.

(3) **Enhanced Home Care Benefit:** Instead of 80%, we will pay 100% of Reasonable and Customary Charges, subject to the Weekly Benefit, for Home Health Aide Services and Homemaker Services provided under the direction of your Case Coordinator. Additionally, we will waive the requirement that Homemaker Services be provided through a Home Health Agency when your Case Coordinator determines that these services may be supplied in a more cost-effective manner by alternate providers. This benefit is subject to your lifetime dollar maximum.

(4) **Assisted Living Care Facility Benefit:** We will pay 80% of the Reasonable and Customary Charge for care in an Assisted Living Care Facility, subject to the Weekly Benefit, when your Case Coordinator recommends this alternative in your Plan of Care. We will not pay home care or community care benefits while you are receiving the Assisted Living Care Facility benefit. This benefit is subject to your lifetime dollar maximum.

PART L BED RESERVATION BENEFIT

Limitations or Conditions on Eligibility for Benefits: To be eligible to receive benefits under this provision, you must meet all of the conditions listed below.

(1) You must be hospitalized temporarily during the course of your covered stay in a Nursing Home or Assisted Living Care Facility.

(2) The Nursing Home or Assisted Living Care Facility must charge you to keep your room available during your hospital stay.

(3) Your hospitalization must be the result of a covered Condition.

(4) You must have satisfied any Elimination Period that applies to the Benefit Period. If you have not, your days in the hospital will apply to the Elimination Period.

Benefit: When you meet the eligibility requirements of this provision we will pay a benefit. It will be equal to the Reasonable and Customary Charge the Nursing Home or Assisted Living Care Facility makes to hold your room during the hospital stay, not to exceed the amount of the Daily Benefit for all covered care shown in the Schedule or in effect at the time you receive care. We will pay this benefit for up to 14 days per calendar year, subject to the Elimination Period and your lifetime maximum dollar amount for all covered care shown in the Schedule or in effect at the time you receive care. Unused benefit days cannot be carried over from one calendar year to the next.

PART M RESTORATION OF BENEFITS IN THE EVENT OF POLICY LAPSE DUE TO COGNITIVE IMPAIRMENT OR LOSS OF FUNCTIONAL CAPACITY

If coverage under this policy ends due to nonpayment of premium, you or any person acting on your behalf will have 5 months to request reinstatement of the policy on the grounds that you suffered from Cognitive Impairment or loss of functional capacity at the time of lapse. We will require the same evidence of Cognitive Impairment or loss of functional capacity that is required for eligibility for benefits under this policy. We also must receive the back premium from the date of default. If these conditions are met, we will reinstate the policy without evidence of insurability. The coverage will be at the same level that existed prior to the date of the lapse. This provision does not apply to a policy that terminated because you requested cancellation or because we paid the maximum dollar amount.

PART N DEFERRED INFLATION PROTECTION OPTION

When you applied for this policy, you were given the opportunity to defer adding an optional Inflation Shield Rider. If you elected that option we will give you the opportunity to add an inflation rider without evidence of insurability within 90 days prior to the third Anniversary Date of the policy, if you have not incurred a claim under the policy. The additional premium required for the inflation rider will be based on your age at the time this benefit is added. Increases will begin to take effect on the first Anniversary Date after the inflation rider is in force.

PART O WAIVER OF PREMIUM

After we have paid benefits for Nursing Home Care for 90 days in a row, we will waive the payment of premiums that come due thereafter during the continuance of consecutive days for which such benefits are paid. This waiver, which includes premiums for any attached rider, will continue until the first day of the month following the date we stop paying benefits for Nursing Home Care.

PART P RIGHT TO REDUCE COVERAGE

You have the right to reduce the benefits of this policy without providing evidence of insurability. Changes may include:

a) a longer Elimination Period;

b) a lower Daily Benefit; or

c) a shorter benefit day option, resulting in a reduced lifetime dollar maximum.

Benefits will not be reduced to a level below the minimum level approved by the Commissioner of Insurance on the date you request reduction.

PART Q HOW TO FILE A CLAIM

(1) **Notice of Claim:** You must give us written notice of a claim within 20 days after loss starts or as soon as you can. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to our Home Office in Omaha, Nebraska, or to one of our agents.

(2) **Claim Forms:** When we receive your notice, we will send you forms for filing proof of loss. If these forms are not sent to you in 15 days, you will have met the proof of loss rule below if, in 90 days after the loss began (or, in the event of a continuing loss, within 90 days after the first month of the loss for which we are liable), you gave us a written statement of what happened.

(3) **Proof of Loss:** You must give us written proof of your loss in 90 days or as soon as you can. In the event of a continuing loss that is eligible for periodic payments, you must give us written proof within 90 days after the end of the period of loss for which we are liable. But proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

PART R PAYMENT OF CLAIMS

(1) **Time of Payment of Claims:** Benefits for continuing care are paid monthly when loss lasts longer than one month. When we receive your proof of loss, benefits that accrued up to the date of the proofs will be paid at the end of each month. All other benefits are paid as soon as we receive your proof of loss. Benefits unpaid when our liability ends are paid when we receive your proof of loss.

(2) **Payment of Claims:** Benefits will be paid directly to you. Benefits unpaid at your death will be paid to your beneficiary or your estate.

If any benefit is payable to your estate, to a minor, or to any person not able to give a valid release, we may pay up to $1,000.00 to any relative by blood or connection by marriage of the Insured or beneficiary that we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

(3) **Claim Review and Appeal Procedure:** In the event of any claim denial with which you do not agree, you have the right to submit a written request to the Company at its Home Office asking for a review of the denial of benefits. That request may include documents from your Physician or care provider that support your basis for the requested review. Within 30 days after we receive that written request, we will notify you or your representative of the results of the review.

PART S POLICY PROVISIONS

(1) **Entire Contract; Changes:** This policy, with any attachments (and the copy of your application), is the entire contract of insurance. No agent may make contracts, determine insurability or change the application or policy in any way. Only an executive officer of ours can approve a change. That change must be shown in the policy.

(2) **Time Limit on Certain Defenses:** After two years from the Policy Date, no misstatements, except knowing and intentional misstatements relating to the Insured's health, can be used to void the policy. If this policy is reinstated on the basis of a health application, the contestable period will be two years from the reinstatement date.

Pre-Existing Conditions: We will not reduce or deny a claim under this policy because a Sickness or Injury existed before the Policy Date.

(3) **Grace Period:** Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period.

(4) **Reinstatement:** Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement and, as may be needed, issue a conditional receipt, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), your policy will be put back in force on that 45th day.

Your reinstated policy will cover only loss due to Injury that begins after the date your policy was put in force. Also, it will cover only loss due to Sickness that begins after the date the policy was put back in force.

In all other respects, you and we will have the same rights under this policy that we had before it lapsed. The premium we accept to reinstate this policy may be used for a period for which premiums had not been paid. But it will not be used for any period more than 60 days before the reinstatement date.

(5) **Physical Examination:** We, at our expense, can have you examined as often as reasonably needed while a claim is pending.

(6) **Legal Action:** You can't bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You can't start such an action more than three years after the date written proof of loss is required.

(7) **Change of Beneficiary; Assignment:** Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.

(8) **Misstatement of Age:** If your age has been misstated, the amount payable will be that which the premium would have bought at the correct age.

(9) **Illegal Occupation:** We will not be liable for any loss to which a contributing cause was your commission of or attempt to commit a felony. Nor will we be liable for any loss to which a contributing cause was your being engaged in an illegal occupation.

(10) **Other Insurance With Us:** You may have only one policy like this one at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.

(11) **Extension of Benefits:** Termination of this policy will be without prejudice to any benefits payable for institutionalization if such institutionalization began while the policy was in force and continues without interruption after termination. "Institutionalization" means Nursing Home Care, as defined in the policy. This extension of benefits beyond the period the policy was in force will be limited to the duration of the Benefit Period, if any, or to the payment of the maximum dollar amount. It will be subject to the policy Elimination Period and all other applicable provisions of the policy.

(12) **Term of Coverage:** Your coverage starts on the Policy Date at 12:01 a.m. standard time where you live. It ends at 12:01 a.m. on the same standard time on the first renewal date. Each time you renew your policy, the new term begins when the old term ends.

(13) **Conformity With State Statutes:** The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

(14) **Annual Meeting:** Our annual meeting is held at 10:00 a.m. on the second Friday of May at our Home Office.

This policy is signed in our behalf by our Chief Executive Officer and Secretary.

Chairman of the Board
Chief Executive Officer

Secretary

DUPLICATE

Countersigned By _____
Licensed Resident Agent

MUTUAL PROTECTIVE INSURANCE COMPANY

1515 SOUTH 75TH STREET
OMAHA, NE 68124

DUPLICATE

SCHEDULE

POLICY NO. - 0S34226

POLICY TYPE - 696

INSURED - GLADYS E WHITE
9223 60 AVE CT E
PUYALLUP WA 98371-6155

POLICY DATE..... 08/08/1999

POLICY PREMIUMS
SEMI-ANNUAL..... $3,013.92
ANNUAL..... $5,796.00

DAILY BENEFIT, REASONABLE AND CUSTOMARY CHARGES UP TO.....	$120.00
ELIMINATION PERIOD FOR ANY ONE BENEFIT PERIOD.....	90 DAYS
BENEFIT DAY OPTION.....	1095
LIFETIME DOLLAR MAXIMUM.....	$131,400.00

POLICY 696/3 YR., PLAN 9 OPTION F

-ENDORSEMENT-

MEDICO® INSURANCE COMPANY

1515 SOUTH 75TH STREET
OMAHA, NE 68124

POLICY NUMBER - 0S34226

Insured: GLADYS E WHITE

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NAME CHANGE ENDORSEMENT

Name Change: Whenever in the policy the name MUTUAL PROTECTIVE INSURANCE COMPANY is set forth, the name Medico™ Insurance Company is hereby substituted.

The notice of the **Annual Meeting** in the policy is deleted and the following provision substituted in lieu thereof:

Medico™ Mutual Insurance Holding Company Provision: Pursuant to the laws of the State of Nebraska, as a policyholder of the Company, you are a member of the Medico™ Mutual Insurance Holding Company and are entitled to vote either in person or by proxy at any and all meetings of the Medico™ Mutual Insurance Holding Company. An annual meeting of Medico™ Mutual Insurance Holding Company shall be held at the Home Office of the Company in the city of Omaha, Nebraska, on the second Friday of May each year at 10:00 a.m., Central Time.

All other provisions and conditions of the policy remain unchanged. The effective date of this endorsement is January 1, 2006.

ANY ENDORSEMENT IS A PART OF YOUR POLICY. THE NUMBER IS SHOWN ABOVE.

Secretary

President

PRIVACY NOTICE TO MEDICO™ INSURANCE COMPANY AND MEDICO™ LIFE INSURANCE COMPANY POLICYHOLDERS

Your privacy is our concern. Certain laws regulate the collection, use and disclosure of a consumer or customer's nonpublic information. Medico™ Insurance Company and Medico™ Life Insurance Company do not sell or otherwise disclose any nonpublic personal information about our customers or former customers to anyone outside the Medico™ Group Family, except as permitted by law. ***You don't need to take any action to prevent disclosure***; this notice is solely for your information.

General Privacy Information: It is the policy of Medico™ Insurance Company and Medico™ Life Insurance Company, their independent agents and those companies whose policies we administer together with ours to:

- Collect only information necessary or relevant to our business.
- Make a reasonable effort to ensure that information we act upon is accurate, relevant, timely and complete.
- Use only legitimate means to collect information.
- Make personal information available externally only to respond to legitimate business needs, to regulatory or other government authorities or as otherwise permitted by law.
- Limit employees' access to those who need to and are trained in the proper handling of personal information.
- Require anyone outside our corporate family (nonaffiliates) who perform services for us to conform to our privacy standards. We also require them not to use your nonpublic personal information for any other purpose.
- Not to disclose your nonpublic personal information to others for their own marketing purposes.
- Not to reveal your health, character, personal habits or reputation to anyone for marketing purposes.

The following summary explains the kinds of information that Medico™ Insurance Company and Medico™ Life Insurance Company or their agents may collect, what is done with the information and how you can find out about information, if any, we have about you in our records.

What kind of information do we collect about you and from whom? Most of our information comes directly from you. The application you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage from outside sources, such as medical records, credit reports, court records or other public records. We also might obtain information from third parties, such as other insurance companies or financial institutions that you have notified us of.

What do we do with the information collected about you? The information is kept with your application/policy records. We review it in evaluating your request for insurance coverage and in determining your rates. We will also refer to and use information in our policy records for purposes related to issuing and servicing insurance policies and settling claims. Your agent may use information about you in his/her files for insurance marketing purposes or to help you with your overall insurance program.

To whom do we disclose information about you? We will not disclose information about you to others without your written consent unless the disclosure is necessary to conduct our business. By law, we are also permitted to share some or all of your nonpublic personal information with affiliates or nonaffiliates without prior permission under certain circumstances to certain persons and organizations such as:

- Our affiliated insurance companies.
- Your agent or broker.
- Parties who perform a business, professional or insurance function for our company, including our reinsurance companies.
- Businesses that conduct actuarial or underwriting studies.
- Affiliates or nonaffiliates that market our products. The parties we may share nonpublic personal information with include life and health insurers, insurance agents and marketing firms.
- Other insurance companies, agents or consumer reporting agencies as reasonably necessary in connection with any application, policy or claim involving you.
- Insurance support organizations which are established to collect information for the purpose of detecting and preventing insurance crimes or fraudulent claims.
- Insurance regulatory or law-enforcement agencies in connection with the regulation of our business.

Should you cease to be one of our policyholders or after your claim is settled, it is our policy to archive our information for a period of 5 years.

How do we protect the confidentiality of information about you? We restrict access to nonpublic information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information. Confidentiality agreements are obtained from third-party vendors where services they perform for us in connection with our normal business operation may give them access to nonpublic information. Finally, Medico™ Insurance Company and Medico™ Life Insurance Company educate their employees regarding privacy so that they know about its importance.

How can you find out about information we have about you? You have the right to know what kind of information we keep in our files about you, to have reasonable access to it and receive a copy. Write to us if you have questions about information that you would like to receive. When you write us, please provide your complete name, address, type of policy and policy number that was issued or applied for with us and identify the information you seek.

Medico™ Group
Attn: Policyholder Services
1515 South 75th Street
Omaha, NE 68124

CAPS - Claims and Policy System

Policy Search | Claim Search | Diary Search | Provider Search | Prov. Diary Search | Personal Queue | Untagged Calls

Policy : 94673 | Claim : 1129715 | Claim : 652988

Policy Holder: GLADYS WHITE
Claim #: 652988
Carrier Claim #: 980004-001
Loss Date: 06/01/2007
PolicyID: 94673
Issuing Company: Medico Insurance
Issue State: WA
Policy Status: Terminated - Lapsed
Status Eff Date: 02/08/2009
Tag Call Type
Tag Call
Claim Status: Closed - Benefit Qualifier Not Met
Policy #: 0S34226
Policy Type: 696
Tax Qualified: TQ

Claim Detail | Addresses | Plan Detail | Diary List | Claim Providers | Claim/Payment List | Notes | Documents | Related Items | Diary: 216272 Complaint

Create/Edit Policy Note

Created By
Created Date
Note ID
Note Text
Policy Related
Claim Related
Save | Clear

Show Policy Notes | Show Claims Notes

group by area Drag a field here to group by that field

112213	SENT NEW AUTH TO PI. WHEN RECEIVED, REQUEST MED RECORDS. ORDERED ONSITE. FILE IN MY AREA FILE TO LH 11-27- DR REC.RECD FILE IN MY AREA	Legacy System Notes	P	SYSTEM	07/16/2007
112212	NEED TO ADD TO CASE MANAGEMENT AND UPDATE MED INFO. RELEASEDHHC 7-9-07 WITH COMMENT 395 AND RETURNED TO EXAM. TRANS TO TIE	Legacy System Notes	P	SYSTEM	07/09/2007
112211	RECEIVED BILL FOR APRIL REQUSTED COPY SHOWING THE DAYS AND HOURS WORKED.	Legacy System Notes	P	SYSTEM	06/14/2007
112210	ATTENDING PHYSICIAN'S STATEMENT RECEIVED.... DATED 10-12-06	Legacy System Notes	P	SYSTEM	10/19/2006
112209	*POLICY IS $ AMT-$131,400.00MAX*($120 XS 109S DAYS) *PAY DAILY NOT BULK PER BK 12-19-06 WEEKLY BENEFIT* SPOKE W/ DAUGHTER OF PI 05-17-06, PI FELL 1 WEEK AGO & IS GOING TO REQUIRE MORE CARE. I EXPLAINED ROLL-OVER PROCESS IF SHE GOES TO A ASSISTED FACILITY & THAT WE WILL CONSIDER MORE HRS FOR HHC IF	Legacy System Notes	P	SYSTEM	05/17/2006
112208	FILE TO IMAGING 04/26/2006	Legacy System Notes	P	SYSTEM	04/26/2006
112205	IS GOING TO START WITH PRIVATE CARE GIVER DUE TO THE FACT THAT HOME HELPERS IS NOT WORKING OUT 3 HOURS IS STILL ADEQUATE FOR CARE PER DAUGHTER CHERYL SILVERNAIL I O K'D THIS CHANGE IN CARE DR. ALEXANDER MIHALI 1901 S UNION TACOMA WA 98405 PHONE IS 253-459-6510	Legacy System Notes	P	SYSTEM	12/07/2004

Version: 11.5.6.1

Stoner, Bianca (OIC)

From: Stoner, Bianca (OIC)
Sent: Wednesday, August 11, 2010 9:27 AM
To: 'Jwhitebball@aol.com'
Cc: Marquis, Stephanie (OIC)
Subject: RE: Ask Mike - Category: Long term care insurance

Thank you for contacting the Office of the Insurance Commissioner. Commissioner Kreidler has asked me to respond on his behalf regarding your insurance issue, and we have also forwarded your e-mail to him regarding your acquaintance with him.

We're going to open a case regarding your issue, so we're sending the information that you sent to us to Ability. When they respond, we'll let you know what they say, and we'll go from there.

Thank you for contacting us, and if you have any further questions or concerns, please feel free to let us know.

Bianca Stoner
Compliance Analyst
Consumer Advocacy
Washington State Office of the Insurance Commissioner
1-800-562-6900
BiancaS@oic.wa.gov

Want to learn more about the Office of the Insurance Commissioner and our services?
Read our WAinsurance blog | Follow our consumer updates on Twitter | Get our news releases and updates on new laws

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From: Jwhitebball@aol.com [mailto:Jwhitebball@aol.com]
Sent: Monday, August 09, 2010 4:12 PM
To: OIC Ask Mike
Cc: Jwhitebball@aol.com
Subject: Ask Mike - Category: Long term care insurance

Your Contact Information:

Name:	JACK R WHITE
Address:	5812 STARBOARD DR
City:	GREENSBORO
State:	NC
zip:	27410
Email	Jwhitebball@aol.com
Phone	336 643 1236 or 336 508 1376

Category: Long term care insurance

Your comment or question:
Mike..I hope you recognize my name..I went to high school with you at Curtis..I am living in NC now but my

concern is about my mom who do... live in a nursing home in Puyallup Wa., ..u probably remember her from the lunchroom at school...anyway I will try to make this brief..mom purchased longterm care from mutual protective medico life in 8/7/99..from 2002-2007 a claim was processed for mom's broken hip.My sister Cheri has the durable power of attorney for our mom..she sent all claims in for this period of time and she put her name,phone #,cell#,work#,on all claims.On 6/27 claim was closed for not meeting benefit qualifiers..7/23/09 mom broke her wrist in a fall at home,she was hospiatized for 3 days,then sent to a nursing home..8/4/09 Cheri talked to the claims dept for the insurance co.the guy she talked to told her to get a claim form online and submit,she did and sent it in on 8/6/09,he did not inform Cheri the insurance had lapsed due to non-payment..9/8/09 a claim form was faxed from franklin house(mom's residence) and a copy of the durable power of attorney.A letter was recvd from ability insurance saying they had recvd the power of attorney papers,in order to proceed with them they had to have the addresses and phone#'s of each person on the durable power of attorney,all info was mailed back to them..9/9/09 a letter was recvd from ability insurance(they apparently purchased mutual protective medco life)it was mailed to my mom's house dated 8/31/09,they acknowledged Cheri's correspondence of 8/4/09.They informed Cheri the insurance had lapsed due to non payment.9/11/09 Cheri faxed a letter to the insurance company and asked them to contact her in regard to the letter written on 8/31..Sharon from the claims dept contacted Cheri on 9/15/09 and discussed the fact mom had quit making payments on the policy..Cheri told her about mom's cognitive impairment and that she had been shredding bills and hiding other correspondence..Cheri asked why she(cheri) hadn't been informed of the non-payment since she was the one taking care of the previous claims,and that there was numerous ways to contact Cheri..Cheri was told that they weren't sure they still had access to those records because of the changes of the insurance companies..Cheri was told to to get documentation of mom's cognitive impairment and send them in..9/30/09 documentation from good samaritan hospital in puyallup stating she had dementia..10/12/09 Cheri faxed over the october invoice from franklin house.10/25/09 Cheri called Ability insurance and asked why she hadn't heard from them,they said they hadn't recvd any correspondence..on 10/27 again faxed over again the invoice that was sent previous..11/5/09 Cheri recvd a letter from Ability stating the contract lapsed for non-payment of premium on Feb 7,2009..they said notice was sent to mom on 3 occasions to her home address,they said they also had sent a letter to Cheri giving notice,to her address in eatonville which was given to them in Sept 2007..11/30/09 Cheri wrote a letter in response..saying when talking to Sharon in claims that Cheri had moved from her home in eatonville in July of 2008,Cheri had a forward on her mail and never recvd notice from this company,also stating they had numerous phone numbers to contact her..12/4 Cheri recvd a letter denying the claim..Mike I would appreciate you looking into this as my mom can't afford to pay for this on her own ..I look forward to hearing from YOU on this and maybe we can catch up also..Thanks again Jack White class of 1962.

How did you hear about us?

Please tell us how you heard of this office and the services provided.

Relative/Friend

We will try to respond to your comments and questions at the soonest time possible. If you would like immediate assistance, contact the Insurance Consumer Hotline at 1-800-562-6900.

Visit the Washington Insurance Blog at http://wainsurance.blogspot.com for news, updates, and information from Washington State's office of the Insurance Commissioner.

MEDICO™ GROUP

Medico™ Insurance Company
Medico™ Life Insurance Company
1515 South 75th Street • P.O. Box 3477

Patient: #268593
White,Gladys E
DOB: 7/08/1923
SEX: Female
PH: 253-845-1228
W/C:
9223 80TH AVE CT E
PUYALLUP, WA 98371
LW ID: 00048387

ENC#: 6764269 7/3/07 11:30 AM
ALLENMORE IM
PROV: #1533 MIHALI, ALEXANDER K
PCP: MIHALI, ALEXANDER K
REF:
ACCT: #134452 Personal/Family
GUARANTOR: WHITE,GLADYS E
MEDICARE
MEDICARE A & B
1ST CH NET
CARPENTERS TRUST

ATTENDING PI
Must Be Co

PATIENT'S NAME _____

Policy # 0S34226

1. Primary Diagnosis/ICD9 Code 716.15 Date of Onset 2000
   Secondary Diagnosis/ICD9 Code 733.13 250.00 Date of Onset 2006 / PTO
2. Date you last saw this patient 3 Jul 07 Reason for visit above issues
3. Are any of the following services necessary? Please check all that apply.

RN	☐	Occupational Therapist	☐
Certified Aide	☐	Speech Therapist	☐
Homemaker	☐	Other Caregiver	☒
Physical Therapist	☐		

4. Care Setting

Nursing Home	☐	Adult Day Care	☐
Assisted Living Facility	☐	Other own home	☒
Personal Residence	☐		

5.

[ADLs]	Performs Completely Independently	Performs Independently Using Assistive Device	Able to Complete Only with Cueing or Supervision of Another Person	Requires Some Human Assistance with Certain Elements of Task	Requires Substantial Assistance from Another Person to Complete
Bathing/Showering/Sponge	☐	☒	☐	☐	☐
Transferring	☐	☒	☐	☐	☐
Continence Bladder/Bowel	☒	☐	☐	☐	☐
Eating	☒	☐	☐	☐	☐
Toileting	☐	☒	☐	☐	☐
Dressing	☒	☐	☐	☐	☐

6. Expected amount of care required: 3 Hrs/Day 5 Days/Wk 4 Weeks/Months

   Note: Recommendations for the care described above are theoretical, based upon your observations. A definitive opinion of the need for the services is based upon all documentation including, but not limited to, assessments, medical records, and actual utilization of support services.

   Failure to complete this form in full could possibly result in benefit qualifiers not being met. Use of "lifetime" and/or "99 years" is not acceptable for #6 unless insured has a terminal diagnosis or a severe progression of disease process.

7. Should this patient be capable of returning to prior level of independence with rehabilitation? ☐ Yes ☒ No
   If no, why Expect ~~prog~~ progressive decline — assistive living.
8. If this care was not available, would this patient require nursing facility confinement? ☒ Yes ☐ No
   If yes, why Not relevent — needs cleaning & transportation

Long-term care policies vary in the definitions of the Activities of Daily Living. This request is for general medical information. Additional medical information may be required.

Thank you for completing this form; please fax it to 402-398-0898.

Physician Signature _____ Date 3 Jul 07

Name and Address of Attending Physician Alexander K Mihali
1961 S. Union Ave, Tacoma, WA 98405

RECEIVED JUL 2007

Please see our website at www.gomedico.com for additional copies of forms.

U3F-208 03202007

Intake - Old Carrier Information - Pol# 0S34226, Clm# 1129715 - DocID 147249, CLAIMS

MultiCare
Allenmore Internal Medicine

BetterConnected

Allenmore Internal Medicine
MultiCare Medical Group
3124 S 19th St.
Tacoma, WA 98405-1706
(253) 459-6510
www.multicare.org

3/21/2011

To Allen Singer Attorney at Law

Ms. Gladys E White has been under my care since 1983. On the office visit of June 11, 2009 she was noted to have mild cognitive impairment in that she had no recollection of what she had for breakfast or lunch. In fact she was not even certain she had eaten. She was oriented to self and and place but not time. She knew the name of the president at that date. On a prior visit on November 6, 2008, her daughter noted significant problems with memory. This was not apparent on my brief mental evaluation and unfortunately she was not seen in follow-up the following month as requested.
In summary Mrs. White was demonstrating mild cognitive impairment on the June 2009office visit, and a more probable than not basis this was present in November 2008.

Sincerely,

Alexander K Mihali, MD

Oct. 24. 2007 9:57AM No. 5008 P. 1

Ballou Junior High

facsimile transmittal

To: Tic Van Dyke Fax: 402-398-0898

From: Cheryl Silvernale Date: 10/24/07

Re: Gladys White Pages:

CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Claim # 0534226

Ballou Junior High
9916 136th Street East
Puyallup, WA 98373
253-841-5725
Fax: 253-840-8819

October 23, 2007

Dear Ms. Van Dyke,

I am writing in regards to the phone conversation you and I had yesterday, after which I went back through some of the correspondence that I have on file regarding my mother's claim.

You stated in your letter of August 31 that she no longer meets the benefit qualifiers to continue the claim. You said that in order to qualify for benefits, she had to require hands on assistance with two of the six Activities of Daily Living. I believe she does.

1. Help in bathing
2. Incontinence

A letter was written and sent on April 14, 2004 by her caregiver at that time. (I have attached a copy of the letter) This letter was sent to Daniel Bowen, her claim adjuster. It outlined all the work that her caregiver performed for my mother. She stated in the letter that because of the walker, she is unable to move as quickly and has a problem with incontinence. This problem has not improved. In fact, it is worse. I know that when she gets up during the night, she rarely makes it to the bathroom before she wets herself and/or her bed. Because of this problem, she requires assistance with a daily bath.

Her present caregiver is providing all the services as outlined in the chart contained in the attached letter.

Based on this information, I believe my mother is still entitled to continuing insurance coverage.

I appreciate any assistance you can give us in resolving this issue. Thank you for your prompt attention to this matter.

Cheryl Silvernail

April 14, 2004

Dear Mr. Bowen:

Listed below is work that I perform for my client, Gladys White, on a daily and/or weekly basis.

Job	Daily	Bi -Weekly	Weekly	Monthly	Semi-annually
Dust			x		
Vacuum			x		
Clean Bathroom	x				
Clean Kitchen	x				
Make Bed	x				
Change Bed Sheets	x				
Sweeping	x				
Mopping: Kitchen Bathroom	 x		 x		
Clean oven				x	
Defrosting				x	
Wash windows					x
Wash walls					x
Laundry	x				
Grocery shopping			x		
Pharmacy			x		
General Shopping			x		
Prepare meals (3 times a day)	x				
Bathing	x				

Since Gladys broke her hip and uses her walker full time, she has not been able to get a driver's license. With her unable to drive, I have to take her grocery shopping, pick up her prescriptions, and do her general errands.

Due to the walker, and her inability to move as quickly, Gladys has a problem with incontinence with urinating. I have to bathe her and do her laundry daily.

Besides her physical limitations, I don't feel emotionally, Gladys could handle being by herself for a full day. Her husband passed away in September, and I have been her companion during the week. Her children offer her support and care on the weekends.

As you can see, she still requires quite a bit of daily care. If you have any further questions, please call me at Glady's home (253-845-1228) or at my home (253-537-5079).

Thank you,

Gertrud Callendar

Gertrud Callendar
Caregiver

(6)

MEDICO™ GROUP

Medico™ Insurance Company • Medico™ Life Insurance Company

August 27, 2007

REC'D P.S.

SEP 10 '07

GLADYS E WHITE
9223 60 AVE CT E
PUYALLUP WA 98371

Policy No.: 0S34226

Dear Gladys E White,

You may name an Advisor(s) to provide extra security against the unintentional lapse of your insurance policy. This will enable us to send a notification to the person you name in case of an unpaid premium. If you do not wish to take advantage of this opportunity, please sign the waiver below and return the form to us.

Please designate a person in the space provided and sign below,
– or –
sign the Waiver that follows.

1. Advisor's Name: Cheryl Silvernail
   Home Address: 3440 2 Thomas Rd. E
   City: Eatonville State: Wash Zip: 98328
   Phone Number: (253) 360 879 5543
2. Name of Second Advisor (Optional): _____
   Home Address: _____
   City: _____ State: _____ Zip: _____
   Phone Number: ( ) _____

You have the right to change this written designation at least once every two years.

X DATE: Sept 16-07 X SIGNATURE: Gladys E White

WAIVER OF PROTECTION AGAINST UNINTENDED 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 insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice.

X DATE: Sept 16-07 X SIGNATURE: Cheryl Silvernail

Please return this completed form in the enclosed postage-paid envelope.

U2460

02052004

Protecting Your Future Today®

1515 South 75th Street • Omaha, NE 68124 • (402) 391-6900 • fax (402) 391-6489 • www.gomedico.com

7

MEDICO® GROUP
Medico® Insurance Company

March 20, 2009

CHERYL SILVERNAIL
34402 THOMAS RD E
EATONVILLE WA 98328

RE: Gladys E White
Policy No.: 0S34226
Due: 02/08/2009

Dear Cheryl Silvernail,

You have been named as the Advisor to receive notification of this past due premium for Gladys E White.

All of our long-term care/home health care policyholders are given the opportunity to name an Advisor. The Advisor receives a notice from us any time the policyholder's premium is 30 days past due. Our policyholder trusts you to contact him/her to discuss the importance of paying the policy premium.

If the premium is not received within 35 days from the date of this letter, the policy will lapse for nonpayment of premium.

Thank you,

Timothy J. Hall
President

U2462

02162009

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08/12/2009 pg003

August 6, 2009

TO: Claims Department (Fax # - 402-391-6489)

FROM: Cheryl Silvernail (daughter of Gladys White)

RE: New Claim

I spoke with Jerry in the claims department on Tuesday, August 4th. We went over some information regarding my mom's long term care insurance. He advised me to get the claim form on line. If you have any questions or need additional information, please call me at:

Home: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

FAX: 253-840-8819

Thank you.

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AUG 07 2009
CLAIMS DEPARTMENT

08/12/2009 pg001

Ability Ins
ABILITY INSURANCE CO.
Long Term Care Claims Department
P.O. Box 3735 • Omaha, NE 68103
Phone (877) 795-8493 Fax (866) 498-0689 Customersupport@abilityre.net

Claimant's Proof of Loss

Long-Term Care Insurance Claim Request Form

Claimant and Contact Information

Insured's Name: Gladys E. White
Date of Birth: 7/8/1923
Policy #: 0534226
Home Address: 9223 60th Av. Ct. E Puyallup WA 98371
Daytime Phone #:
Social Security #:

In order for this request to be further processed, a member of our Claims department will need to speak with either the Insured or their representative about this claim. For best service and most timely processing, please provide all of the information requested in the spaces below.

Name of Person to Contact About this Claim: Cheryl Silvernail
Relationship to Insured: daughter
Power of Attorney: ☐ Yes ☒ No
Address: 13714 143RD Av. E. Orting WA 98360
Daytime Phone #: 253-841-8726
Alternate Phone #:
Best Time to Call:

Claimant's Condition

Event (Illness, Injury, etc...) that led to a need for Long Term Care services: fainted - fell - broke her wrist
Date Illness/Injury Started:

Level of Assistance- Please check the box that best describes the assistance the Insured requires with each activity

	Independent	Standby Assist	Hands-On Assist	Date this Assistance Began
Bathing	☐	☐	☒	
Dressing	☐	☐	☒	
Eating	☒	☐	☐	
Toileting	☐	☐	☒	
Transferring	☐	☒	☐	
Continence	☐	☐	☒	
Other:				

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CLAIMS DEPARTMENT

Does the Insured have a diagnosis of Alzheimer's Disease or other type of Dementia? ☒ Yes ☒ No Symptoms

If Yes, please describe the Insured's Cognitive Status (memory, judgment, ability to manage medications, safety concerns, etc...) insulin
Doesn't remember to take medications - she's a diabetic high blood pressure

Medical Provider Information

Attending Physician's Name: Dr. Rudnick
Office Phone #: 253-840-4400
Office Fax #: 253-840-6733
Physician's Address: 4002 29th St. NE Puyallup WA 98372

Has the Insured Been Hospitalized within the past 12 months? ☐ No ☒ Yes, Complete Section Below

Name of Hospital: Good Samaritan Hosp.
Address: 407 14th Av. S.E. Puyallup WA 98372
Phone #: 253-697-4000
Admission Date: 7/25/09
Discharge Date: 7/28/09

NE 3F-220 06/22/2009

08/12/2009 ps892

Long-Term Care Provider Information

What Type of Care Does the Insured Need?

☐ Nursing Home ☒ Assisted Living ☐ Home Health Care ☐ Hospice ☐ Other:

Does the Insured currently have Long Term Care Services In Place? ☒ No ☒ Yes, Complete Section Below

Name of Facility/Agency:	Phone #:	Type of Care:
Lynden Grove	253-840-4400	

Facility/Agency Address: 400 29th St. N.E. Puyallup WA

Date Care Began:	Date Care Ended:	Name of Contact Person at Facility/Agency:	Fax #:
7/28/09			

Please Note: If you are currently receiving services from more than 1 Long Term Care provider, please provide all of the information requested above for each provider in the white space at the bottom of this form.
If you obtain services from any non-qualified provider, they will not be covered under your policy.
If you obtain services that are not covered under the Policy, we will not be able to reimburse for these services.

Medicare and Other Insurance Information

Are you eligible for or currently enrolled in

Medicare Part A	☒ Yes	☐ No
Medicare Part B	☐ Yes	☐ No
Medicaid	☐ Yes	☐ No

Have any of your Long-Term Care expenses been paid for by Medicare? ☐ No ☐ Yes, Complete Section Below

Start Date:	End Date:	Agency/Facility:
7/28/09		Linden Grove

Do you have any other Long-Term Care Insurance Policies? ☒ No ☐ Yes, Complete Section Below

Insurance Company Name:	Address:	Policy #:	Daily Benefit Amt.:
			$

Signature

My signature below indicates that I understand that the claims processing procedure includes the collection of personal medical information. I also understand that an on-site assessment may also be required. This assessment will be completed at no cost to me by a licensed health care practitioner of Ability Insurance Company's choice.

Signature of the Insured or POA:	Date Signed:

Please return this form and any additional documents to the address at the top of the first page.

Please Remember to Include the Following with this Form:

- ☐ A Copy of the Power of Attorney Document (If applicable)
- ☐ The signed Authorization to Use and Disclose Personal Information form (see page 3 of this form)
- ☐ Copies of invoices for any long term care costs you have incurred thus far
- ☐ A statement of the hourly and/or daily charge for the service you are receiving
- ☐ A copy of the license of the provider you are using and their tax ID number

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AUG. 07 2009
CLAIMS DEPARTMENT

WARNING – Fraud Notice: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as further defined by your state statute.

08/12/2009

Policyholder's Name: Gladys E. White
Policy Number(s): OS34226

AUTHORIZATION TO USE AND DISCLOSE PERSONAL INFORMATION

MEANING OF TERMS
Health Care Provider means: all physicians; medical or dental practitioners; hospitals; other health care facilities (including nursing facilities and assisted living facilities); pharmacies; pharmacy benefit managers; the Medical Information Bureau; and any other person or organization that furnishes, bills or is paid for care, services or supplies related to the health of an individual.
Personal Information means: all information about the health of an individual, including medical records in their entirety, information about physical condition and mental condition (excluding psychotherapy notes), prescription drug records and information about drug and alcohol use. Personal Information also includes information about personal finances, occupation, general reputation and insurance claims.

AUTHORIZATION TO DISCLOSE
I authorize any Health Care Provider, government agency, insurance company, insurance agent, employer or consumer reporting agency to disclose Personal Information about me, or my dependent named below, to Ability Insurance Company and to any persons acting on the Company's behalf for the purposes described below.

AUTHORIZATION TO USE
I authorize Ability Insurance Company, or any person or entity employed by the Company, to use the Personal Information covered by this authorization for the purposes described below.

PURPOSES OF DISCLOSURE
Personal Information will be used to determine my and, if applicable, my dependents' eligibility for insurance and to resolve any issues regarding incomplete or incorrect information on my application for insurance that may arise during the processing of the application or in connection with a claim for insurance benefits.

POTENTIAL FOR REDISCLOSURE
The Personal Information used or disclosed based on this authorization may be subject to further disclosure without the protections of federal privacy regulations.

REFUSAL TO SIGN
I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, Ability Insurance Company will not accept my application for insurance, and insurance benefits will not be payable.

EXPIRATION AND REVOCATION
This authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time by written notice to: Ability Insurance Company, PO Box 3735, Omaha NE 68103.

I understand that my right to revoke this authorization is limited to the extent that Ability Insurance Company has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under my insurance policy.

COPY OF THIS AUTHORIZATION
I understand that I will receive a copy of this authorization. A copy of this authorization is as valid as the original.

NAMES AND SIGNATURES

Gladys White
Printed Name of Applicant/Insured

Gladys E. White
Signature of Applicant/Insured

8/4/09
Date

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AUG 07 2009
CLAIMS DEPARTMENT

If applicable: I am the personal representative of the insured named above whose Personal Information is to be disclosed, and I am authorized to grant permission for disclosure.

Cheryl Silvernail
Printed Name of Personal Representative

daughter
Description of Personal Representative's Authority

Cheryl Silvernail
Signature of Personal Representative

8/4/09
Date

PS - HIPAA Authorization - Pol# OS34226 - DocID 1228377

AbilityIns
ABILITY INSURANCE CO.
Administered on behalf of Medico Life Insurance Company
Long Term Care Customer Support Department
PO Box 3735 • Omaha, NE 68103
Phone (877) 795-8493 • Fax (866) 498-0689 • www.abilityinsurance.com

POA

GLADYS E WHITE
9223 60 AVE CT E
PUYALLUP WA 98371

Policy: 0S34226

We recently received Power of Attorney papers, Guardian, Conservator, or Trustee papers from you. In order to proceed with adding them to our database we must have their address and phone number. Please provide us with this information in the spaces below for every person listed on those papers. If you have any questions please contact us at 877-795-8493.

Thank you,

Ability Insurance Company
Customer Support

RECEIVED
OCT 09 2009
ABILITY - OMAHA

Name William White
Address 28039 177th Av. S.E. Kent, WA 98042
Phone 253-335-2099
253-630-1855 | WINTERS IN ARIZONA - Oct - May
215 E. LOS RINCONES
GREEN VALLEY, AZ. 85614

Name Nancy Connelly
Address 14623 3RD DR. S.E. Mill Creek, WA. 98012
Phone 425-745-5738

Name Mardee Crawford
Address 7506 144 Av. Ct. E
Sumner, WA 98390 253-891-8540

09/08/2009 pg001

DURABLE POWER OF ATTORNEY OS 34226

I, Gladys E. White (name), of 9223 60th Ave. Ct. E Puyallup, WA (address, including county and state) Pierce County hereby appoint William C. White (name of your agent), to serve as my agent ("Agent") and to exercise the powers set forth below. If said agent is unable or unwilling to act as my agent, then I appoint the following as my successor agent(s) in the order named:

First Successor Agent: Nancy Connelly (name);

Second Successor Agent: Marlee J Crawford (name)

This instrument shall be effective:

- ☑ Immediately upon the date of execution, and shall not be affected by my subsequent disability, incapacity or incompetence except as provided by statute.
- ☑ Upon my disability, incapacity or incompetence except as provided by statute.
- ☑ Immediately upon the date of execution, and shall terminate upon my disability, incapacity or incompetence.

I hereby revoke all powers of attorney, general or limited, previously granted by me, except for powers granted by me on forms provided by financial institutions granting the right to write checks on, deposit funds to and withdraw funds from accounts to which I am a signatory or granting access to a safe deposit, and except to any powers granted by me for health care decisions.

ARTICLE I.

My Agent is authorized in my Agent's sole and absolute discretion at any time, with respect to any of my property, real (including homestead property or any other interest), personal, intangible and mixed, as follows:

(1) To sell any property that I may own now or in the future, including but not limited to contingent and expectant interests, marital rights and any rights of survivorship incident to joint tenancy or tenancy by the entirety, upon such terms, conditions and security as my Agent shall deem appropriate and to grant options with respect to sales thereof; to make such disposition of the proceeds of such sales as my Agent shall deem appropriate;

(2) To buy every kind of property, upon such terms and conditions as my Agent shall deem appropriate; to obtain options regarding such purchases; to arrange for appropriate disposition, use,

09/08/2009 pg002

STATE OF WASHINGTON)
COUNTY OF PIERCE)

On this 16TH day of August, 2009, before me, personally appeared Gladys E. White, principal, and Marcie A. White and Mardee J. Crawford, witnesses, who are personally known to me or who provided Drivers License (Valid + unexpired) as identification, and signed the foregoing instrument in my presence.

Douglas E. Silvernail
Notary Public

DOUGLAS E. SILVERNAIL
COMMISSION EXPIRES
NOTARY
PUBLIC
10-02-09
STATE OF WASHINGTON

My commission expires: 10/2/09

ACKNOWLEDGMENT AND ACCEPTANCE BY AGENT

The undersigned accepts appointment as Agent and agrees to serve as Agent under this instrument.

William C. White
Signature of Agent

Name: William C. White
Address: 28039 177th Ave. S.E. Kent, WA
Soc. Sec. No. 474-44-6243

DURABLE POWER OF ATTORNEY

I, Gladys E. White (name), of 9223 60th Ave. Ct. E Puyallup, WA (address, including county and state) Pierce County hereby appoint William C. White (name of your agent), to serve as my agent ("Agent") and to exercise the powers set forth below. If said agent is unable or unwilling to act as my agent, then I appoint the following as my successor agent(s) in the order named:

First Successor Agent: Nancy Connelly (name);

Second Successor Agent: Marlee J Crawford (name)

This instrument shall be effective:

- ☑ Immediately upon the date of execution, and shall not be affected by my subsequent disability, incapacity or incompetence except as provided by statute.
- ☑ Upon my disability, incapacity or incompetence except as provided by statute.
- ☑ Immediately upon the date of execution, and shall terminate upon my disability, incapacity or incompetence.

I hereby revoke all powers of attorney, general or limited, previously granted by me, except for powers granted by me on forms provided by financial institutions granting the right to write checks on, deposit funds to and withdraw funds from accounts to which I am a signatory or granting access to a safe deposit, and except to any powers granted by me for health care decisions.

ARTICLE I.

My Agent is authorized in my Agent's sole and absolute discretion at any time, with respect to any of my property, real (including homestead property or any other interest), personal, intangible and mixed, as follows:

(1) To sell any property that I may own now or in the future, including but not limited to contingent and expectant interests, marital rights and any rights of survivorship incident to joint tenancy or tenancy by the entirety, upon such terms, conditions and security as my Agent shall deem appropriate and to grant options with respect to sales thereof; to make such disposition of the proceeds of such sales as my Agent shall deem appropriate;

(2) To buy every kind of property, upon such terms and conditions as my Agent shall deem appropriate; to obtain options regarding such purchases; to arrange for appropriate disposition, use,

safekeeping or insuring of any such property; to buy United States Government bonds redeemable at par in payment of the federal estate tax imposed at my death; to borrow money for the purposes described herein and to secure such borrowings in such manner as my Agent shall deem appropriate; to use any credit card held in my name to make such purchases and to sign such charge slips as may be necessary to use such credit cards; to repay from any funds belonging to me any money borrowed and to pay for any purchases made or cash advanced using credit cards issued to me;

(3) To invest and reinvest all or any part of my property in any property or interests in property, wherever located, including without being limited to securities of all kinds, bonds, debentures, notes (secured or unsecured), stocks of corporations regardless of class, interests in limited partnerships, real estate or any interest in real estate whether or not productive at the time of investment, commodities contracts of all kinds, interests in trusts, investments trusts, whether of the open or closed fund types, and participation in common, collective or pooled trust funds or annuity contracts without being limited by any statute or rule of law concerning investments by fiduciaries; to sell (including short sales) and terminate any investments whether made by me or my Agent; to establish, utilize and terminate savings and money market accounts with financial institutions of all kinds; to establish, utilize and terminate accounts (including margin accounts) with securities brokers; to establish, utilize and terminate managing agency accounts with corporate fiduciaries; to employ, compensate and terminate the services of financial and investment advisors and consultants;

(4) With respect to real property (including but not limited to any real property I may hereafter acquire or receive and my personal residence) to lease, sublease, release; to eject, remove and relieve tenants or other persons from, and recover possession by all possession of by all lawful means; to accept real property as a gift or as security for a loan; to collect, sue for, receive and receipt for rents and profits and to conserve, invest or utilize any such rents, profits and receipts for the purposes described in this paragraph; to do any act of management and conservation, to pay, compromise, or to contest tax assessments and to apply for refunds in connections therewith; to employ laborers; to subdivide, develop, dedicate to public use without consideration, or dedicate easements over; to maintain, protect, repair, preserve, insure, build upon, demolish, alter or improve all or any part thereof; to obtain or vacate plats and adjust boundaries; to adjust differences in valuation on exchange or partition by giving or receiving consideration; to release or partially release real property from a lien; to sell and to buy real property; to mortgage or convey by deed of trust or otherwise encumber any real property now or hereafter owned by me, whether acquired by me or for me by my Agent;

(5) With respect to personal property; to lease, sublease, and release; to recover possession of by all lawful means; to collect, sue for , receive and receipt for rents and profits therefrom; to maintain, protect, repair, preserve, insure, alter or improve all or any part thereof; to sell and to buy the same or other personal property; to mortgage, pledge or grant other security interests in any personal property or intangibles now or hereafter owned by me, whether acquired by me or for me by my Agent;

(6) To exercise all rights with respect to corporate securities which I now own or may hereafter acquire, including the right to sell, grant security interests in, and to buy the same or different securities; to make such payments as my Agent deems necessary, appropriate, incidental or convenient to the owning and holding of such securities; to receive, retain, expend for my benefit, invest and reinvest or make such disposition of as my Agent shall deem appropriate all additional securities, cash or property (including the proceeds from the sales of my securities) to which I may be

or become entitled by reason of my ownership of any securities; to vote at all meetings of security holders, regular or special; to lend money to any corporation in which I hold any shares and to guarantee or endorse loans made to such corporation by third parties;

(7) To apply for, demand, arbitrate, settle, sue for, collect, receive, deposit, expend for my benefit, reinvest or make such other appropriate disposition of as my Agent deems appropriate, all cash, rights to the payment of cash, property (real, personal, intangible or mixed), debts, dues rights, accounts, legacies, bequests, devises, dividends, annuities, rights or benefits to which I am now or may in the future become entitled, regardless of the identity of the individual or public or private entity involved, including but not limited to benefits payable to or for my benefit by any governmental agency or body (such as Supplemental Social Security (SSI), Medicaid, Medicare, and Social Security Disability Insurance (SSDI), and for the purposes of receiving social security benefits, my Agent is hereby appointed my "Representative Payee"); to utilize all lawful means and methods to recover such assets or rights, qualify me for such benefits and claim such benefits on my behalf, and to compromise claims and grant discharges in regard to the matters described herein; to make such compromises, releases, settlements and discharges with respect thereto as my Agent shall deem appropriate;

(8) To create and contribute to an employee benefit plan for my benefit; to select any payment option under any IRA or employee benefit plan in which I am a participant or to change options I have selected; to make voluntary contributions to such plans; to make "roll-overs" of plan benefits into other retirement plans; to apply for and receive payments and benefits; to waive rights given to non-employee spouses under state or federal law; to borrow money and purchase assets therefrom and sell assets thereto, if authorized by any such plans; to make and change beneficiary designations, including revocable or irrevocable designations; to consent or waive consent in connection with the designation of beneficiaries and the selection of joint and survivor annuities under any employee benefit plan;

(9) To establish accounts of all kinds, including checking and savings, for me with financial institutions of any kind, including but not limited to banks and thrift institutions; to modify, terminate, make deposits to, write checks on, make withdrawals from, or grant security interests in, all accounts in my name or with respect to which I am an authorized signatory, whether or not any such account was established by me or for me by my Agent; to negotiate, endorse or transfer any checks or other instruments with respect to any such accounts; to contract for any services rendered by any bank or financial institution;

(10) To contract with any institution for the maintenance of a safe-deposit box in my name; to have access to all safe-deposit boxes in my name or with respect to which I am authorized signatory, whether or not the contract for such safe-deposit box was executed by me (either alone or jointly with others) or by my Agent in my name; to add to and remove from the contents of any such safe-deposit box and to terminate any contracts for such boxes;

(11) To institute, supervise, prosecute, defend, intervene in, abandon, compromise, arbitrate, settle, dismiss, and appeal from any and all legal, equitable, judicial or administrative hearings, actions, suits, proceedings, attachments, arrests or distresses, involving me in any way, including but not limited to claims by or against me arising out of property damages or personal injuries suffered by or caused by me or under such circumstances that the loss resulting therefrom will or may be imposed on me and otherwise engage in litigation involving me, my property or any interest of mine, including any property or interest of person for which or whom I have or may have any

responsibility;

(12) To borrow money from any lender for my account upon such terms and conditions as my Agent shall deem appropriate and to secure such borrowing by the granting of security interests in any property or interests in property which I may now or hereafter own; to borrow money upon any life insurance policies owned by me upon my life for any purpose and to grant a security interest in such policy to secure any such loans (including the assignment and delivery of any such policies as security); and no insurance company shall be under any obligation whatsoever to determine the need for such loan or the applications of the proceeds by my Agent;

(13) To execute a revocable trust agreement with such trustee(s) as my Agent shall select which trust shall provide that all income and principal shall be paid to me, to some person for my benefit or applied for my benefit in such amounts as I or my Agent shall request or as the trustee(s) shall determine, and that on my death any remaining income and principal shall be paid to my personal representative, and that the trust may be revoked or amended by me or my Agent at any time, provided, however, that any amendment by my Agent must be such that by law or under the provisions of this instrument such amendment could have been included in the original trust agreement; to deliver and convey any or all of my assets to the trustee(s) thereof; to add any or all of my assets to such a trust already in existence at the time of the creation of this instrument or created by me or my Agent at any time thereafter; and my Agent may be sole trustee or one of several trustees; and to execute such instruments, documents and papers to effect the transfers described herein as may be necessary, appropriate, incidental or convenient; to make such transfers absolutely in fee simple or for my lifetime only with the remainder or reversion (of the property so transferred) remaining in me so that such property will be disposed of at my death by my will or by the intestacy laws of the state in which I shall die a resident;

(14) To withdraw or receive the income or corpus of any trust over which I may have a right of receipt or withdrawal; to request and receive the income or corpus of any trust with respect to which the trustee thereof has the discretionary power to make distributions to or on my behalf, and to execute and deliver to such trustee a receipt and release or similar document for the income or corpus so received; to exercise (in whole or in part), release or let lapse any power of appointment held by me, whether general or special, or any power of amendment or revocation under any trust (including any trust with respect to which I may exercise any such power only with the consent of another person, even if my Agent is such other person), whether or not such power of appointment was created by me, subject however, to any restrictions upon such exercise imposed upon my Agent and set forth in other provisions of this instrument;

(15) To purchase, maintain, surrender, collect, or cancel (a) life insurance or annuities of any kind on my life or the life of any one in whom I have an insurable interest; (b) liability insurance protecting me and my estate against third party claims; (c) hospital insurance, medical insurance, Medicare supplement insurance, custodial care insurance, and disability income insurance for me or any of my dependents; and (d) casualty insurance insuring assets of mine against loss or damage due to fire, theft, or other commonly ensured risk; to pay all insurance premiums, to select any options under such policies, to increase or decrease coverage under any such policy, to borrow against any such policy, to pursue all insurance claims on my behalf, to adjust insurance losses, and the foregoing powers shall apply to private and public plans, including but not limited to Medicare, Medicaid, SSI and Workers' Compensation.

(16) To represent me in all tax matters; to prepare, sign, and file federal, state, or local

income, gift and other tax returns of all kinds, including, where appropriate, joint returns, claims for refunds, requests for extensions of time to file returns or pay taxes, extensions and waivers of applicable periods of limitation, protests and petitions to administrative agencies or courts, including the tax court, regarding tax matters, and any and all other tax related documents, including but not limited to consents and agreements under Section 2032A of the Internal Revenue Code or any successor section thereto and consents to split gifts, closing agreements, and any power of attorney form required by the Internal Revenue Service or any state or local taxing authority; to pay taxes due, collect and make such disposition of refunds as my Agent shall deem appropriate, post bonds, receive confidential information and contest deficiencies determined by the Internal Revenue Service or any state or local taxing authority; to exercise any elections I may have under federal, state or local tax law; to allocate any generation-skipping tax exemption to which I am entitled, and generally to represent me or obtain professional representation for me in all tax matters and proceedings of all kinds and for all periods before all officers of the Internal Revenue Service or any state or local taxing authority and in all courts; to engage, compensate and discharge attorneys, accountants and other tax and financial advisors and consultants to represent or assist me in connection with all tax matters involving or in any way related to me or any property in which I have or may have an interest or responsibility;

ARTICLE II.

My Agent is authorized in my Agent's sole and absolute discretion at any time to exercise the authority described below relating to matters involving the control and management of my person, and my health and medical care. In exercising the authority granted to my Agent herein, I first direct my Agent to try to discuss with me the specifics of any proposed decision regarding the control and management of my person or my health and medical care if I am able to communicate in any manner, however rudimentary. My Agent is further instructed that if I am unable to give an informed consent to medical treatment and my Agent cannot determine the treatment choice I would want made under the circumstances, my Agent shall give or withhold such consent for me based upon any treatment choices that I may previously have expressed on the subject while competent, whether under this instrument or otherwise. If my Agent cannot determine the treatment choice I would want made under the circumstances, then my Agent should make such choice for me based upon what my Agent believes to be in my best interests. Accordingly, my Agent is authorized as follows:

(1) To request, receive and review any information, verbal or written, regarding my personal affairs or my physical or mental health, including medical and hospital records, and to execute any releases or other documents that may be required in order to obtain such information, and to disclose or deny such information to such persons, organizations, firms or corporations as my Agent shall deem appropriate;

(2) To employ and discharge medical personnel including physicians, psychiatrists, dentists, nurses, and therapists as my Agent shall deem necessary for my physical, mental and emotional well-being, and to pay them (or cause them to be paid) reasonable compensation;

(3) To give or withhold consent to any medical procedures, tests or treatments, including surgery; to arrange for my hospitalization, convalescent care, hospice or home care; to summon paramedics or other emergency medical personnel and seek emergency treatment for me, as my Agent shall deem appropriate; and under circumstances in which my Agent determines that certain

medical procedures, tests or treatments are no longer of any benefit to me or where the benefits are outweighed by the burdens imposed, to revoke, withdraw, modify or change consent to such procedures, tests and treatments, as well as hospitalization, convalescent care, hospice or home care which I or my Agent have previously allowed or consented to or which may have been implied due to emergency conditions. My Agent's decisions should be guided by taking into account (a) the provisions of this instrument, (b) any reliable evidence of preferences that I may have expressed on the subject, whether before or after the execution of this document, (c) what my agent believes I would want done in the circumstances if I were able to express myself, and (d) any information given to my Agent by the physicians treating me as to my medical diagnosis and prognosis and the intrusiveness, pain, risks and side effects of the treatment;

(4) To take whatever steps are necessary or advisable to enable me to remain in my personal residence as long as it is reasonable under the circumstances. I realize that my health may deteriorate so that it becomes necessary to have round-the-clock personal or nursing care, and I authorize my Agent to make all necessary arrangements, contractual or otherwise, for home health care, or care for me at any hospital, nursing home, adult congregate living facility, hospice, or similar establishment, and I direct my Agent to obtain such care (including any such equipment that might assist in my care) as is reasonable under the circumstances. Specifically, I want to remain in my personal residence as long as it is reasonable;

(5) To exercise my right of privacy and my right to make decisions regarding my medical treatment; to consent to and arrange for the administration of pain-relieving drugs of any kind, or other surgical or medical procedures calculated to relieve pain, including unconventional pain-relief therapies which my Agent believes may be helpful to me; even though such actions may lead to permanent damage, addiction or even hasten the moment of (but not intentionally cause) my death;

(6) To grant, in conjunction with any instructions given under this Article, releases to hospital staff, physicians, nurses and other medical and hospital administrative personnel who act in reliance on instructions given by my Agent or who render written opinions to my Agent in connection with any matter described in this Article from all liability for damages suffered or to be suffered by me; to sign documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice" *as* well *as* any necessary waivers of or releases from liability required by any hospital or physician to implement my wishes regarding medical treatment or nontreatment;

(7) To assist and facilitate the carrying out of my wishes as set forth in any living will or life-prolonging procedures declaration I have executed; to request, require or consent to the writing of a "No-Code" or "Do Not Resuscitate" order by any attending physician.

ARTICLE III.

(1) In connection with the exercise of the powers herein described, my Agent is fully authorized and empowered to perform any acts and things and to execute and deliver any documents, instruments, and papers necessary, appropriate, incident or convenient to such exercise, including pursuing any legal or judicial remedies to which I would otherwise be entitled to pursue.

(2) No person, organization, corporation or entity, who relies in good faith upon the

authority of my Agent under this instrument, shall incur liability to me, my estate, my heirs or assigns, as a result of such reliance.

(3) If any part of any provision of this instrument shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity only, without in any way affecting the remaining parts of such provision or the remaining provisions of this instrument.

(4) In regard to medical decisions affecting me, I intend for this instrument to be honored in any jurisdiction where it may be presented and given the most liberal interpretation available for purposes of granting my Agent the fullest amount of discretion in making decisions on my behalf. Should any physician or health care institution fail to honor this instrument, then my Agent is authorized to terminate the services of such persons and institutions and to transfer my care to another physician or health care institution that will honor the instructions of my Agent.

(5) If this instrument has been executed in multiple originals, each such counterpart original shall have equal force and effect. Any photocopy of this instrument shall have the same force and effect as an original.

(6) This instrument and the actions taken by my Agent properly authorized hereunder shall be binding upon my heirs, successors, assigns, and personal representatives.

(7) The powers granted to my Agent are nondelegable.

IN WITNESS WHEREOF, I have executed this Durable Power Of Attorney this 16th day of August, 2009.

Principal:

Gladys E. White
Signature of Principal

Name: Gladys E. White

Address: 9223 60th Ave. Ct. E.

Soc. Sec. No. 561-36-2379

Witnesses:

Maede J Crawford
Signature of Witness

Name: MAEDE E J CRAWFORD

Address: 7506 144 Av Ct E
Sumner Wa 98390

Marci A White
Signature of Witness

Name: MARCI A WHITE

Address: 28039 177th Ave SE
Kent, Wa. 98042

STATE OF WASHINGTON)
COUNTY OF PIERCE)

On this 16TH day of August, 2009, before me, personally appeared Gladys E. White, principal, and Marcie A. White and Mardee S. Crawford, witnesses, who are personally known to me or who provided Drivers License (Valid + unexpired) as identification, and signed the foregoing instrument in my presence.

Douglas E. Silvernail
Notary Public

DOUGLAS E. SILVERNAIL NOTARY PUBLIC COMMISSION EXPIRES 10-02-09 STATE OF WASHINGTON

My commission expires: 10/2/09

ACKNOWLEDGMENT AND ACCEPTANCE BY AGENT

The undersigned accepts appointment as Agent and agrees to serve as Agent under this instrument.

William C. White
Signature of Agent

Name: William C. White
Address: 28039 177th Ave. S.E. Kent, WA
Soc. Sec. No. 474-44-6243

AbilityIns
ABILITY INSURANCE CO.
Administered on behalf of Medico Insurance Company
Long Term Care Claims Department
PO Box 3735 • Omaha, NE 68103
Phone (877) 795-8493 • Fax (866) 498-0689 • www.gomedico.com

August 31, 2009

GLADYS WHITE
9223 60TH AVE CT E
PUYALLUP WA 98371

Policy No. 0S34226

This will acknowledge your recent correspondence. According to our records, your contract lapsed effective 2-7-2009; therefore, you have no benefits available.

Please contact us if you have any additional questions concerning this matter.

Sincerely,

Claim Service Department

7

09/08/2009 pg003

September 8, 2009

TO: Claims Department (FAX # 402-391-6489)

FROM: Cheryl Silvernail (daughter of Gladys White)

RE: New claim

Attached is the claim and invoice for my mother, Gladys White. She is now at the Franklin House, an assisted living facility. They are helping her with her prescription medications, insulin, bathing and dressing, etc. If you have any questions or need additional information, please call me at:

Home: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

Address:
13714 143rd Ave. E.
Orting, WA 98360

Thank you,

Cheryl Silvernail

I have also included the front + back of the durable power of attorney.

09/08/2009 pg001

TO CE

AbilityIns
ABILITY INSURANCE CO.
Long Term Care Claims Department
P.O. Box 3735 • Omaha, NE 68103
Phone: (877) 795-8493 Fax: (866) 498-0689 Email: Customersupport@abilityre.net

Claimant's Proof of Loss

Long-Term Care Insurance Claim Request Form

Claimant and Contact Information

Insured's Name: Gladys E. White
Date of Birth: 7/8/1923
Policy #: 0S34226
Home Address: 9223 60th Av Ct E
Daytime Phone #: 253-845-1228
Social Security #: 561-36-2379

In order for this request to be further processed, a member of our Claims department will need to speak with either the insured or their representative about this claim. For best service and most timely processing, please provide all of the information requested in the spaces below.

Name of Person to Contact About this Claim: Cheryl Silvernail
Relationship to Insured: daughter
Power of Attorney: ☐ Yes ☒ No
Address: 13714 143RD Av. E. Orting, WA 98360
Daytime Phone #: 253-841-8926
Alternate Phone #: 253-232-2499 253-446-7190
Best Time to Call: day time at work

Claimant's Condition

Event (illness, injury, etc...) that led to a need for Long Term Care services: BROKEN left wrist - after fall at home
Date Illness/Injury Started: 7/25/09

Level of Assistance- Please check the box that best describes the assistance the insured requires with each activity

	Independent	Standby Assist	Hands-On Assist	Date this Assistance Began
Bathing	☐	☐	☒	
Dressing	☐	☒	☐	
Eating	☒	☐	☐	
Toileting	☐	☒	☐	
Transferring	☒	☐	☐	
Continence	☐	☐	☒	

Other: Dementia, HELP WITH MEDICATIONS

Does the Insured have a diagnosis of Alzheimer's Disease or other type of Dementia? ☒ Yes ☐ No

If Yes, please describe the Insured's Cognitive Status (memory, judgment, ability to manage medications, safety concerns, etc...): ALL OF the ABOVE - she's fallen several times at home

Medical Provider Information

253-840-4400 253-840-4733

Attending Physician's Name: DR. Rudnick DR Alex Mihali
Office Phone #: 253-459-6510
Office Fax #:
Physician's Address: 1901 S. Union Ave. Tacoma WA 98405 400 29th St. N.E. Puyallup WA 98372

Has the Insured Been Hospitalized within the past 12 months? ☐ No ☒ Yes, Complete Section Below

Name of Hospital: GOOD SAMARITAN
Address: 407 14th Av SE Puyallop
Phone #: 253-697-4000
Admission Date: 7/25/09
Discharge Date: 7/28/09

05/08/2009 PM01

Policyholder's Name: Gladys E. White
Policy Number(s): 0S34226

AUTHORIZATION TO USE AND DISCLOSE PERSONAL INFORMATION

MEANING OF TERMS
Health Care Provider means: all physicians; medical or dental practitioners; hospitals; other health care facilities (including nursing facilities and assisted living facilities); pharmacies; pharmacy benefit managers; the Medical Information Bureau; and any other person or organization that furnishes, bills or is paid for care, services or supplies related to the health of an individual.
Personal Information means: all information about the health of an individual, including medical records in their entirety, information about physical condition and mental condition (excluding psychotherapy notes), prescription drug records and information about drug and alcohol use. Personal Information also includes information about personal finances, occupation, general reputation and insurance claims.

AUTHORIZATION TO DISCLOSE
I authorize any Health Care Provider, government agency, insurance company, insurance agent, employer or consumer reporting agency to disclose Personal Information about me, or my dependent named below, to Ability Insurance Company and to any persons acting on the Company's behalf for the purposes described below.

AUTHORIZATION TO USE
I authorize Ability Insurance Company, or any person or entity employed by the Company, to use the Personal Information covered by this authorization for the purposes described below.

PURPOSES OF DISCLOSURE
Personal Information will be used to determine my and, if applicable, my dependents' eligibility for insurance and to resolve any issues regarding incomplete or incorrect information on my application for insurance that may arise during the processing of the application or in connection with a claim for insurance benefits.

POTENTIAL FOR REDISCLOSURE
The Personal Information used or disclosed based on this authorization may be subject to further disclosure without the protections of federal privacy regulations.

REFUSAL TO SIGN
I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, Ability Insurance Company will not accept my application for insurance, and insurance benefits will not be payable.

EXPIRATION AND REVOCATION
This authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time by written notice to: Ability Insurance Company, PO Box 3735, Omaha NE 68103.

I understand that my right to revoke this authorization is limited to the extent that Ability Insurance Company has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under my insurance policy.

COPY OF THIS AUTHORIZATION
I understand that I will receive a copy of this authorization. A copy of this authorization is as valid as the original.

NAMES AND SIGNATURES

Gladys White
Printed Name of Applicant/Insured

Gladys E. White
Signature of Applicant/Insured

8/4/09
Date

If applicable: I am the personal representative of the insured named above whose Personal Information is to be disclosed, and I am authorized to grant permission for disclosure.

Cheryl Silvernail
Printed Name of Personal Representative

daughter
Description of Personal Representative's Authority

Cheryl Silvernail
Signature of Personal Representative

8/4/09
Date

ML3F-220-08222009

09/08/2009 PM 02

Long-Term Care Provider Information

What Type of Care Does the Insured Need?

☐ Nursing Home ☒ Assisted Living ☐ Home Health Care ☐ Hospice ☐ Other:

Does the Insured currently have Long Term Care Services In Place? ☐ No ☒ Yes, Complete Section Below

Name of Facility/Agency:	Phone #:	Type of Care:
Franklin House	891-3569	

Facility/Agency Address: 5713 Parker Road Sumner WA 98390

Date Care Began:	Date Care Ended:	Name of Contact Person at Facility/Agency:	Fax #:
8/24/09		Cheryl Hanni	253-891-9433

Please Note: If you are currently receiving services from more than 1 Long Term Care provider, please provide all of the information requested above for each provider in the white space at the bottom of this form.

If you obtain services from any non-qualified provider, they will not be covered under your policy.

If you obtain services that are not covered under the Policy, we will not be able to reimburse for these services.

Medicare and Other Insurance Information

Are you eligible for or currently enrolled in

Medicare Part A	☐ Yes	☐ No
Medicare Part B	☐ Yes	☐ No
Medicaid	☐ Yes	☒ No

Have any of your Long-Term Care expenses been paid for by Medicare? ☐ No ☒ Yes, Complete Section Below

Start Date:	End Date:	Agency/Facility:
7/28/09	8/24/09	Linden Grove

Do you have any other Long-Term Care Insurance Policies? ☒ No ☐ Yes, Complete Section Below

Insurance Company Name:	Address:	Policy #:	Daily Benefit Amt.:
			$

Signature

My signature below indicates that I understand that the claims processing procedure includes the collection of personal medical information. I also understand that an on-site assessment may also be required. This assessment will be completed at no cost to me by a licensed health care practitioner of Ability Insurance Company's choice.

Signature of the Insured or POA:	Date Signed:
William White	9-6-2009

Please return this form and any additional documents to the address at the top of the first page.

Please Remember to Include the Following with this Form:

- ☐ A Copy of the Power of Attorney Document (if applicable)
- ☐ The signed Authorization to Use and Disclose Personal Information form (see page 3 of this form)
- ☐ Copies of invoices for any long term care costs you have incurred thus far
- ☐ A statement of the hourly and/or daily charge for the service you are receiving
- ☐ A copy of the license of the provider you are using and their tax ID number

WARNING -- Fraud Notice: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as further defined by your state statute.

09/08/2009 pg001

MOVE IN SUMMARY 0534226

FRANKLIN HOUSE
5713 Parker Rd.
Sumner, WA 98390
(253) 891-3569

Resident ID: 13910195
Resident Name: Gladys White
Move-In Date: 8/21/2009

Apartment Type: One Bedroom
Apartment Number: 118
Service Points: 20
Residency Type: Private

Previous Balance: $ 0.00

PRO-RATED RENT CALCULATIONS

Standard Room/Board:	$	104.00	Per Day
Standard Resident Care:	$	32.00	Per Day
Days in House:		11	Days

ACTUAL RENT CHARGED 13914416

Description	Period	Amount
Room and Board - One Bed	Aug	$ 1,144.00
Resident Care - Level 20	Aug	$ 352.00
Room and Board - One Bed	Sep	$ 3,120.00
Resident Care - Level 20	Sep	$ 960.00
		$ 5,576.00

Total Rent Due: $ 5,576.00

Preliminary Preparing

REFUNDABLE DEPOSITS

Description	Amount
	$ 0.00

NON-REFUNDABLE FEES

Description	Amount
	1000.00
	$ 0.00

Total Deposits / Fees: $ 0.00

ADDED CREDITS / CHARGES

Description	Comments	Amount	Qty	Extended Price
No Added Credits or Charges				

Total Added Credits / Charges: $ 0.00

BILLING INFORMATION

C S SILVERNAIL
J J SILVERNAIL
13714 143RD AVE E
ORTING, WA 98360

8378
04-0293/0251

8/21/09
Date

Pay to the Order of Franklin House $ 6576.00
Six thousand five hundred seventy six & 00/100 Dollars

RAINIER PACIFIC BANK
P.O. Box 11158 • Tacoma, WA 98411-0828
www.rainierpacific.com • 800-229-2858

DIRECT CHECKING

For

Cheryl Silvernail

⑆325182946⑆ 10160027476 1⑈ 8378

Total Due: $ 5,576.00
JRF + 1000.00
6576.00

v1.4.6

09/08/2009 pg881

DURABLE POWER OF ATTORNEY OS 34226

I, Gladys E. White (name), of 9223 60th Ave. Ct. E Puyallup, WA (address, including county and state) Pierce County hereby appoint William C. White (name of your agent), to serve as my agent ("Agent") and to exercise the powers set forth below. If said agent is unable or unwilling to act as my agent, then I appoint the following as my successor agent(s) in the order named:

First Successor Agent: Nancy Connelly (name);

Second Successor Agent: Marlee J Crawford (name)

This instrument shall be effective:

- ☑ Immediately upon the date of execution, and shall not be affected by my subsequent disability, incapacity or incompetence except as provided by statute.
- ☑ Upon my disability, incapacity or incompetence except as provided by statute.
- ☑ Immediately upon the date of execution, and shall terminate upon my disability, incapacity or incompetence.

I hereby revoke all powers of attorney, general or limited, previously granted by me, except for powers granted by me on forms provided by financial institutions granting the right to write checks on, deposit funds to and withdraw funds from accounts to which I am a signatory or granting access to a safe deposit, and except to any powers granted by me for health care decisions.

ARTICLE I.

My Agent is authorized in my Agent's sole and absolute discretion at any time, with respect to any of my property, real (including homestead property or any other interest), personal, intangible and mixed, as follows:

(1) To sell any property that I may own now or in the future, including but not limited to contingent and expectant interests, marital rights and any rights of survivorship incident to joint tenancy or tenancy by the entirety, upon such terms, conditions and security as my Agent shall deem appropriate and to grant options with respect to sales thereof; to make such disposition of the proceeds of such sales as my Agent shall deem appropriate;

(2) To buy every kind of property, upon such terms and conditions as my Agent shall deem appropriate; to obtain options regarding such purchases; to arrange for appropriate disposition, use,

09/08/2009 pg002

STATE OF WASHINGTON)
COUNTY OF PIERCE)

On this 16TH day of August, 2009, before me, personally appeared Gladys E. White, principal, and Marcie A. White and Mardee J. Crawford, witnesses, who are personally known to me or who provided Drivers License (Valid + unexpired) as identification, and signed the foregoing instrument in my presence.

Douglas E. Silvernail
Notary Public

My commission expires: 10/2/09

DOUGLAS E. SILVERNAIL
COMMISSION EXPIRES
NOTARY
PUBLIC
10-02-09
STATE OF WASHINGTON

ACKNOWLEDGMENT AND ACCEPTANCE BY AGENT

The undersigned accepts appointment as Agent and agrees to serve as Agent under this instrument.

William C. White
Signature of Agent

Name: William C. White
Address: 28039 177th Ave. S.E. Kent, WA
Soc. Sec. No. 474-44-6243

September 11, 2009

Ability Insurance
Long Term Care Claims Department
PO Box 3735
Omaha, NE 68103
FAX #: 866-498-0689

I am writing regarding the recent correspondence my mother received about her Long Term Care Insurance, stating that her contract had lapsed effective 2/7/2009.

I am not quite sure what this means as my mother has been paying for this insurance since August, 1999.

Please contact me regarding this. My mom is now in an assisted living home because she has not been able to care for herself or her financial matters for quite some time.

Thank you,

Cheryl Silvernail, daughter of Gladys White

Address:
13714 143rd Ave. E.
Orting, WA 98360

Phone: 253-446-7190
Cell: 253-232-7499
Work: 253-841-8726

Gladys White

Policy No. 0S34226

Lapsed 2-7-2009

OnBase: Primary Claim form received via fax 8-6-09 imaged on 8-12-09. According to it care began on 7-28-09. Sent letter advising that contract lapsed on 2-7-09.

OnBase: Primary Claim form received again on 9-8-09. Since I had already sent letter, I called daughter and explained that contract lapsed. She stated that mother was cognitively impaired. Told her that she could send a letter with documentation and that the dept that handles the reinstatement would have to review and determine if the contract was eligible for reinstatement.

OnBase: Inquiry received on 9-15-09 asking about status of claim.

OnBase: Medical records received on 10-2-09 indicating the cognitive issues.

Refer corr to Erin/Don L to handle since per the contract it is outside the reinstatement time frame for cognitive issues.

According to the Admin system policy lapsed eff. 2-7-2009

(14)

FAX #: 402-391-6489

September 30, 2009

TO: Sharon, Claims Department

FROM: Cheryl Silvernail

RE: Documentation of Cognitive Impairment

Policy #OS34226

RECEIVED
OCT 02 2009
ABILITY - OMAHA

September 30, 2009

To Whom It May Concern:

As per my phone conversation with Sharon in the Claims Department, I am attaching documentation of my mom's cognitive impairment as observed at Good Samaritan Hospital in Puyallup.

From my personal observation, I would also like to include the following:

1. My mother began hiding bills that she didn't understand or didn't want to deal with. Just two examples of this are:

- The Internal Revenue Service notice stating that she owed money. My sister finally found the notices so that we could take care of them.
- Her invoices for Lutheran Community Service (an invoice for her caregiver that was coming in each day for a few hours.) This bill was unpaid for several months, until they contacted me regarding the past due invoices.

2. My mother couldn't remember to take her medications on the days that her caregiver wasn't at her home. She's a diabetic and was not remembering to take her insulin. Because of this, her blood sugar was out of control. She was not taking her high blood pressure medication, which had also soared out of control.

RECEIVED
OCT 02 2009
ABILITY - OMAHA

I have also enclosed a letter from her caregiver, Alexandria Farmin, who works for Lutheran Community Services. She wrote about her cognitive impairment and other problems she was encountering in April of 2008.

I'm still a little unsure of why I wasn't contacted when the insurance premiums weren't being paid. My name and phone number have been on all correspondence that was submitted when she had her previous claim. I would think you would still have records of these.

My mother has paid for this insurance since August of 1999. It appears to me that one of the problems of aging, cognitive impairment (dementia), would prevent her from paying the premium notice that would keep her insurance in tact.

Please reconsider your denial of this claim due to non-payment of the premium. Let us know what we would have to pay to put this insurance policy back in force. Thank you.

Cheryl Silvernail
Daughter of Gladys White

1

TRIAGE

Time 2148 ☐ PA
☐ Police ☐ Amb. #
☐ Walk ☑ Stretcher
☐ W/C ☐ Carried
☐ Relative ☐ Self
☑ Other ☐ EMS
☐ ER-E ☑ ER ☐ OBS
☐ WR ☐ FR
☑ ER-C ☐ X-RAY

TETANUS IMM. STATUS
☐ UTD ☐ > 10 yrs. | Unk.
Tdap (Tet./Dip./Pertusis)
☐ Yes ☐ No
(19-64 years of age only)

Chief Complaint: Age 86 y/o F
? FALL CONFUSED
NEW/OLDER TOTE
? MEMORY LOSS
Blood ALT
(C) Also PAIN

☐ EKG ☐ Shown to MD (@ Time)
Pain (0-10) To X-Ray from Triage for
Signature / Print Name
Signature / Print Name

ACUITY
☐ 5 ☐ 4 ☑ 3 ☐ 2 ☐ 1

HISTORY
☐ Cardiac ☐ HTN
☐ Respiratory ☐ Seizure
☐ Psych ☑ Diabetes
☐ Smoker ☐ DV
☐ Surgeries INSULIN
☐ Language ☐ Needs Interpreter
☐ Home Health ☐ Hospice
☐ MRSA ☐ Yes ☐ No
If Yes: Open Wound? ☐

Time	BP	P/Rhythm	R	Temp.	SpO2	EKG (Time)	Glucose (Time)
Initial	212	90	16	36.7 R O	99%		
Repeat	195/84	7		R O			

GLASCOW COMA
Eye Opening
4. Spontaneous
3. To Speech
2. To Pain
1. No Eye Opening
Best Verbal Response
5. Appropriate Conversation
4. Confused Conversation
3. Inappropriate Speech
2. Incomprehensible Speech
1. Mute
Best Motor Response
6. Obeys Commands
5. Localizes to Stimuli
4. Semi Purposeful or Withdrawal
3. Flexor Response
2. Extensor Response
1. Flaccid

NEURO Triage	BEHAVIOR Triage	SKIN VITALS Triage	RESPIRATORY Triage
☐ Alert	☑ Cooperative	☑ Normal (PWD)	☑ Normal
☑ Confused	☐ Restless	☐ Cyanotic	☐ Labored
☐ Unconscious	☐ Agitated	☐ Pale	☐ Wheezes
☐ Lethargic	☐ Hostile	☐ Flushed	☐ Shallow
☐	☐ Appropriate	☐ Diaphoretic	☐ Tachypneic
☐	☐ Combative	☐	☐ Retracting
☐	☐	☐	☐ Intubated

Weight kg ☐ stated ☐ actual ☐ estimate
LMP:
Trauma Code called: ☐ Yes ☐ No ☐ Full ☐ Modified
Time Called
Trauma Band #

ASSESSMENT

Interventions PTA: ☐ C-Collar ☐ Backboard ☐ Splint ☐ O2 ☐ ETT ☐ CPR
IV Site #1 (R) AC Gauge 18 IVF
IV Site #2 Gauge IVF
☐ Meds PTA 150/76 132/90 16
Vital Signs DEAT 298

☐ MVC ☐ Driver ☐ Passenger ☐ Pedestrian Seat Belted: ☐ Lap ☐ Lap/Shoulder ☐ Air Bag
☐ MCC ☐ Helmet ☐ Extricated ☐ Bicycle ☐ Roller Blades ☐ Skate/Snow Board Time of Injury Cervi
☐ GSW ☐ Burn ☐ Fall ☐ Protective Gear ☐ LOC Time ☐ ETOH ☐ Known Drugs

SUICIDE RISK ASSESSMENT	YES	NO
S Sex (Male)		
A Age < 19 or > 45 years		
D Depression (Patient admits to depression or decreased concentration, sleep, appetite or libido)		
P Previous suicide attempt or psychiatric care		
E Excessive alcohol or drug use		
R Rational thinking loss: psychosis, organic brain syndrome		
S Separated, divorced or widowed		
O Organized plan or serious attempt		
N No social support		
S Sickness, chronic disease		

Total Score (One point per Yes answer)
1-2 = Low Risk 3-4 = Minimal Risk 5-6 = Moderate Risk 7-10 = High Risk
If score ≥ 5, place pt in Rm or Obs and call crisis. Crisis called @ time
Int. Signature / Print Name

Yes	No	FALL RISK ASSESSMENT
☐	☑	Intoxicated
☐	☑	SBP < 85
☐	☑	HR > 120
☐	☑	Symptomatic Bradycardia or other arrythmia
☐	☑	Complaint of dizziness
☑	☐	History of recent falls (within past 90 days)
☐	☑	Complaint of confusion or altered LOC
☑	☐	Age > 75

Yes to any of these items indicates fall risk.
Fall risk intervention: Pt To Bed Rail Up
Int. RB Signature / Print Name Renata Bailey

Name: WHITE, GLADYS
Patient Identification

V011556037 07/25/09 2244 REG ER
WHITE,GLADYS E
M342843 F 86 07/08/1923
MEDICARE
PHYSICIAN

23

MultiCare
Good Samaritan Hospital

ER Nursing Record (Triage)

Date	Time	Physician Start Here	Health Team Start Here
7/26/09	0224 AM	medicine -	
		1) SP fall	
		2) Syncope : CE ; 2D echo	
		3) DM : on insulin	
		4) CAD	
		5) Dementia	
		6) Hyperlipidemia	
		7) Deptomach (HTD)	
		8) HTN OA	
		10) Tenuchaytosis	
		11) PUD/MT-P	
		12) full code	
7/26/09	1105	PT	PT order received & chart reviewed. Initial eval completed. Pt will benefit from PT while in care but may transition to supervised amb. as able. Determine (L) UE WB restrictions for FWW use & ortho consult. Would benefit from (R) shoulder eval & orthopedic as well to r/o RCT. Thank you for your referral.

Do Not Use Abbreviations

U	MS	AD	OU
IU	MS04	AU	TIW
QD	MGS04	OD	cc
QOD	AS	OS	µg

Trailing zeros & lack of leading zeros

#191573

VD11556031 07/25/09 2244 REG ER
WHITE,GLADYS E
M342843 F 86 07/09/1923
MEDICARE
OTHER PHYSICIAN

MultiCare
Good Samaritan Hospital

Progress Notes

3

MULTICARE
GOOD SAMARITAN HOSPITAL
DISCHARGE SUMMARY
** Signed Report **

PATIENT NAME: WHITE, GLADYS E
MRN: M342843
DOB: 07/08/1923
ACCOUNT: V011556031
DATE OF ADMIT: 07/26/2009
DATE OF DISCHARGE: 07/28/2009

ADMITTING DIAGNOSIS: Status post fall and wrist fracture.

HOSPITAL COURSE: This is an addendum to the discharge summary dictated by Dr. Meyers 07/27/2009, please review for complete details. I completely agree with the following updates.

The patient was agreeable for discharge to skilled nursing facility along with the family, so arrangements were made for transfer to skilled nursing facility this afternoon.

Discharge medications will be the same, instructions the same, and her status is stable. She is feeling good today. Her vitals were reviewed and stable. Physical exam unremarkable.

Dictated by:
Bassam Arodak MD*
Internal Medicine

D: 07/28/2009 11:47:52
T: 07/29/2009 10:34:53
Job#: 316188/MCF

<Electronically signed by BASSAM ARODAK MD>

Electronic Authentication Status: Signed
Sign Date/Time: 08/01/09 0725
Dictating Dr: ARODAK,BASSAM MD

Account Number: V011556031
Patient Name: WHITE,GLADYS E
Birth Date: 07/08/1923
M.R. Number: M342843

Female

DISCHARGE SUMMARY

Report Number: 0729-0199
Admit/Service Date: 07/26/09 Status: DIS IN

4

MULTICARE
GOOD SAMARITAN HOSPITAL
DISCHARGE SUMMARY
** Signed Report **

PATIENT NAME: WHITE, GLADYS E
MRN: M342843
DOB: 07/08/1923
ACCOUNT: V011556031
DATE OF ADMIT: 07/26/2009
DATE OF DISCHARGE: 07/26/2009

DISCHARGE DIAGNOSIS:
1. Syncope.
2. Hyperglycemia.
3. Urinary tract infection.
4. Left wrist fracture.

HOSPITAL COURSE: Ms. White is a very pleasant 86-year-old lady. She lives alone but has assistants during the day in her home. She apparently passed out at home and when she awoke had left arm pain. She was brought to the emergency room where she was found to have a left wrist fracture. She was seen by orthopedic surgery and placed in a cast. She was admitted to the hospital for syncope evaluation. She had a head CT that showed no evidence of any acute disease. She was ruled out for an MI by cardiac enzymes overnight and all were normal. She underwent an echocardiogram that showed normal LV function, normal wall motion, mild diastolic dysfunction, but otherwise no acute abnormalities. The patient's mental status has been alert and oriented. Her telemetry has been normal while here. Her abnormalities while here were that she had evidence of a urinary tract infection on admission as well as some moderate hyperglycemia from her diabetes. Likely, her syncopal episode was secondary to her urinary tract infection with hyperglycemia and moderate dehydration from her diabetes. No other etiology has been found. The patient has been neurologically intact and hemodynamically intact. At this time, the patient is stable for discharge home; however, because she lives alone, even though she does get some assistance during the day, there has been a question of whether she should go to an assisted living or skilled nursing facility temporarily until her wrist heals; however, in discussion with the patient, she adamantly refuses that and states that she wants to go home and that she gets enough assistance at home. Will discuss this with social work and arrange for home health care, home P.T., home O.T. as well as continued assistance by her caretaker. I have also discussed with the patient that she needs to follow up with her PCP this week to further evaluate her hyperglycemia and whether or not it is secondary to her urinary tract infection or whether it is due to just chronically undertreated diabetes. The patient is otherwise stable, however, and will be discharged home.

CONDITION ON DISCHARGE: Good.

DISCHARGE MEDICATIONS: The patient has been instructed to resume all of her prior medications including:
1. Insulin 70/30, 50 units every day.
2. Benicar 20 mg a day.
3. Lipitor 40 mg a day.
4. Actos 15 mg a day.
5. Metoprolol 25 mg b.i.d.
6. Metformin 1000 mg b.i.d.
7. Robaxin 75 mg a day.
8. She will also be on Cipro 250 mg b.i.d. for 7 days.

DISCHARGE INSTRUCTIONS: Diet: Diabetic. Activity: As tolerated. Home health care and P.T., O.T. will be arranged for the patient.

5

Dictated by:
Glen C Meyers MD*
Internal_Medicine

D: 07/27/2009 10:12:30
T: 07/27/2009 10:36:15
Job#: 315175/KLJ

<Electronically signed by GLEN C MEYERS MD>

Electronic Authentication Status: Signed
Sign Date/Time: 08/05/09 0708
Dictating Dr: MEYERS,GLEN C MD

Account Number: V011556031
Patient Name: WHITE,GLADYS E Female
Birth Date: 07/08/1923
M.R. Number: M342843
Report Number: 0727-0230
Admit/Service Date: 07/26/09 Status: DIS IN

DISCHARGE SUMMARY

6

MULTICARE
GOOD SAMARITAN HOSPITAL
EMERGENCY ROOM REPORT
** Signed Report **

PATIENT NAME: WHITE, GLADYS E
MRN: M342843
DOB: 07/08/1923
ACCOUNT: V011556031
DATE: 07/26/2009

CHIEF COMPLAINT: Passed out.

HISTORY OF PRESENT ILLNESS: The patient is an 86-year-old white female who still lives by herself and is widowed. She notes that she had no prodrome when she woke up on the floor with left wrist pain an hour prior to admission. Paramedics were called and transported her here with an IV. She notes when she woke up she had some mild nausea and vomiting for 1-2 minutes and denied any other complaints to include chest pain, headache, cough, arm, neck, shoulder or abdominal pain, or back pain, calf pain, tenderness, swelling, arthralgias, myalgias, fever, chills, dysuria, frequency, urgency, any other aggravating or relieving factors. Paramedics found her with a good blood sugar. A Dexi-stick at the scene was noted to be 348, and obviously her fall was not secondary to hypoglycemia. Her only complaint after waking up was a brief nausea and vomiting, and now she has some moderate left wrist pain with some moderate swelling. She denies any injuries, complaints, or pain anywhere else.

REVIEW OF SYSTEMS: All other review of systems is negative.

PAST MEDICAL HISTORY: Remarkable for insulin-dependent diabetes, hypertension.

PAST SURGICAL HISTORY: She denies any operations in the past.

SOCIAL HISTORY: She is widowed, lives by herself, retired kitchen remodeler. Denies cigarette, illicit drug, or alcohol use.

FAMILY HISTORY: Noncontributory.

ALLERGIES: She has no known drug allergies.

MEDICATIONS: Her only current medication is insulin, and high blood pressure medicine she cannot remember.

PHYSICAL EXAMINATION:
GENERAL: She has a slightly overweight body habitus.
VITAL SIGNS: Blood pressure 198/84, pulse 90, respiratory rate 16, oral temperature 36.7, saturation 95% interpreted by me as normal without evidence of major pulmonary dysfunction or hypoxemia.
HEENT: Normocephalic. Pupils are PERRLA without scleral icterus or conjunctival injection. Extraocular movements are intact. Nares normal without discharge or flaring. TMs are clear. Oropharynx exam is unremarkable without postnasal drip, tonsillar swelling, or pustular haze. Mucous membranes are well hydrated. No ketones on her breath.
NECK: Supple. No cervical adenopathy or meningeal signs. Thyroid exam is not palpable.
LUNGS: Exam reveals very faint basilar wheezes. No wheezes or rhonchi are appreciated.
CARDIOVASCULAR: Reveals a regular rate and rhythm without murmurs, rubs, or gallops.
ABDOMEN: Flat. Bowel sounds are present. There is no hepatosplenomegaly, mass, rebound, guarding, tenderness, or peritoneal signs anywhere in the

abdomen.
EXTREMITIES: Homans sign is negative. Calf circumferences are equal. No cords are appreciated. Very trace ankle edema present.
NEUROLOGIC: Awake, alert, and oriented x3. No evidence of toxidrome or alcohol. 5+ strength in all 4 extremities.

IMPRESSION:
1. Syncope of unclear etiology without prodrome.
2. Probable left distal radius fracture.
3. Insulin-dependent diabetes with a normal Accu-Chek on the scene.

EMERGENCY DEPARTMENT COURSE: IV normal saline was started. A 4-view x-ray of her left wrist ordered and interpreted by me as abnormal, secondary to her distal left radius nondisplaced fracture. No other fractures, dislocations, or subluxations are present. All joint spaces are appropriately aligned, _____ intact. No soft tissue swelling, foreign bodies, or joint effusions appreciated. Abnormal 4 view left wrist x-ray secondary to distal radius nondisplaced fracture on my interpretation. Portable chest x-ray, single view, PA and upright, is ordered and interpreted by me as normal. There is a normal cardiac silhouette. No acute infiltrates, effusions, pneumothoraces. Normal soft tissues, normal bony structures, normal chest x-ray as interpreted by me. An EKG is ordered and interpreted by me as abnormal secondary to nonspecific ST-T wave changes, not consistent with acute ischemia, myocardial infarction, or pericarditis. Ventricular rate 91, PR interval 188, QRS duration 90, QT/QTc 360/442 milliseconds with P, R, and T axes of 62, 10, and 85 respectively. Abnormal EKG unchanged from 08/24/2002 upon review of records. A CT of the head ordered by me, read by the radiologist, reveals marked atrophy with no intracranial bleeding or events are appreciated with ischemic changes. Initial i-STAT troponin is 0.0. I-STAT electrolytes are normal. Her blood sugar is up a little bit at 334 and normal H&H. Her white count returns mildly elevated at 12 with a normal H&H. Her coags reveal an INR of is 0.91, and her chemistries reveal an elevated blood sugar of 337 and a creatinine 1.2 with a BUN of 28. CKs, troponins, and the rest of her laboratory is normal.

IMPRESSION:
1. Syncope of unclear etiology.
2. Left distal radius fracture.
3. Insulin-dependent diabetes.

PLAN: She is placed in a volar Orthoplast splint. Post splint evaluation reveals good neurovascular exam, good positioning, and good technique, and will be seen by the orthopedist on call in 3-7 days. The case is discussed with SIP who graciously accepts her to medical telemetry for further evaluation and treatment and will consult the orthopedic surgeon on call. I find no evidence of stroke, acute arrhythmia, arrhythmia, atrial fibrillation, V-tach, intracranial hemorrhage, subarachnoid hemorrhage or subdural or epidural.

Dictated by:
Blake P Gendron MD*
Emergency Medicine

D: 07/26/2009 01:08:37
T: 07/27/2009 07:41:28
Job#: 314357/LSM

<Electronically signed by BLAKE P GENDRON M.D.>

Electronic Authentication Status: Signed
Sign Date/Time: 07/27/09 2340
Dictating Dr: GENDRON,BLAKE P M.D.

Account Number: V011558031
Patient Name: WHITE,GLADYS E Female
Birth Date: 07/08/1923
M.R. Number: M342843
Report Number: 0727-0098
Admit/Service Date: 07/26/09 Status: ADM IN

EMERGENCY ROOM REPORT

9

MULTICARE
GOOD SAMARITAN HOSPITAL
CONSULTATION
** Signed Report **

Orthopedic Surgery Consultation

PATIENT NAME: WHITE, GLADYS E
MRN: M342843
DOB: 07/08/1923
ENCOUNTER: V011556031
DATE OF ADMIT: 07/26/2009
DATE OF CONSULT: 07/26/2009

IDENTIFICATION: An 86-year-old retired female, right-hand dominant.

CHIEF COMPLAINT: Syncopal episode and fall with left wrist fracture, right shoulder pain.

HISTORY OF PRESENT ILLNESS: The patient has a significant past medical history of insulin-dependent diabetes mellitus, coronary artery disease, dementia, and had a recent syncopal episode where she was outside and fell. She woke up and was complaining of left arm pain. The ambulance came to get her and brought her into the hospital. She also was complaining more recently of some right shoulder pain, which she did not report in her ER admission. There was no open wound. Her left wrist was splinted. She does not report history of left wrist problems. She has no known prior history of shoulder problems. She has never seen an orthopedic doctor or other specialists for her right shoulder in the past. On careful questioning of the family, they did say she had some chronic shoulder pain years ago when she was working about 20 years ago, they think on the right.

PAST MEDICAL HISTORY: Diabetes mellitus, insulin-dependent; osteoarthritis.

PAST SURGICAL HISTORY: Previous right hip surgery from a fall, coronary artery disease, chronic stable angina, hyperlipidemia, depression.

SOCIAL HISTORY: The patient does not smoke. She is widowed and lives on her own at home. There is no history of alcohol intake.

FAMILY HISTORY: Previous family history not known to the patient. Her children live in the area and are reasonably healthy, and they live nearby.

REVIEW OF SYSTEMS: No significant chest pain recently. No neck pain, no headache, no significant visual changes. No cough, respiratory distress, wheezing, or shortness of breath. No history of incontinence or back pain.

PHYSICAL EXAMINATION:
GENERAL: The patient was examined lying in bed. She seemed comfortable, in no specific distress.
MUSCULOSKELETAL: She had tenderness at the anterior right shoulder near the glenohumeral joint with movement. She could forward elevate only about 30-40 degrees, limited by pain. With her arm resting on the side, she could internally rotate comfortably against her body. She could only externally rotate about 45 degrees, limited by anterior pain. She had decreased ability to abduct her shoulder secondary to pain. Passive range of motion was much more comfortable, and I could passively elevate the shoulder about 90-100 degrees. Left wrist showed a slight dinner-fork deformity and swelling with slight radial inclination and tenderness to palpation. She was too sore to perform detailed Range of motion testing. She had good movement of her fingers with intact

radial, ulnar, and median nerve function, both sensory and motor. Radial pulses within normal limits. There was no open wound or laceration on the left wrist after removing the splint that was placed in the ER.
HEENT: Head was atraumatic and normocephalic. Pupils were equal. Neck was supple, with good movement.

DIAGNOSTIC DATA: X-rays, I reviewed a chest x-ray, which did show the right shoulder partially. It showed some what looked like degenerative joint disease at the glenohumeral and the acromioclavicular joint, but no obvious fracture of the right proximal humerus was noted.
Proper shoulder series x-rays have been ordered and are pending. Left wrist shows an intra-articular, slightly impacted, Colles-type fracture of the left distal radius. It appears to be well positioned with just slight shortening and slight dorsal angulation but satisfactory alignment. She has significant osteopenia.

ASSESSMENT AND PLAN: At this point, I think for the wrist she does not require surgical treatment. I think that she will do well with gentle closed manipulation and casting with the help of her family. I carefully held her arm up by the fingers and removed the splint and personally applied a short-arm plaster cast from the metacarpophalangeal joints down to the elbow. I then gently molded the fracture and performed a limited reduction maneuver to help slightly improve the position without causing undue pain. We will obtain 3-view shoulder and post-reduction x-rays of the left wrist. Unless the wrist is significantly displaced, I do not think she will need any kind of surgical repair. I did warn her and her family about the risk of a bump and the risk of stiffness. I do not think that in her medical situation, being a nondominant hand, that open reduction and internal fixation or even pin fixation is in her best interest for the wrist.

I will review after the shoulder x-rays are done.

Thank you for the consult.

Dictated by:
Anthony B Van Bergeyk MD*
Orthopedic Surgery

D: 07/26/2009 15:50:30
T: 07/27/2009 05:35:56
Job#: 314723/EAH

cc: Laura E Keeter MD*
Umar Waheed MD*

<Electronically signed by ANTHONY B VANBERGEYK MD>

Electronic Authentication Status: Signed
Sign Date/Time: 08/03/09 1006
Dictating Dr: VANBERGEYK,ANTHONY B MD

11

Account Number: V011556031
Patient Name: WHITE,GLADYS E Female
Birth Date: 07/08/1923
M.R. Number: M342843 CONSULTATION
Report Number: 0727-0010
Admit/Service Date: 07/26/09 Status: DIS IN

12

MULTICARE
GOOD SAMARITAN HOSPITAL
HISTORY AND PHYSICAL
** Signed Report **

PATIENT NAME: WHITE, GLADYS E
MRN: M342843
DOB: 07/08/1923
ACCOUNT: V011556031
DATE OF ADMIT: 07/26/2009

CHIEF COMPLAINT: Syncopal episode and left wrist fracture.

HISTORY OF PRESENT ILLNESS: The patient is an 86 year old female with prior medical history significant for diabetes mellitus, on insulin and a history of coronary artery disease, which is retrieved from the prior records, and history of dementia. She is not a very good historian and came in after the syncopal episode. The patient said that the last thing she remembered was later in the afternoon, she was going to the bathroom and she came out, she was outside the bathroom and her left arm was hurting. She does not even remember how she came to the emergency room, but she says that she probably thought she called 911 and came to the emergency room. Nevertheless, the patient had an initial evaluation by the ER physician, who did the initial CT scan of head and x-ray of the left wrist, which was painful and patient was found to have a fracture of the left wrist. As well, a CT of the head that showed generalized atrophy and chronic ischemic changes but no acute intracranial abnormality. At the time when she had a syncopal episode, her blood sugar was tested and it was over 300. The patient is currently not complaining of anything at all, however, during my interview, there is a very significant memory finding pauses. She was unable to tell me about her recent medical problems or even dosing of the medication that she has been on. Denies any chest pain, denies any history of urine or stool incontinence. Denies any history of any dizziness before or even after the fall. The downtime is not known to the patient as well.

PAST MEDICAL HISTORY:
1. Insulin-dependent diabetes mellitus.
2. History of osteoarthritis.
3. Prior hip surgery for a fall.
4. Coronary artery disease with chronic stable angina.
5. History of hyperlipidemia.
6. History of depression.

SOCIAL HISTORY: She does not smoke. She is widowed and lives alone at home. No alcohol intake.

FAMILY HISTORY: Not known to the patient. She states that her kids are completely fine and they live close by.

REVIEW OF SYSTEMS: Essentially remarkable except for the left hand pain and denies any other complaints at all. Review of systems in all the other systems has been extensively reviewed and essentially unremarkable other than the left arm pain. The patient denies any chest pain, denies any cough, phlegm. Denies any history of shortness of breath, denies dizziness, vertigo. No history of urine or stool incontinence. No history of any visual or auditory problem. No headaches.

PHYSICAL EXAMINATION:
GENERAL: The patient lying in the bed, comfortable, in no obvious distress at this point in time.
VITAL SIGNS: Blood pressure 156/72, pulse 58, respiration 16, and 97% on room air.

HEENT: Head atraumatic, normocephalic. Pupils equal, reactive to light and accommodation.
NECK: Supple, no JVD, no lymph node, no thyromegaly.
LUNGS: Bilaterally clear to auscultation. No rhonchi, no wheezes.
CARDIOVASCULAR: S1 and S2 normal, no gallops, no murmur.
ABDOMEN: Soft, nontender. Bowel sounds are audible. No visceromegaly noted.
BACK: No costovertebral angle tenderness. No back tenderness.
SKIN: No rashes, bruises, or ulcers are seen.
EXTREMITIES: Negative for edema, swelling, or deformity, or any Homans sign. Left upper extremity has a cast placed.
NEUROLOGIC: Intact. Nonfocal CNS examination but she does have dementia, significant memory finding problems. She was able to tell me the year but was unable to tell me the month and the date, unable to recall who is the president of the United States. She told me she lives in Puyallup.

DIAGNOSTIC DATA: Includes INR 0.91, PT 12.5, potassium 4.1. Sodium 136, BUN 28, creatinine 1.2, glucose 87. AST 11, ALT 32, troponin 0.04, CK-MB 8.8, total CK 70, _____ 12.25, hemoglobin of 12.7, platelet count 330. EKG showed normal sinus rhythm and essentially unremarkable EKG although some artifact in it.

ASSESSMENT AND PLAN:
1. Status post fall with left of the forearm or wrist injury. The x-ray report of this left hand is not reported yet. Also has been put on consult for that and will follow the recommendation with ortho. The patient currently has a cast, and she is completely asymptomatic and stating that her pain is already better.
2. Syncope. Cardiac enzymes x1 set is done. I will get an echocardiogram. She has a completely nonfocal CNS examination. The way she explained her syncopal attack does not seem like any neurological problem, though she had a CT scan, which was negative also. She should at least get cardiac enzyme into the echo and should be reassessed in the neurologic examination to see if she has any seizures.
3. Diabetes mellitus type 2, currently on insulin. Prior records show that she was on oral hypoglycemic agents. The patient's home regime of insulin to be verified before restarting. In the meanwhile, will just continue with sliding scale insulin.
4. Coronary artery disease. Her home medications are not known at this point in time. I will give her aspirin 81 mg PO daily. Home medication dose should be reviewed, verified and should be resumed.
5. History of hyperlipidemia.
6. Medications unknown. We will get home medications before we will resume them.
7. Leukocytosis seems reactive in origin; however, she has a history of UTI. I will check her UA.
8. Peptic ulcer disease, prophylaxis through the Protonix.
9. DVD, prophylaxis through the Fragmin.
10. Code status is discussed with the patient, and she wants herself to be full code.

Dictated by:
Umar Waheed MD*
Internal Medicine

D: 07/26/2009 02:39:00
T: 07/26/2009 05:55:18
Job#: 314382/SPB

<Electronically signed by UMAR WAHEED MD>

Electronic Authentication Status: Signed
Sign Date/Time: 07/27/09 0044
Dictating Dr: WAHEED,UMAR MD

Account Number: V011556031
Patient Name: WHITE,GLADYS E Female
Birth Date: 07/08/1923
M.R. Number: M342843
Report Number: 0728-0010
Admit/Service Date: 07/26/09 Status: ADM IN

HISTORY AND PHYSICAL

In regards to Gladys White

To whom it may concern:

I have been working for Gladys for the past three years in the caregiver role. I have noticed a lot of things during this time that a visit won't disclose. As should be noted, she uses a walker. This makes it virtually impossible to operate a vacuum properly and without the risk of bodily harm (cord is a trip hazard). She cannot even assist in bringing groceries inside, as her hands are already occupied with holding the walker.

She does not drive. Not only because she can't, but due to medical conditions, she would be a hazard to herself and others on the road. She suffers from depression and has an occasional spell of blacking out. It is imperative for her to get out, not just for the exercise she gets with walking at the store, but to alleviate her depression. Hence, I am the one who sees to it that she gets out when we go and get her prescriptions and groceries. These are short outings that she both enjoys and looks forward to doing.

As with anyone of advanced age, she has a memory problem. There have been times she has put a pot on the burner, turned it on and forgot it was there. This is dangerous for anyone, but combined with someone who can't move fast, it could be fatal. Another factor in her memory-loss is her medicine. She has forgotten she has taken it and wants to double up, or forgets she even has medicine to take. Her medicine is imperative for her health and well-being.

Her depression and lack of balance are of great concern to me. She has told me that on weekends there have been times when she just sits and cries all day. This is not healthy. She has also had blackouts while in the shower. It is a good thing she uses a shower chair, otherwise she would have fallen. As it was, she just slumped against the wall in her chair.

She has also had some incidents which are embarrassing to her, which I feel compelled to relay to you, as it plays into all this. She has incontinence problems. I have come into the kitchen and discovered her standing in a puddle of urine. The best she can do to clean it up is to throw a towel over it, as she cannot stoop down to thoroughly clean the mess up. This then presents a slip hazard if not cleaned properly. I have also had to scrub spots of dribbles off the carpet.

She really could use more hours, and I hope this letter will help persuade that to happen. I can't imagine just tossing her to the garbage, as seems the case. She is a person who deserves all the care and respect we should show our elderly population. I would invite another assessment to reevaluate this situation. It would be more productive, I feel, if I or her daughter, Cheri could be present. As we are familiar to her, she is more prone to open up in the presence of people she is familiar with. She gets frustrated with her memory and clams up.

If you have any questions, please feel free to contact me at (253)314-7407.

Thank you,

Alexandria Farmin

November 5, 2009

CHERYL SILVERNAIL
13714 143RD AVE E
ORTING WA 98360

FILE COPY

RE: Insured: Gladys E. White
Policy No.: 0S34226

Dear Ms. Silvernail:

I am writing in response to your letter of September 11, 2009 and thank you for same.

Please be advised that the above contract lapsed for non-payment of premium on February 7, 2009. Notice was given to Ms. White on three occasions at the address on file. Additionally, a Third Party Advisor Notice was sent to you at the Eatonville, Washington address we had on file. This address was given to us on September 10, 2007 by Ms. White.

The policy has a Restoration of Benefits provision in Part M on page 9, but the provision is limited to a five-month period in which to request reinstatement. The five-month period expired in July and we did not receive any contact from you until August.

I am sorry I could not write more favorably. If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

DK

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

Encs.

0S34226

November 30, 2009

Dear Mr. Lawler,

I am writing in response to your letter of November 5.

As I told Sharon from the claims department in September, I moved from my home in Eatonville in July of 2008. I had a forward on our mail that continued for one calendar year, but never received the notice that you're speaking of. I also told her, that all correspondence related to my mother's previous claim was submitted by me over a 4 – 5 year period. In all correspondence that was faxed to your company, I provided my work phone, my cell phone, and my home phone. I don't understand why more effort wasn't made to contact me, since you had all of that information on file.

My mother's previous claim was suspended in June of 2007 because your insurance company did not feel she met the criteria for assistance with Activities of Daily Living or have severe cognitive impairment. Still, we had to continue with a caregiver in her home because she could not care for herself and we paid for this each month without the assistance of the long term care insurance that she had paid for since August of 1999.

In the past year and a half, she has become even more cognitively impaired. We discovered that she was hiding or destroying mail that she didn't understand or did not want to deal with. We were not aware of any correspondence she received from your company. Had we known of this situation, we would have taken care of it. Her plan, when she purchased this insurance, was to be able to take care of herself when she needed it. She would never have let it lapse, had she been mentally stable.

When I contacted your company the first part of August of this year, I spoke with a man named Jerry who was working in the Claim's Department. I asked him what I needed to do to start a claim for my mother because of her injury on July 23. I gave him my mother's name and birth date. He checked her file and gave me her policy number. He never once mentioned that the policy had lapsed because of non-payment. I didn't find that out until I spoke with Sharon in September.

I would like you to reconsider your decision. If not, I will be forced to seek legal council. If you need any additional information, please call me at my home phone, 253-446-7190.

Thank you,

Cheryl Silvernail
(daughter of Gladys White)

December 4, 2009

CHERYL SILVERNAIL
13714 143RD AVE E
ORTING WA 98360

RE: Insured: Gladys E. White
Policy No.: 0S34226

Dear Ms. Silvernail:

I am writing in response to your letter of November 30, 2009 and thank you for same.

Your letter confirms that we were not advised of your change of address and that although you were aware that Ms. White could not properly handle her affairs you did not intervene. Again, the policy has a Restoration of Benefits provision in Part M on page 9, but the provision is limited to a five-month period in which to request reinstatement. The five-month period expired in July and we did not receive any contact from you until August.

I am sorry I could not write more favorably. If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

DL

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

January 13, 2010

FILE COPY

CHERYL SILVERNAIL
13714 143RD AVE E
ORTING WA 98360

RE: Insured: Gladys E. White
Policy No.: 0S34226

Dear Ms. Silvernail:

Enclosed please find a check from Online Resources, #101603665, in the amount of $5,796.00 made payable to Medico Insurance Company. Pursuant to the check, it was intended for Gladys E. White and Policy #0S34226. As previously explained, that policy has lapsed. I am returning this check to you as Power of Attorney for Ms. White.

If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

DL

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

Encs.

BACK OF THIS CHECK CONTAINS A SECURITY MARK - DO NOT ACCEPT WITHOUT HOLDING AT AN ANGLE TO VERIFY SECURITY MARK

Online Resources Corporation
4795 Meadow Wood Lane, Suite 300
Chantilly, VA 20151

Acct # 0S34226
Re: Gladys E. White

Online RESOURCES

Paid by: Gladys E White

431595956

101603665

62-38
311

01/07/2010

check@orc.com
1-800/788-2550 option 1
fax: 703-653-2227

Five Thousand Seven Hundred Ninety Six and NO/100 Dollars

$ *****5,796.00

PAY to the order of

MEDICO INSURANCE COMPANY
Payment Processing
1515 S 75th St
Omaha, NE 68124-1618

Deutsche Bank Trust Company Delaware
Wilmington, Delaware
Void after 90 days

⑈0101603665⑈ ⑆031100380⑆ 005904.50⑈

PS - Inquiry Response - Pol# 0S34226, Clm# - DocID 1494105

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

OFFICE OF
INSURANCE COMMISSIONER

Phone: (360) 725-7000
WWW.INSURANCE.WA.GOV

August 12, 2010

ABILITY INSURANCE COMPANY
COMPLIANCE DEPARTMENT
1515 S 75TH STREET
OMAHA NE 68124-1655

Re: Consumer: Jack R White
OIC Case No.: 1041891

Dear Sir / Madam:

Enclosed is a copy of a complaint our office recently received. Please review your policy and/or claim file and respond to the coverage issues raised in the complaint. Your response should include all supporting documentation that would help resolve any factual disputes (do not send film or recordings); however, please do not send your entire file. In your response verify the name and NAIC number of the issuing company and the specific type of contract involved in this complaint. This verification will be used to report complaint data to the NAIC.

A detailed response within 15 working days of your receipt of this letter is required under WAC 284-30-360 and WAC 284-30-650. We presume a maximum of 5 days for delivery of this letter. Accordingly, we expect your answer by September 14, 2010. Any correspondence with regard to this complaint should be directed to me at PO Box 40256, Olympia, WA 98504-0256, or electronically to CAP.mailbox@oic.wa.gov, or fax (360) 586-2018. Please do not send duplicate responses via different delivery methods, e.g. email and U.S. Mail.

Sincerely,

Bianca Stoner

BIANCA STONER
Compliance Analyst, L&D
(800) 562-6900

BS:lv
Enclosure

cc: JACK R WHITE

Stoner, Bianca (OIC)

From: Stoner, Bianca (OIC)
Sent: Wednesday, August 11, 2010 9:27 AM
To: 'Jwhitebball@aol.com'
Cc: Marquis, Stephanie (OIC)
Subject: RE: Ask Mike - Category: Long term care insurance

Thank you for contacting the Office of the Insurance Commissioner. Commissioner Kreidler has asked me to respond on his behalf regarding your insurance issue, and we have also forwarded your e-mail to him regarding your acquaintance with him.

We're going to open a case regarding your issue, so we're sending the information that you sent to us to Ability. When they respond, we'll let you know what they say, and we'll go from there.

Thank you for contacting us, and if you have any further questions or concerns, please feel free to let us know.

Bianca Stoner
Compliance Analyst
Consumer Advocacy
Washington State Office of the Insurance Commissioner
1-800-562-6900
BiancaS@oic.wa.gov

Want to learn more about the Office of the Insurance Commissioner and our services?
Read our WAinsurance blog | Follow our consumer updates on Twitter | Get our news releases and updates on new laws

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From: Jwhitebball@aol.com [mailto:Jwhitebball@aol.com]
Sent: Monday, August 09, 2010 4:12 PM
To: OIC Ask Mike
Cc: Jwhitebball@aol.com
Subject: Ask Mike - Category: Long term care insurance

Your Contact Information:

Name:	JACK R WHITE
Address:	5812 STARBOARD DR
City:	GREENSBORO
State:	NC
zip:	27410
Email	Jwhitebball@aol.com
Phone	336 643 1236 or 336 508 1376

Category: Long term care insurance

Your comment or question:
Mike..I hope you recognize my name..I went to high school with you at Curtis..I am living in NC now but my

concern is about my mom who do... live in a nursing home in Puyallup Wa.. ou probably remember her from the lunchroom at school...anyway I will try to make this brief..mom purchased longterm care from mutual protective medico life in 8/7/99..from 2002-2007 a claim was processed for mom's broken hip.My sister Cheri has the durable power of attorney for our mom..she sent all claims in for this period of time and she put her name,phone #,cell#,work#,on all claims.On 6/27 claim was closed for not meeting benefit qualifiers..7/23/09 mom broke her wrist in a fall at home,she was hospiatized for 3 days,then sent to a nursing home..8/4/09 Cheri talked to the claims dept for the insurance co.the guy she talked to told her to get a claim form online and submit,she did and sent it in on 8/6/09,he did not inform Cheri the insurance had lapsed due to non-payment..9/8/09 a claim form was faxed from franklin house(mom's residence) and a copy of the durable power of attorney.A letter was recvd from ability insurance saying they had recvd the power of attorney papers,in order to proceed with them they had to have the addresses and phone#'s of each person on the durable power of attorney,all info was mailed back to them..9/9/09 a letter was recvd from ability insurance(they apparently purchased mutual protective medco life)it was mailed to my mom's house dated 8/31/09,they acknowledged Cheri's correspondence of 8/4/09.They informed Cheri the insurance had lapsed due to non payment.9/11/09 Cheri faxed a letter to the insurance company and asked them to contact her in regard to the letter written on 8/31..Sharon from the claims dept contacted Cheri on 9/15/09 and discussed the fact mom had quit making payments on the policy..Cheri told her about mom's cognitive impairment and that she had been shredding bills and hiding other correspondence..Cheri asked why she(cheri) hadn't been informed of the non-payment since she was the one taking care of the previous claims,and that there was numerous ways to contact Cheri..Cheri was told that they weren't sure they still had access to those records because of the changes of the insurance companies..Cheri was told to to get documentation of mom's cognitive impairment and send them in..9/30/09 documentation from good samaritan hospital in puyallup stating she had dementia..10/12/09 Cheri faxed over the october invoice from franklin house.10/25/09 Cheri called Ability insurance and asked why she hadn't heard from them,they said they hadn't recvd any correspondence..on 10/27 again faxed over again the invoice that was sent previous..11/5/09 Cheri recvd a letter from Ability stating the contract lapsed for non-payment of premium on Feb 7,2009..they said notice was sent to mom on 3 occasions to her home address,they said they also had sent a letter to Cheri giving notice,to her address in eatonville which was given to them in Sept 2007..11/30/09 Cheri wrote a letter in response..saying when talking to Sharon in claims that Cheri had moved from her home in eatonville in July of 2008,Cheri had a forward on her mail and never recvd notice from this company,also stating they had numerous phone numbers to contact her..12/4 Cheri recvd a letter denying the claim..Mike I would appreciate you looking into this as my mom can't afford to pay for this on her own ..I look forward to hearing from YOU on this and maybe we can catch up also..Thanks again Jack White class of 1962.

How did you hear about us?

Please tell us how you heard of this office and the services provided.

Relative/Friend

We will try to respond to your comments and questions at the soonest time possible. If you would like immediate assistance, contact the Insurance Consumer Hotline at 1-800-562-6900.

Visit the Washington Insurance Blog at http://wainsurance.blogspot.com for news, updates, and information from Washington State's office of the Insurance Commissioner.

AbilityIns

ABILITY INSURANCE CO

August 23, 2010

(20)

RECEIVED

AUG 26 2010

INSURANCE DEPT. OLYMPIA
CONSUMER ADVOCACY DIVISION

BIANCA STONER
COMPLIANCE ANALYST L&D
WA OFFICE OF INSURANCE COMMISSIONER
PO BOX 40256
OLYMPIA WA 98504-0256

RE: Your File No.: 1041891
Consumer: Jack R. White
Insured: Gladys White
Policy No.: 0S34226
Policy Type: Individual – Long-Term Care, Form MP-LT696(WA)
NAIC No.: 71471

Dear Ms. Stoner:

Your letter of August 12, 2010 has been forwarded to me for review and response.

Enclosed please find a Specimen copy of the above numbered policy with relevant provisions highlighted for your convenience. As Mr. White's letter indicates, the above numbered policy lapsed for non-payment of premium on February 7, 2009. Also, enclosed please find a Timeline documenting contact with Ms. White's daughter and Power of Attorney, Cheryl Silvernail, and my subsequent correspondence to Ms. Silvernail.

A Premium Notice and Past Notice was sent to Ms. White prior to the policy lapse. Additionally, we sent a Reinstatement Notice to Ms. White and a Third Party Advisor Notice to Ms. Silvernail. Because the policy is lapsed no benefits are payable for the confinement which began on July 25, 2010.

If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

Encs.

MUTUAL PROTECTIVE INSURANCE COMPANY

1515 SOUTH 75TH STREET • OMAHA, NEBRASKA 68124

A Mutual Company

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 is attached to the policy. If your answers are incorrect or untrue, the Company has 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 the address shown above.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company.

Insuring Clause: We agree to provide the benefits set out in this policy for any insured loss. This agreement is subject to all of the provisions of the policy. A "loss" is an expense you incur for care or services this policy covers and that you receive after the Policy Date and while the policy is in force.

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.** Also, read the copy of your application and the policy Schedule. If there is any error or omission, tell us. We will make any needed change.

The first premium you, the Insured, paid before the Policy Date (and the copy of your application, attached hereto), put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

PART A **PLEASE READ — 30-DAY RIGHT TO RETURN**

Please read your policy. If you are not satisfied, send it back to us, or to the agent who sold it to you, within 30 days after you receive it. We will return your money. That will mean your policy was never in force. We will pay a 10% penalty if the requested premium refund is not made within 30 days of our receipt of the returned policy.

PART B **GUARANTEED RENEWABLE FOR LIFE**
SUBJECT TO OUR LIMITED RIGHT TO CHANGE PREMIUMS

We guarantee to renew your policy for life, subject to the Lifetime Maximum Benefits provision, as long as the premium is paid within the allowable time; but, we do have the right to change your premium as stated below.

We can change your premium only if we do the same to all policies of this form and any similar form issued to persons of your class in your state. If a change is made, it will not be based on any physical impairment you might have or any claims you have incurred under this policy, and it will be consistent with the Rate Guarantee provision on page 2. If it is necessary to change the premium for your policy, we will send you notice at least 30 days before your premium is due.

NOTICE TO BUYER: This policy may not cover all of the 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.

A QUALIFIED LONG-TERM CARE POLICY FOR FEDERAL TAX PURPOSES

Rate Guarantee: The premium we charge for this policy is based on the benefit amounts shown in the policy Schedule and the disclosures made in your application. That premium rate is guaranteed for at least a three year period measured from the Policy Date. If subsequent rate increases are needed after that initial three year period, each new rate will be guaranteed for an additional two year period.

ALPHABETICAL GUIDE TO YOUR POLICY

	Part
Benefits	H, I, J, K, L & M
Deferred Inflation Protection	N
Definitions	E
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Exceptions	C
General Benefit Information	F
How To File A Claim	Q
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Right To Reduce Coverage	P
Right To Return	A
Schedule	Last Page
Waiver Of Premium	O

PART C — EXCEPTIONS

We will NOT pay benefits for:

(1) loss that occurs while this policy is not in force;
(2) intentional, self-inflicted injury or attempted suicide;
(3) alcoholism or drug addiction, unless addiction resulted from narcotics prescribed by a Physician;
(4) care provided by a member of your immediate family;
(5) services for which you are not liable or for which no charge normally is made in the absence of insurance; and
(6) loss that occurs outside the United States.

Non-Duplication: This contract will not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance. But it will pay benefits for covered expenses you incur that exceed the amount paid or payable by such governmental plans or laws.

PART D — LIFETIME MAXIMUM BENEFITS

The maximum dollar amount for all covered care that we will pay during the lifetime of the policy is shown in the Schedule. That lifetime dollar maximum is determined by multiplying the Daily Benefit amount by the benefit day option, both of which are shown in the Schedule. The lifetime dollar maximum may be greater than the amount shown in the Schedule if the optional inflation shield rider is in force. Coverage under this policy automatically ends after we have paid out the lifetime dollar maximum.

If the Schedule shows your lifetime dollar maximum as Unlimited/Lifetime, there is no lifetime dollar maximum for this policy.

PART E DEFINITIONS

When we use the following words in this policy or in any optional rider, this is what we mean:

Activities of Daily Living: (a) eating; (b) dressing; (c) toileting; (d) transferring; (e) continence and (f) bathing. You are considered to need assistance for each of these activities when:

Eating:	You cannot, without the aid of another person, maintain an adequate food and fluid intake consistent with your dietary needs.
Dressing:	You cannot, without the aid of another person, put on and take off all necessary items of clothing, including medically necessary braces and artificial limbs.
Toileting:	You cannot, without the aid of another person, get to and from the toilet, get on and off the toilet and maintain a reasonable level of associated personal hygiene.
Transferring:	You cannot, without the aid of another person, walk or get in or out of a chair, wheelchair, bed, or other stationary position.
Continence:	You cannot, without the aid of another person, voluntarily control bowel and bladder functions or use an external catheter or other equipment.
Bathing:	You cannot, without the aid of another person, wash yourself by sponge bath in either a tub or shower, including getting into or out of the tub or shower.

Adult Day Health Care: A program of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Adult Day Health Care Center: (a) a facility licensed or certified by the state in which it is located to provide Adult Day Health Care; or (b) if licensing/certification is not required, a part of a facility (or center operated by a facility) that is licensed or certified as a hospital or any type of nursing home by the state in which it is located; or (c) a facility that is approved for Medicaid.

Anniversary Date: The same day and month as the Policy Date in each later year.

Assisted Living Care Facility: A facility that is licensed or certified as an Assisted Living Care Facility in accordance with any applicable state or local laws, with the primary purpose of providing care and services to support needs resulting from Cognitive Impairment or loss of functional capacity. The facility must have a trained employee available at all times to provide that care, and the facility must have established procedures for overseeing the administration of medications. The specific section or unit of the facility where you receive assisted living care must meet all of the above stated requirements.

Benefit Period: A period of covered care for the same or related Conditions, that is not separated by at least 180 days during which you are free of such care.

Case Coordinator: A licensed health care professional, from an agency we will choose, whose training includes managing and arranging for the type of care and services covered under this policy. This person can be a Doctor, Nurse, social worker or other similarly trained and licensed professional. Your Case Coordinator will provide a comprehensive evaluation of your status and will be responsible for developing, implementing and coordinating your Plan of Care. This person will further be responsible for assisting in the selection of providers, making arrangements to initiate services, providing ongoing care monitoring, and revising the Plan of Care as circumstances dictate. The Case Coordinator will work in consultation with your Physician.

Chronically Ill Individual: Any individual who has been certified within the preceding twelve (12) month period by a Licensed Health Care Practitioner as: being unable to perform (without Substantial Assistance from another individual) at least two (2) Activities of Daily Living for a period of at least ninety (90) days due to a loss of functional capacity; having a similar level of disability; or requiring substantial supervision to protect such individual from threats to health and safety due to severe Cognitive Impairment.

Cognitive Impairment: Deterioration of or loss in your intellectual capacity due to organic brain disease or disorder, which requires supervision to protect yourself or others, as measured by clinical evidence and standardized tests that measure your impairment in the following areas:

(a) Your short or long-term memory;

(b) Your orientation as to person (such as who you are), place (such as where you are) and time (such as day, date and year);

(c) Your deductive or abstract reasoning.

Such loss in intellectual capacity can result from Alzheimer's Disease or related degenerative and dementing illnesses.

Condition: Sickness, disease or injury. These include Mental or Nervous Disorders that cause Cognitive Impairment.

Elimination Period: The number of days for which no benefit is payable. The Elimination Period, if any, starts on the date that benefits would otherwise begin and is in effect for the number of days shown in the Schedule. Only one Elimination Period will be applied to any one Benefit Period.

Home Health Agency: An entity that provides home care services and is: (a) certified for participation in the Medicare program; or (b) licensed or certified as a Home Health Agency where required by the state; or (c) is otherwise acceptable to us if licensing or certification is not required. The Home Health Agency must keep records of nursing reports and the Plan of Care. These records must be available to us upon authorized request.

Home Health Aide Services: Assistance with simple health care tasks, personal hygiene, Activities of Daily Living, managing medications, and other related services provided by a Home Health Agency.

Home Health Professional Services: One or more of the following services for your care and treatment that are provided by a Home Health Agency in a noninstitutional setting, under the direction of a Nurse and according to a written diagnosis and Plan of Care:

(a) nursing services;
(b) physical therapy;
(c) speech therapy;
(d) respiratory therapy;
(e) occupational therapy; and
(f) nutritional services provided by a licensed dietician.

Homemaker Services: Assistance provided by a Home Health Agency with managing and maintaining a household, when you can no longer manage those activities and an informal caregiver is not available. This may include preparing meals, doing laundry and incidental household tasks.

Hospice Care: Services (not drugs or other supplies) provided by a Hospice Facility or a Home Health Agency that are designed to provide you with palliative care or to alleviate discomfort during the last phases of life. To be eligible for Hospice Care you must be diagnosed by your Doctor as having no more than 6 months to live.

Hospice Facility: A facility that is primarily engaged in providing care for terminally ill patients whose life expectancy is six months or less. It must be licensed, certified or registered as may be required by the state.

Injury: Accidental bodily Injury that results in loss independent of Sickness and other causes.

Licensed Health Care Practitioner: Any Physician and any registered professional Nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

Maintenance or Personal Care Services: Any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a Chronically Ill Individual (including the protection from threats to health and safety due to severe Cognitive Impairment).

Mental or Nervous Disorder: A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder.

Nurse: A person duly licensed as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Nursing Home: A health care facility that is licensed as a Nursing Home by the state in which it is located and that provides, as its main function, Skilled Nursing Care, Intermediate Nursing Care or Custodial Care. The facility must: (a) provide this care on a continuing inpatient basis as prescribed by a Plan of Care; (b) supervise the care through a nursing staff; (c) maintain clinical records for all patients; (d) maintain control and records of medications given; and (e) have arrangements for the services of a Doctor to furnish medical care in case of an emergency. The specific section or unit of the facility where you receive Nursing Home Care must meet the above described licensing requirements and also must provide, as the main function of that section or unit, care that meets all of the other requirements above. (Items (c) and (d) need not apply when you receive only Custodial Care.)

A Nursing Home is NOT a facility for the treatment of alcoholism, drug addiction or chemical dependency.

Nursing Home Care: Skilled Nursing Care, Intermediate Nursing Care or Custodial Care provided in a Nursing Home.

(a) **Skilled Nursing Care or Intermediate Nursing Care** must be prescribed in your Plan of Care. This care uses professional nursing methods and procedures that are administered by licensed or certified health care personnel. It includes posthospital care, rehabilitation nursing care, maintenance therapy, administration of medication, injections and catheterization.

(b) **Custodial Care** means care that is given to residents of a Nursing Home who, not needing daily nursing care, cannot properly care for themselves due to age or a covered Condition. This care must be prescribed in your Plan of Care.

Physician or Doctor: A licensed practitioner of the healing arts acting within the scope of his/her license.

Plan of Care: A written document prescribing individualized treatment or services that your Condition requires. The plan must be prepared by your Case Coordinator and approved by your Doctor. If case coordination is not used, the plan must be prepared by a Doctor or other licensed medical professional, and must be approved by your Doctor. The Plan of Care must be updated or recertified at least once every 90 days, and the updated or recertified plan must be approved by your Doctor.

Policy Date: The date on which this policy first became effective. That date is shown on the Schedule.

Qualified Long-Term Care Services: Any necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are required by a Chronically Ill Individual or are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Reasonable and Customary Charge: An amount measured by comparing it with charges normally made for similar services and supplies to individuals of similar medical Condition in the locality where the charge is made. All covered charges for which this policy provides benefits are based on the Reasonable and Customary Charges for covered services.

Schedule: Is attached to and is a part of this policy.

Sickness: An illness or disease that you have or acquire.

Substantial Assistance: Physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the Activities of Daily Living.

We, Us or Our: Mutual Protective Insurance Company.

You or Your: The Insured named in the Schedule.

PART F GENERAL BENEFIT INFORMATION

(1) **The Schedule Shows:**

(a) The Daily Benefit which is the basis for our payment of the services we cover. (That amount may be greater if the optional inflation shield rider is in force.)
(b) The Elimination Period that applies to the Benefit Period; and
(c) The dollar maximum for all covered care that we will pay during the lifetime of the policy. (That amount may be greater if the optional inflation shield rider is in force.)

If the Schedule shows your lifetime dollar maximum as Unlimited/Lifetime, there is no lifetime dollar maximum for this policy.

(2) **Receipt of Multiple Covered Services on the Same Day:** If you receive more than one type of covered service on the same day, we will pay the Reasonable and Customary Charge for each service, but in no event shall the total amount paid exceed the Daily Benefit. This is subject to the weekly benefit option under Part K, Care Coordination Benefit.

PART G ELIGIBILITY FOR THE PAYMENT OF BENEFITS

To be eligible for any type of benefit under this policy, your Doctor must show that you are chronically ill. A chronically ill person has been certified by a Licensed Health Care Practitioner as:

(1) Being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to loss of functional capacity;

(2) Having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (1); or

(3) Requiring substantial supervision to protect such individual from threats to health and safety due to severe Cognitive Impairment.

Independent Evaluation: We may, at our expense, have you examined or evaluated by independent medical experts. The studies they perform will be for the purpose of assessing and confirming that you are eligible for care as shown above, and the treatment or services prescribed in the Plan of Care meet all of the requirements of this policy.

PART H NURSING HOME CARE BENEFITS

Limitations or Conditions on Eligibility for Benefits: All of the following conditions apply to receipt of Nursing Home Care benefits.

(1) You must qualify under one of the eligibility requirements set out in Part G.

(2) You must receive Nursing Home Care in a Nursing Home, as defined.

(3) The care received must be prescribed in your Plan of Care.

(4) Your Plan of Care must be updated or recertified at least once every 90 days.

(5) You must receive covered care in excess of the number of days shown in the Schedule as the Elimination Period that applies to each Benefit Period.

Benefit: When you are eligible for and receive Nursing Home Care covered by this policy, we will pay a benefit. That benefit will be the Reasonable and Customary Charges made by the Nursing Home, not to exceed the amount of the Daily Benefit shown in the Schedule or in effect at the time you receive care. It will be paid for each day you receive care in a Nursing Home. This benefit is subject to your lifetime dollar maximum.

PART I HOME CARE BENEFITS

Limitations or Conditions on Eligibility for Benefits: All of the following conditions apply to receipt of home care benefits: (Home care benefits consist of Home Health Professional Services, Home Health Aide Services and Homemaker Services.)

(1) You must qualify under one of the eligibility requirements set out in Part G.

(2) You must receive Home Health Professional Services, Home Health Aide Services or Homemaker Services, as defined.

(3) The care received must be prescribed in your Plan of Care.

(4) Your Plan of Care must be updated or recertified at least once every 90 days.

(5) You must receive covered care in excess of the number of days shown in the Schedule as the Elimination Period that applies to each Benefit Period.

Benefit: When you are eligible for and receive Home Health Professional Services, Home Health Aide Services or Homemaker Services in your home, we will pay a benefit. That benefit will be the Reasonable and Customary Charges for each day of Home Health Professional Services, and 80% of the Reasonable and Customary Charges for each day of Home Health Aide Services or Homemaker Services, not to exceed the amount of the Daily Benefit shown in the Schedule or in effect at the time you receive care. Benefits are subject to your lifetime dollar maximum.

Additional Home Care Benefits: We will also pay a benefit for the following items, which can serve as cost-effective alternatives that allow you to remain in your own home. These benefits are not subject to the Elimination Period, and will not satisfy it. These benefits (except respite care) are not subject to the Daily Benefit, but will count toward your lifetime dollar maximum. These benefits are subject to all other conditions that apply to home care benefits.

(1) **Caregiver Training Benefit:** We will pay a lifetime benefit of up to 5 times the amount of your original Daily Benefit for the reasonable and customary cost of training a friend or family member to help you at home. We will not pay this benefit for anyone who will be paid to care for you.

(2) **Equipment Benefit:** We will pay a lifetime benefit of up to 50 times the amount of your original Daily Benefit for the purchase or rental of supportive equipment or in-home safety devices that allow you to stay in your home for at least 90 days. Such equipment or devices may include ramps, grab bars, a special bed, or an emergency medical alert system.

(3) **Respite Care Benefit:** We will pay the Reasonable and Customary Charge of temporary care in your home, an institution, or community-based program in order to give your primary in-home caregiver a rest. This benefit is subject to the amount of the Daily Benefit for all covered care shown in the Schedule or in effect at the time you receive care, and is further subject to a 21-day maximum per calendar year.

PART J COMMUNITY CARE BENEFITS

Limitations or Conditions on Eligibility for Benefits: All of the following conditions apply to the receipt of community care benefits: (Community care benefits consist of Adult Day Health Care and Hospice Care.)

(1) You must qualify under one of the eligibility requirements set out in Part G.

(2) You must receive Adult Day Health Care or Hospice Care, as defined. Adult Day Health Care must be received in an Adult Day Health Care Center. Hospice Care must be provided by a Hospice Facility or a Home Health Agency.

(3) The care received must be prescribed in your Plan of Care.

(4) Your Plan of Care must be updated or recertified at least once every 90 days.

(5) You must receive covered care in excess of the number of days shown in the Schedule as the Elimination Period that applies to each Benefit Period.

Benefit: When you are eligible for and receive Adult Day Health Care or Hospice Care, we will pay a benefit. That benefit will be the Reasonable and Customary Charges made for each day of Adult Day Health Care or Hospice Care, not to exceed 50% of the Daily Benefit shown in the Schedule or in effect at the time you receive care. Benefits are subject to your lifetime dollar maximum.

PART K CARE COORDINATION BENEFIT

Additional benefits are available under this policy when you agree to and receive coordination of care through a Case Coordinator. When you agree to coordination of care, we will pay for all expenses associated with the services of your Case Coordinator, as well as the following benefits:

(1) **Elimination Period Waiver:** You will receive benefits for the first day of care for any type of care covered under this policy. The policy Elimination Period will not apply.

(2) **Weekly Benefit:** Instead of a Daily Benefit, you will receive a Weekly Benefit. The Weekly Benefit will consist of a weekly (Monday through Sunday) maximum of up to 7 times your Daily Benefit for the Reasonable and Customary Charges for care received during the week. This benefit is subject to your lifetime dollar maximum. The added flexibility of this benefit is valuable because the amount and kind of care you need could exceed your Daily Benefit on any given day.

(3) **Enhanced Home Care Benefit:** Instead of 80%, we will pay 100% of Reasonable and Customary Charges, subject to the Weekly Benefit, for Home Health Aide Services and Homemaker Services provided under the direction of your Case Coordinator. Additionally, we will waive the requirement that Homemaker Services be provided through a Home Health Agency when your Case Coordinator determines that these services may be supplied in a more cost-effective manner by alternate providers. This benefit is subject to your lifetime dollar maximum.

(4) **Assisted Living Care Facility Benefit:** We will pay 80% of the Reasonable and Customary Charge for care in an Assisted Living Care Facility, subject to the Weekly Benefit, when your Case Coordinator recommends this alternative in your Plan of Care. We will not pay home care or community care benefits while you are receiving the Assisted Living Care Facility benefit. This benefit is subject to your lifetime dollar maximum.

PART L BED RESERVATION BENEFIT

Limitations or Conditions on Eligibility for Benefits: To be eligible to receive benefits under this provision, you must meet all of the conditions listed below.

(1) You must be hospitalized temporarily during the course of your covered stay in a Nursing Home or Assisted Living Care Facility.

(2) The Nursing Home or Assisted Living Care Facility must charge you to keep your room available during your hospital stay.

(3) Your hospitalization must be the result of a covered Condition.

(4) You must have satisfied any Elimination Period that applies to the Benefit Period. If you have not, your days in the hospital will apply to the Elimination Period.

Benefit: When you meet the eligibility requirements of this provision we will pay a benefit. It will be equal to the Reasonable and Customary Charge the Nursing Home or Assisted Living Care Facility makes to hold your room during the hospital stay, not to exceed the amount of the Daily Benefit for all covered care shown in the Schedule or in effect at the time you receive care. We will pay this benefit for up to 14 days per calendar year, subject to the Elimination Period and your lifetime maximum dollar amount for all covered care shown in the Schedule or in effect at the time you receive care. Unused benefit days cannot be carried over from one calendar year to the next.

PART M RESTORATION OF BENEFITS IN THE EVENT OF POLICY LAPSE DUE TO COGNITIVE IMPAIRMENT OR LOSS OF FUNCTIONAL CAPACITY

If coverage under this policy ends due to nonpayment of premium, you or any person acting on your behalf will have 5 months to request reinstatement of the policy on the grounds that you suffered from Cognitive Impairment or loss of functional capacity at the time of lapse. We will require the same evidence of Cognitive Impairment or loss of functional capacity that is required for eligibility for benefits under this policy. We also must receive the back premium from the date of default. If these conditions are met, we will reinstate the policy without evidence of insurability. The coverage will be at the same level that existed prior to the date of the lapse. This provision does not apply to a policy that terminated because you requested cancellation or because we paid the maximum dollar amount.

PART N DEFERRED INFLATION PROTECTION OPTION

When you applied for this policy, you were given the opportunity to defer adding an optional Inflation Shield Rider. If you elected that option we will give you the opportunity to add an inflation rider without evidence of insurability within 90 days prior to the third Anniversary Date of the policy, if you have not incurred a claim under the policy. The additional premium required for the inflation rider will be based on your age at the time this benefit is added. Increases will begin to take effect on the first Anniversary Date after the inflation rider is in force.

PART O WAIVER OF PREMIUM

After we have paid benefits for Nursing Home Care for 90 days in a row, we will waive the payment of premiums that come due thereafter during the continuance of consecutive days for which such benefits are paid. This waiver, which includes premiums for any attached rider, will continue until the first day of the month following the date we stop paying benefits for Nursing Home Care.

PART P RIGHT TO REDUCE COVERAGE

You have the right to reduce the benefits of this policy without providing evidence of insurability. Changes may include:

a) a longer Elimination Period;

b) a lower Daily Benefit; or

c) a shorter benefit day option, resulting in a reduced lifetime dollar maximum.

Benefits will not be reduced to a level below the minimum level approved by the Commissioner of Insurance on the date you request reduction.

PART Q HOW TO FILE A CLAIM

(1) **Notice of Claim:** You must give us written notice of a claim within 20 days after loss starts or as soon as you can. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to our Home Office in Omaha, Nebraska, or to one of our agents.

(2) **Claim Forms:** When we receive your notice, we will send you forms for filing proof of loss. If these forms are not sent to you in 15 days, you will have met the proof of loss rule below if, in 90 days after the loss began (or, in the event of a continuing loss, within 90 days after the first month of the loss for which we are liable), you gave us a written statement of what happened.

(3) **Proof of Loss:** You must give us written proof of your loss in 90 days or as soon as you can. In the event of a continuing loss that is eligible for periodic payments, you must give us written proof within 90 days after the end of the period of loss for which we are liable. But proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

PART R PAYMENT OF CLAIMS

(1) **Time of Payment of Claims:** Benefits for continuing care are paid monthly when loss lasts longer than one month. When we receive your proof of loss, benefits that accrued up to the date of the proofs will be paid at the end of each month. All other benefits are paid as soon as we receive your proof of loss. Benefits unpaid when our liability ends are paid when we receive your proof of loss.

(2) **Payment of Claims:** Benefits will be paid directly to you. Benefits unpaid at your death will be paid to your beneficiary or your estate.

If any benefit is payable to your estate, to a minor, or to any person not able to give a valid release, we may pay up to $1,000.00 to any relative by blood or connection by marriage of the Insured or beneficiary that we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

(3) **Claim Review and Appeal Procedure:** In the event of any claim denial with which you do not agree, you have the right to submit a written request to the Company at its Home Office asking for a review of the denial of benefits. That request may include documents from your Physician or care provider that support your basis for the requested review. Within 30 days after we receive that written request, we will notify you or your representative of the results of the review.

PART S POLICY PROVISIONS

(1) **Entire Contract; Changes:** This policy, with any attachments (and the copy of your application), is the entire contract of insurance. No agent may make contracts, determine insurability or change the application or policy in any way. Only an executive officer of ours can approve a change. That change must be shown in the policy.

(2) **Time Limit on Certain Defenses:** After two years from the Policy Date, no misstatements, except knowing and intentional misstatements relating to the Insured's health, can be used to void the policy. If this policy is reinstated on the basis of a health application, the contestable period will be two years from the reinstatement date.

Pre-Existing Conditions: We will not reduce or deny a claim under this policy because a Sickness or Injury existed before the Policy Date.

(3) **Grace Period:** Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period.

(4) **Reinstatement:** Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement and, as may be needed, issue a conditional receipt, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), your policy will be put back in force on that 45th day.

Your reinstated policy will cover only loss due to Injury that begins after the date your policy was put in force. Also, it will cover only loss due to Sickness that begins after the date the policy was put back in force.

In all other respects, you and we will have the same rights under this policy that we had before it lapsed. The premium we accept to reinstate this policy may be used for a period for which premiums had not been paid. But it will not be used for any period more than 60 days before the reinstatement date.

(5) **Physical Examination:** We, at our expense, can have you examined as often as reasonably needed while a claim is pending.

(6) **Legal Action:** You can't bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You can't start such an action more than three years after the date written proof of loss is required.

(7) **Change of Beneficiary; Assignment:** Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.

(8) **Misstatement of Age:** If your age has been misstated, the amount payable will be that which the premium would have bought at the correct age.

(9) **Illegal Occupation:** We will not be liable for any loss to which a contributing cause was your commission of or attempt to commit a felony. Nor will we be liable for any loss to which a contributing cause was your being engaged in an illegal occupation.

(10) **Other Insurance With Us:** You may have only one policy like this one at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.

(11) **Extension of Benefits:** Termination of this policy will be without prejudice to any benefits payable for institutionalization if such institutionalization began while the policy was in force and continues without interruption after termination. "Institutionalization" means Nursing Home Care, as defined in the policy. This extension of benefits beyond the period the policy was in force will be limited to the duration of the Benefit Period, if any, or to the payment of the maximum dollar amount. It will be subject to the policy Elimination Period and all other applicable provisions of the policy.

(12) **Term of Coverage:** Your coverage starts on the Policy Date at 12:01 a.m. standard time where you live. It ends at 12:01 a.m. on the same standard time on the first renewal date. Each time you renew your policy, the new term begins when the old term ends.

(13) **Conformity With State Statutes:** The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

(14) **Annual Meeting:** Our annual meeting is held at 10:00 a.m. on the second Friday of May at our Home Office.

This policy is signed in our behalf by our Chief Executive Officer and Secretary.

Chairman of the Board
Chief Executive Officer

Secretary

Countersigned By_____
Licensed Resident Agent

0534226 Gladys White 696 Issued 8-8-1999

Lapsed 2-7-2009

Claim 980004 Closed Benefit Qualifier Not Met

Claim 980001 Closed Benefit Qualifier Not Met

It appears that benefits were paid for DOS 9-21-02 to 5-31-07 for a total of 89872.38

8-12-09 Claim Form Received---Added not to doc in OnBase

8-31-09 Sent letter to pi advising them that contract lapsed – copy attached

9-8-09 2nd Claim Form Received along with Invoices

9-15-09 Called Daughter Cheryl explained that policy lapsed on 2-8-09

9-15-09 Inquiry Received from Cheryl

This was handled by Judy and it appears that she referred letter to Tie to discuss with Daughter

10-2-09 Medical Records

10-21-09 referred Medical Records to Don L/Erin to review and handle

10-13-09 Invoice

10-28-09 Another Primary Claim Form along with invoices

Notes in caps indicated:

10-27-09 Daughter Cheryl called regarding reinstatement

11-10-09 ltr to daughter Cheryl Reinstatement denied

12-12-09 follow up ltr to same daughter regarding denial of reinstatement.

STATE OF WASHINGTON

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

Phone: (360) 725-7080
www.insurance.wa.gov

OFFICE OF
INSURANCE COMMISSIONER

August 30, 2010

Ability Insurance
Donald Lawler,
Senior Vice President
PO Box 3735
Omaha NE 68103

Re: Case Number 1041891

Dear Mr. Lawler:

Thank you for your recent response to our office regarding Mrs. White's long-term care policy.

After reading the response, I have some remaining questions:

1) Under WAC 284-54-253 (2), companies that provide long-term care policies must "offer each insured in writing an opportunity to change the designee, or update the information concerning the designee, no less frequently than once in every twenty-four months." Does Ability do this, and if so, what's Ability's process for doing this?
2) Was Mrs. White's daughter, Cheri Silvernail, listed as the designee on Mrs. White's policy?
3) Did Ability mail a letter to Cheri Silvernail before the policy lapsed notifying her that the policy was going to lapse?
4) If so, when did Ability mail the letter to Ms. Silvernail?
5) If Ability mailed such a letter to Ms. Silvernail, did Ability receive the letter back as non-deliverable? If so, what further action did Ability take to follow up with Ms. Silvernail?

Mailing Address: P.O. Box 40256 • Olympia, WA 98504-0256
Street Address: 5000 Capitol Blvd. • Tumwater, WA 98501

Mr. White explains in his e-mail that Ability had Ms. Silvernail's cell phone number and work number. Did Ability ever contact Ms. Silvernail using her cell phone number or work number to notify her that the policy was about to lapse?

Thank you for addressing this issue. A detailed response within 15 working days of your receipt of this letter is required under WAC 284-30-360 and WAC 284-30-650. We presume a maximum of 5 days for delivery of this letter. Accordingly, we expect your answer by September 30, 2010. Any correspondence with regard to this complaint should be directed to me at PO Box 40256, Olympia, WA 98504-0256, or electronically to CAP.mailbox@oic.wa.gov, or fax (360) 586-2018. Please do not send duplicate responses via different delivery methods, e.g. email and U.S. Mail.

Sincerely,

Bianca Stoner

Bianca Stoner
Compliance Analyst
1-800-562-6900
(Fax) 360-586-2018

CC: Jack White

Mailing Address: P.O. Box 40256 • Olympia, WA 98504-0256

Mailing Address: P.O. Box 40256 • Olympia, WA 98504-0256
Street Address: 5000 Capitol Blvd. • Tumwater, WA 98501

AbilityIns

ABILITY INSURANCE CO.

September 8, 2010

RECEIVED

SEP 13 2010

INSURANCE DEPT. OLYMPIA
CONSUMER ADV & OUTREACH

BIANCA STONER
COMPLIANCE ANALYST L&D
WA OFFICE OF INSURANCE COMMISSIONER
PO BOX 40256
OLYMPIA WA 98504-0256

RE: Your File No.: 1041891
Consumer: Jack R. White
Insured: Gladys White
Policy No.: 0S34226
Policy Type: Individual – Long-Term Care, Form MP-LT696(WA)
NAIC No.: 71471

Dear Ms. Stoner:

I am writing in response to your letter of August 30, 2010 and thank you for same.

Please be advised that we are in compliance with WAC248-54-253(2). As my previous letter indicated, the Third Party Advisor Notice was sent to Ms. Silvernail after return of an Advisor Letter we mailed to Ms. White on August 27, 2007. Pursuant to the 24 month requirement, another Advisor Letter would have been mailed in August 2009, but the policy had already lapsed in February of that year. A copy of the August 27, 2007 letter is enclosed for your review.

Yes, Ms. Silvernail was listed as a designee on Mrs. White's response. Ability did mail a letter to Ms. Silvernail. Both Reinstatement Notice and the Third Party Advisor Notice were mailed on March 20, 2009. A billing history is enclosed for your convenience. Neither was returned as undeliverable. Premium Notices and Third Party Advisors Notices are in writing and there was no attempt made to follow up via telephone when payment was not received.

If you have any other questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

Encs.

MEDICO™ GROUP

Medico™ Insurance Company • Medico™ Life Insurance Company

August 27, 2007

REC'D P.S.

SEP 10 '07

GLADYS E WHITE
9223 60 AVE CT E
PUYALLUP WA 98371

Policy No.: 0S34226

Dear Gladys E White,

You may name an Advisor(s) to provide extra security against the unintentional lapse of your insurance policy. This will enable us to send a notification to the person you name in case of an unpaid premium. If you do not wish to take advantage of this opportunity, please sign the waiver below and return the form to us.

Please designate a person in the space provided and sign below,
– or –
sign the Waiver that follows.

1. Advisor's Name: Cheryl Silversail
   Home Address: 3440 E. Thomas Rd. E
   City: Eatonville State: Wash Zip: 98328
   Phone Number: (253) 360 879 5543
2. Name of Second Advisor (Optional): _____
   Home Address: _____
   City: _____ State: _____ Zip: _____
   Phone Number: (_____) _____

You have the right to change this written designation at least once every two years.

X DATE: Sept 16-07 X SIGNATURE: Gladys E White

WAIVER OF PROTECTION AGAINST UNINTENDED 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 insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice.

X DATE: Sept 16-07 X SIGNATURE: Cheryl Silversail

Please return this completed form in the enclosed postage-paid envelope.

U2460 02052004

Protecting Your Future Today®

1515 South 75th Street • Omaha, NE 68124 • (402) 391-6900 • fax (402) 391-6489 • www.gomedico.com

0S34226 White, Gladys

Bill From	Bill To	Billing Mode
2/8/2009	8/7/2009	Semi-Annual
2/8/2009	8/7/2009	Semi-Annual
2/8/2009	8/7/2009	Semi-Annual
8/8/2008	8/7/2009	Annual
8/8/2008	8/7/2009	Annual
8/8/2007	8/7/2008	Annual
8/8/2007	8/7/2008	Annual
8/8/2006	8/7/2007	Annual
8/8/2005	8/7/2006	Annual
8/8/2004	8/7/2005	Annual

Billing History

Bill Date	Status	Iteration
3/20/2009		2
2/19/2009	VDB	2
1/9/2009	VDB	1
8/19/2008	VDB	2
7/9/2008	VDB	1
8/20/2007		2
7/9/2007	VDB	1
6/30/2006		1
7/11/2005		1
7/9/2004		1

STATE OF WASHINGTON

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

Phone: (360) 725-7080
www.insurance.wa.gov

OFFICE OF
INSURANCE COMMISSIONER

September 24, 2010

Ability Insurance
Donald Lawler,
Senior Vice President
PO Box 3735
Omaha NE 68103

Re: Case Number 1041891

Dear Mr. Lawler:

Thank you for your recent response to our office regarding Mrs. White's long-term care policy. In the response, you explained that Ability mailed the reinstatement notice and the third-party advisor notice to Cheri Silvernail on March 20, 2009.

Under WAC 284-54-253(1)(a), the designee's notice must "provide that the contract or certificate will not lapse until at least thirty days after the notice is mailed to the insured's designee." Thus, the contract could not lapse until April 19, 2009, at the earliest. Moreover, WAC 284-54-253(2) requires, in the event of lapse for nonpayment of premium where the insurer is provided with proof of the insured's cognitive impairment, that the insurer allow reinstatement when reinstatement is requested within the five months after the lapse. Therefore, the insured in this case had until September 19, 2009 to request reinstatement. Because Ms. Silvernail spoke with Ability on September 15, 2009, asking to reinstate the policy, Ability was obligated under Washington law to comply and reinstate the policy. Of course, Ability is entitled to any premiums to which is it entitled under the contract that it has not yet received for the period

We look forward to hearing from Ability regarding the reinstatement of this policy.

Thank you for addressing this issue. A detailed response within 15 working days of your receipt of this letter is required under WAC 284-30-360 and WAC 284-30-650. We presume a maximum of 5 days for delivery of this letter. Accordingly, we expect your answer by October 25, 2010. Any correspondence with regard to this complaint should be directed to me at PO Box 40256, Olympia, WA 98504-0256, or electronically to CAP.mailbox@oic.wa.gov, or fax (360) 586-2018. Please do not send duplicate responses via different delivery methods, e.g. email and U.S. Mail.

Sincerely,

Bianca Stoner

Bianca Stoner
Compliance Analyst
1-800-562-6900
(Fax) 360-586-2018

CC: Jack White
Carol Sureau

AbilityIns

ABILITY INSURANCE CO.

October 4, 2010

RECEIVED

OCT 12 2010

INSURANCE DEPT. OLYMPIA
CONSUMER ADVOCACY DIVISION

BIANCA STONER
COMPLIANCE ANALYST L&D
WA OFFICE OF INSURANCE COMMISSIONER
PO BOX 40256
OLYMPIA WA 98504-0256

RE: Your File No.: 1041891
Consumer: Jack R. White
Insured: Gladys White
Policy No.: 0S34226
Policy Type: Individual – Long-Term Care, Form MP-LT696(WA)
NAIC No.: 71471

Dear Ms. Stoner:

I am writing in response to your letter of September 24th and received in our office on September 30th.

Please be advised that WAC 284-54-253 (1) (a) extends the grace period and prevents the policy from lapsing during said grace period, but if premium is not received in this extended grace period, the policy termination date reverts back to the paid to date. In this case, the policy lapsed for non-payment of premium on February 7, 2009. The extended grace period does not affect the termination or lapse date.

I am sorry I could not write more favorably. If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

STATE OF WASHINGTON

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

Phone: (360) 725-7080
www.insurance.wa.gov

OFFICE OF
INSURANCE COMMISSIONER

October 21, 2010

Ability Insurance
Donald Lawler,
Senior Vice President
PO Box 3735
Omaha NE 68103

Re: Case Number 1041891

Dear Mr. Lawler:

Thank you for your recent response to our office regarding Mrs. White's long-term care policy.

Under WAC 284-54-253(2), if a consumer's family wants to reinstate the policy, they're required to request the reinstatement before the end of the grace period. Under the plain language of the law, the family is not required to catch up on the back payments before the end of the grace period. However, even if the law did require the family to catch up on back payments before the end of the grace period, Ability did not act in good faith in its communications with Mrs. White's family regarding this policy.

Mrs. White's daughter, Cheri Silvernale, would have paid the late premiums within the grace period if she had known that this option existed. As Ability is aware, Ms. Silvernale had moved, so she didn't receive the notice that Ability mailed to her. Fortunately, Ms. Silvernale found out about the lapse on her own, which is why she contacted Ability to discuss how to reinstate the policy.

Specifically, on September 15, 2009 during a phone conversation with an Ability representative named Sharon, Ms. Silvernale explained that she hadn't known about the lapse and that she wanted to reinstate the policy. This phone conversation occurred several days before the end of the grace period, which was September 19, 2009.

The Ability representative didn't tell Ms. Silvernale that there was a way to reinstate the policy, much less inform her that Ability would require her to bring the payments up to date by September 19, 2009 (the end of the grace period) to reinstate the policy.

Ability was not acting in good faith under WAC 284-54-800(2) when, despite Ms. Silvernale's specific request to reinstate the policy, Ability failed to inform her that she had a right to reinstate the policy, and that Ability required her to take certain steps before the end of the grace period in order to reinstate the policy.

Because of Ability's failure to act in good faith regarding this policy, Ms. Silvernale deserves an opportunity now to reinstate the policy.

Please send a reinstatement application to Ms. Silvernale along with a bill for the reinstatement premium.

Thank you for addressing this issue. A detailed response within 15 working days of your receipt of this letter is required under WAC 284-30-360 and WAC 284-30-650. We presume a maximum of 5 days for delivery of this letter. Accordingly, we expect your answer by November 22, 2010. Any correspondence with regard to this complaint should be directed to me at PO Box 40256, Olympia, WA 98504-0256, or electronically to CAP.mailbox@oic.wa.gov, or fax (360) 586-2018. Please do not send duplicate responses via different delivery methods, e.g. email and U.S. Mail.

Sincerely,

Bianca Stoner

Bianca Stoner
Compliance Analyst
1-800-562-6900
(Fax) 360-586-2018

CC: Jack White
Carol Sureau

Mailing Address: P.O. Box 40256 • Olympia, WA 98504-0256
Street Address: 5000 Capitol Blvd. • Tumwater, WA 98501

Mailing Address: P.O. Box 40256 • Olympia, WA 98504-0256
Street Address: 5000 Capitol Blvd. • Tumwater, WA 98501

Mailing Address: P.O. Box 40256 • Olympia, WA 98504-0256
Street Address: 5000 Capitol Blvd. • Tumwater, WA 98501

26

AbilityIns

ABILITY INSURANCE CO.

November 1, 2010

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NOV. 05 2010

INSURANCE DEPT. OLYMPIA
CONSUMER ADVOCACY DIVISION

BIANCA STONER
COMPLIANCE ANALYST L&D
WA OFFICE OF INSURANCE COMMISSIONER
PO BOX 40256
OLYMPIA WA 98504-0256

RE: Your File No.: 1041891
Consumer: Jack R. White
Insured: Gladys White
Policy No.: 0S34226
Policy Type: Individual – Long-Term Care, Form MP-LT696(WA)
NAIC No.: 71471

Dear Ms. Stoner:

I am writing in response to your letter of October 21, 2010 received in our office on October 25th.

Per WAC 284-54-253 (2) Every insurer shall provide a limited right to reinstate coverage in the event of lapse or termination for nonpayment of premium, if the insurer is provided proof of the insured's Cognitive Impairment or Loss of Functional Capacity and reinstatement is requested within the 5 months after the policy lapsed or terminated due to nonpayment of premium.

As previously explained, Ms. White's policy lapsed due to nonpayment of premium on February 7, 2009. Five months from that date is July 7th, not September 19th or even September 15th when we were first contacted by Ms. Silvernale concerning the fact that the contract lapsed. Ms. Silvernale's first correspondence on this subject is dated September 11th and was received in our office on September 15th (Copy enclosed), not within five months. We have never been provided proof of the insured's Cognitive Impairment or Loss of Functional Capacity either.

I am sorry I could not write more favorably. If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

Encs.

September 11, 2009

Ability Insurance
Long Term Care Claims Department
PO Box 3735
Omaha, NE 68103
FAX #: 866-498-0689

I am writing regarding the recent correspondence my mother received about her Long Term Care Insurance, stating that her contract had lapsed effective 2/7/2009.

I am not quite sure what this means as my mother has been paying for this insurance since August, 1999.

Please contact me regarding this. My mom is now in an assisted living home because she has not been able to care for herself or her financial matters for quite some time.

Thank you,

Cheryl Silvernail, daughter of Gladys White

Address:
13714 143rd Ave. E.
Orting, WA 98360

Phone: 253-446-7190
Cell: 253-232-7499
Work: 253-841-8726

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

OFFICE OF
INSURANCE COMMISSIONER

Phone: (360) 725-7000
www.insurance.wa.gov

December 1, 2010

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
Ability Insurance Co.
1515 S 75th St
Omaha, NE 68124-1655
Via US Mail and e-mail: dlawler@abilityre.net

RE: Insured Gladys White, consumer complaint of Jack White

Dear Mr. Lawler:

This letter follows our brief conversation yesterday concerning this matter. You informed me during that conversation that the company's March 20, 2009 letter (which you told me was mailed on that date) served as the company's "notice of lapse or termination for nonpayment of premium" as required under WAC 284-54-253(1)(a).

As I explained, WAC 284-54-253(1)(a) requires that the notice "provide that the contract or certificate will not lapse until at least thirty days after the notice is mailed to the insured's designee." The letter that the company sent did not include this information. Had the letter contained the correct notification as prescribed by the rule, the very soonest that the contract could have lapsed would have been no sooner than 30 days from the date of that letter. Thirty days after the March 20, 2009 notice was Sunday, April 19, 2009. This is important, because your company was responsible to reinstate coverage within five months of that date as indicated under WAC 284-54-253(2).

You acknowledge that on September 11, 2009, the insured's WAC 284-54-253(1) designee contacted the company. A few days later – and still within five months of the contract's prescribed lapse date – the designee told the company that she had just learned of the lapse for nonpayment of premium, and that the nonpayment was because of the insured's cognitive impairment or loss of functional capacity. Yet the company has consistently refused to reinstate the insured's policy.

The company's conduct in this matter violated several provisions of the Washington Insurance Code. The Insurance Code provides that every violation is punishable by a penalty up to $10,000, in addition to suspension or revocation of the violator's certificate of authority. This agency has a process for determination of enforcement actions. I have discussed this matter with my supervisor and we will proceed to present this matter at the December 15 meeting of the agency's Compliance Group for consideration of enforcement action against the company.

Should you have any questions about this process, please do not hesitate to contact me at (360) 725-7046.

Sincerely,

Alan Michael Singer, Staff Attorney
Legal Affairs Division

Abilityins

ABILITY INSURANCE CO.

December 16, 2010

ALAN M SINGER, STAFF ATTORNEY
LEGAL AFFAIRS DIVISION
WA OFFICE OF INSURANCE COMMISSIONER
PO BOX 40255
OLYMPIA WA 98504-0255

RE: Your File No.: 1041891
Consumer: Jack R. White
Insured: Gladys White
Policy No.: 0S34226
Policy Type: Individual – Long-Term Care, Form MP-LT696(WA)
NAIC No.: 71471

Dear Mr. Singer:

I am writing in response to your letter of December 1, 2010 and thank you for same.

Contrary to your letter, our notice does state, "If the premium is not received within 35 days from the date of this letter, the policy will lapse for nonpayment of premiums". In full compliance with WAC 284-54-253 (1)(a).

The Grace Period, Extended Grace Period for Third Party Notification or Limited Right to Reinstatement all act independently of each other and most importantly, will only extend the policy's term of coverage should payment actually be made within said period. Once the period comes and goes without payment, the lapse date reverts back to the termination for nonpayment date with no reference given to the additional period per WAC 284-54-253 (1)(b) and please see Washington case Hanson v. Mutual of Enumclaw Insurance Company (WAC, 1999). That case involved a claim by plaintiffs after the policy had been canceled for nonpayment of premium. The Hanson's sent a check to the insurance company after the policy had terminated. "Because reinstatement does not affect coverage, but rather governs conduct after coverage is terminated, it does not conflict with the policy terms or Washington Statute."

To further advance our position that reinstatement or extended grace period has a short shelf life we reference West's Encyclopedia of American Law definition of "Grace Period". West states, "In insurance law, a period beyond the due date of the premium (usually 30 or 31 days) during which the insurance is continued in force during which payment may be made to keep the policy in good standing. The grace period for payment of premium does not provide free insurance or operate to continue the policy in force after it expires by agreement of the parties". Clearly, if payment is not received the lapse date reverts back to the termination date.

Additionally, should we accept the extended lapse date, the insured's representative was still required to provide proof of the insured's Cognitive Impairment or Loss of Functional Capacity and request reinstatement within 5 months after the policy lapsed or terminated due to nonpayment of premium. Ms. Silvernail did neither as required by WAC 284-54-253 (2). Contrary to your letter, we were not told that nonpayment was because of the insured's Cognitive Impairment or Loss of Functional Capacity. Instead, we received a Claim Form for confinement due to a wrist fracture on July 28, 2009. Ms. White would not be considered a Chronically Ill individual as required by Part G of the policy for Benefit Eligibility.

I am sorry I could not write more favorably. If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

DAVID E. HANSON and MARY R. HANSON, husband and wife, Appellants, v. MUTUAL OF ENUMCLAW INSURANCE COMPANY, Respondent.

No. 17322-4-III

COURT OF APPEALS OF WASHINGTON, DIVISION THREE, PANEL TEN

1999 Wash. App. LEXIS 945

May 27, 1999, Filed

NOTICE: [*1] RULES OF THE WASHINGTON COURT OF APPEALS MAY LIMIT CITATION TO UNPUBLISHED OPINIONS. PLEASE REFER TO THE WASHINGTON RULES OF COURT.

SUBSEQUENT HISTORY: Reported in Table Case Format at: *95 Wn. App. 1056.*

PRIOR HISTORY: Appeal from Superior Court of Kittitas County. Docket No: 96-2-00312-6. Date filed: 01/30/1998. Judge signing: Hon. Michael E. Cooper.

DISPOSITION: Affirmed.

COUNSEL: For Appellants: William M. Wood Jr., Meikle & Wood, Tacoma, WA.

For Respondent: Jeffory E. Adams, Murray Dunham & Murray, Seattle, WA.

For Other Parties: Jewel Smith (Appearing Pro Se), Official Court Reporter, Ellensburg, WA.

JUDGES: Authored by Frank L. Kurtz. Concurring: Stephen M. Brown, Kenneth H Kato.

OPINION BY: FRANK L. KURTZ

OPINION

KURTZ, A.C.J. - The Hansons' insurance policy on their home was cancelled three times for nonpayment of premium in one year. Mutual of Enumclaw Insurance Company refused to reinstate coverage after the third cancellation, pursuant to an in-house policy that denies reinstatement of an insurance contract in the event it has been cancelled three times in a 12 month period. After cancellation, a fire destroyed the Hansons' home. They sued Mutual of Enumclaw arguing that the policy of insurance was not cancelled according to its terms and, alternatively, that [*2] the doctrines of estoppel and waiver barred the cancellation of the contract. On summary judgment, the court found the policy was cancelled on the date of the fire. The Hansons appeal. We affirm the judgment of the superior court.

FACTS

David and Mary Hanson were the owners of property located in Thorp, Washington. In November 1994, the Hansons purchased a farmowner's insurance policy from Mutual of Enumclaw, through the Snowden Agency. This was an annual policy and the initial coverage was from November 15, 1994, to November 15, 1995. The Hansons renewed the coverage for a second year. The Snowden Agency periodically mailed the Hansons a Statement of Account, which informed them of the current balance due on the annual premium, the minimum amount due to prevent cancellation and the date the payment was due. The Snowden Agency mailed a Reminder Notice to any insureds who did not pay the premiums timely. This reminder informed the insureds the date the policy would cancel if the premium was not received. The Statement of Account reads as follows:

NOTICE: PLEASE READ REVERSE SIDE FOR GENERAL INFORMATION AND CANCELLATION PROVISIONS FOR NONPAYMENT OF PREMIUM.

The Reminder Notice [*3] contains the following language:

Please see reverse side for general information and nonpayment cancellation provisions.

On the Statement of Account, the wording is in bold and capitalized type, whereas on the Reminder Notice it is not in bold and appears in lower case.

On the reverse side of both the Statement and Reminder, several provisions appear. The provision that relates to reinstatements reads:

REINSTATMENTS - Reinstatement will not be available if an account has been cancelled for nonpayment three times during a 12 month period.

In 1996, the Hansons' policy was cancelled three times for failure to pay premiums. In the first instance, the premium was due by January 14. The Hansons made a partial payment on January 18. The Reminder Notice

stated that if the premium was received by February 4, coverage would continue uninterrupted. The Hansons paid the premium on February 6. Mutual of Enumclaw reinstated the policy.

The second instance of cancellation occurred in April. The Hansons' premium was due March 17, which they failed to pay. The Reminder Notice stated if the premium was not received by April 7, the policy would be cancelled. The Hansons did not pay the premium [*4] by April 7 and the Snowden Agency sent a letter notifying the Hansons that the policy had lapsed. The Hansons paid the premium due in full on April 24, and Mutual of Enumclaw reinstated the policy effective to March 18.

The third time the policy was cancelled was in July. The premium payment of $ 271.00 due June 14 was not paid. The Reminder Notice indicated if payment was received by July 4, coverage would continue uninterrupted. The Hansons did not pay the premium by July 4. At that time, Mutual of Enumclaw sent a statement to the Hansons informing them that they owed Mutual of Enumclaw $ 174.37 for previous coverage, and explaining payment "does not" reinstate coverage. The Hansons paid Mutual of Enumclaw $ 271.00 on August 1. Mutual of Enumclaw decided not to reinstate the policy because it had been cancelled three times in one year. On August 8, Mutual of Enumclaw retained $ 174.37 and sent a refund check for the remainder of the premium paid to the Snowden Agency to forward to the Hansons. The Snowden Agency sent a letter to the Hansons informing them that Mutual of Enumclaw would not reinstate the policy and they would receive a refund in the amount of $ 96.63. The [*5] letter reminded the Hansons they had not had coverage on the house since July 9. On August 15, a fire occurred at the Hansons' house. Mutual of Enumclaw denied coverage. The Hansons filed suit. Mutual of Enumclaw successfully sought summary judgment. The Hansons appeal.

ANALYSIS

Did the trial court err in granting summary judgment?

Mutual of Enumclaw based its cancellation of the insurance contract upon its in-house policy that denies reinstatement of an insurance policy after it has been cancelled three times in one year. The Hansons argue *RCW 48.18.190* prohibits agreements conflicting or modifying a contract of insurance unless it is in writing and made part of the contract. The insurance company's in-house policy is found on the reverse side of its statements and the reminder notices. These documents are not part of the insurance contract. According to the Hansons, the insurance contract governs cancellation. It provides that Mutual of Enumclaw may cancel by delivering to the insured and the insured's agent a written notice of cancellation, including the actual reason for cancellation 10 days before the effective date of cancellation for nonpayment of premium. The [*6] Hansons believe the court erred by relying upon the in-house policy and instead, it should have analyzed whether the doctrines of waiver and estoppel barred the cancellation of the insurance contract. In reviewing a summary judgment order, the appellate court evaluates the matter de novo, performing the same inquiry as the trial court. *Ski Acres, Inc. v. Kittitas County, 118 Wash. 2d 852, 854, 827 P.2d 1000 (1992).* Summary judgment is appropriate if no genuine issue of material fact exists and the moving party is entitled to judgment as a matter of law. *CR 56(c).* The Hansons contend that the in-house policy of refusing to reinstate policies that have been cancelled three times in one year is inconsistent with the insurance policy and void based on *RCW 48.18.190.* *RCW 48.18.190* provides "no agreement in conflict with, modifying, or extending any contract of insurance shall be valid unless in writing and made a part of the policy." Here, the Hansons' policy provided that Mutual of Enumclaw may "cancel this policy by mailing or delivering to the Insured or the Insured's agent or broker written notice of cancellation, including the actual reason for the cancellation . . . at [*7] least . . . 10 days before the effective date of cancellation if we cancel for nonpayment of premium." The notice regarding reinstatement contained in the account statement and reminder notices states that "reinstatement will not be available if an account has been cancelled for nonpayment three times during a 12 month period." The Mutual of Enumclaw reinstatement policy does not modify or conflict with the Hansons' policy of insurance. It does not affect coverage, premiums, or any other material aspect of the insurance contract. Rather, the reinstatement policy merely informs the insured of the consequences of allowing the policy to be cancelled three times in a 12 month period. Moreover, the policy is silent regarding whether Mutual of Enumclaw is obligated to reinstate the policy after it is cancelled. Because the reinstatement policy does not affect coverage, but rather governs conduct after coverage is terminated, it does not conflict with the policy and, likewise, does not violate *RCW 48.18.190.* Next, the Hansons allege the court should have refused to grant summary judgment because the doctrines of waiver and estoppel apply. Waiver requires that the insurers voluntarily [*8] and intentionally relinquished a known right or that their conduct warrants an inference of the relinquishment of such right. *Saunders v. Lloyd's of London, 113 Wash. 2d 330, 339-40, 779 P.2d 249 (1989).* "'Voluntarily' implies a choice, a conscious decision to relinquish a right; conduct giving rise to a waiver argument cannot be consistent with any other interpretation than intent to waive.'" *Id. at 340.* One must know that certain conduct has the effect of relinquishing a right. Id.

"The focus for waiver, then, is on the insurer, not on the insured." Id.

Here, there is no evidence Mutual of Enumclaw waived its right to decline to reinstate the Hansons' policy. The Hansons argue that because Mutual of Enumclaw accepted late payments in the past, even after the policy was cancelled, it waived its right to refuse to reinstate. However, it is clear from the printed policy on the Statement of Account and Reminder Notice that Mutual of Enumclaw's policy was to allow two reinstatements after policy cancellation, but not a third in a 12 month period. Its acceptance of late payments and reinstatement on two occasions do not arise to a knowing, voluntary waiver. Rather, the reinstatements [*9] were simply in compliance with its practice of allowing two policy cancellations. The Hansons also contend that estoppel applies. "In limited circumstances, an insurer may be equitably estopped by its conduct from denying coverage to its insured if the insured justifiably relies on such conduct." *Isaacson v. DeMartin Agency, Inc., 77 Wash. App. 875, 880, 893 P.2d 1123 (1995).* "To prove equitable estoppel, the insured must show (1) conduct inconsistent with the claim afterward asserted; (2) action by the insured on the faith of such conduct; and (3) injury to the insured resulting from allowing the insurer to contradict or repudiate such conduct." Id.; see *Saunders, 113 Wash. 2d at 340.* "One instance, by itself, will not establish a course of conduct that will support waiver or estoppel." *Saunders, 113 Wash. 2d at 342.* In Saunders, the Washington Supreme Court reversed a directed verdict for the insurance company. In that case, the insured had twice before paid an annual premium after the policy expired. In both previous instances, the insurance company had backdated coverage and reinstated the policy. During the third year, the insurance company sent the renewal notice to [*10] the wrong address. The insured again failed to pay the premium timely. However, in late June after the policy had expired, but prior to the date in which the insured normally paid the premium and received backdated coverage, an accident occurred causing extensive damages. The Supreme Court found that the focus of the estoppel inquiry was whether the insured justifiably relied upon the insurer's practice of accepting late renewal payments, delaying issuing the policy and backdating the coverage without any notice of coverage gaps. *113 Wash. 2d at 341-42.* The court found there was sufficient evidence to present a question of estoppel to the jury. *113 Wash. 2d at 343.* Here, the Hansons' estoppel argument fails. They are unable to show the first element, conduct by Mutual of Enumclaw that is inconsistent with a claim afterward asserted. Mutual of Enumclaw's stated policy is to allow reinstatement of a policy cancelled only two times in one 12 month period. It is clear it is not willing to reinstate a thrice-cancelled policy. Unlike the Saunders case, the Hansons' reliance upon Mutual of Enumclaw's past two reinstatements is not reasonable because of the language regarding reinstatement in the [*11] two forms. The Hansons' claim that the policy was cancelled four times in 1995 is in error. According to the supplemental declaration of Gary Duke, the Hansons' policy was never cancelled in 1995, but in fact the payments were accepted during the grace period. Thus, no course of conduct has been established other than Mutual of Enumclaw's compliance with its own stated policy. Finally, the Hansons argue the doctrine of election is applicable. The doctrine of election may apply where an insurer accepts a late premium payment and later discovers a claim for an accident occurring before the premium was tendered. Where the insurer has accepted such late payments for more than one year, it is put to an election: it must treat all late payments the same. *Saunders, 113 Wash. 2d at 338.* Here, Mutual of Enumclaw expressly rejected the Hansons' tender of premium well in advance of notice of the claim. Thus, election is not applicable here. No material issues of fact were presented. The trial court properly granted summary judgment.

Affirmed.

The majority of the panel has determined this opinion will not be printed in the Washington Appellate Reports, but it will be filed for [*12] public record pursuant to *RCW 2.06.040.*

Kurtz, A.C.J.

WE CONCUR:

Brown, J.

Kato, J.

Singer, Alan (OIC)

From: Don Lawler [dlawler@abilityre.net]
Sent: Tuesday, December 07, 2010 7:32 AM
To: Singer, Alan (OIC)
Subject: RE: Gladys White matter

Dear Mr. Singer,

My understanding (from http://www.abilityresources.com/company_structure.htm) is that Ability Insurance Company (Ability) is a 100% wholly owned subsidiary of Ability Resources, Inc., which is itself a 100% wholly owned subsidiary of Ability Reinsurance Holdings Ltd. (a "Bermuda Holding Company"), which *it*self owns 100% of Ability Reinsurance (Bermuda) Ltd., a "Bermuda Limited Reinsurer."

Answer: Correct, except that Ability Reinsurance (Bermuda) Ltd. Is a subsidiary of Ability Reinsurance Holdings Limited not the other way around that you describe.

Another AbilityResources.com webpage indicates that, in 2007, Ability acquired Medico Life Insurance Company from Medico Insurance Company. According to http://www.abilityresources.com/market_activity.htm, in this transaction Ability assumed the responsibilities for administering the insurance of some 60,000 long term care policyholders it acquired, as well as the $600 million of reserves and $100 million of annual premium it acquired.

Answer: Correct. Ability Resources, Inc. acquired Medico Life Insurance Company, a former subsidiary of Medico Insurance Company, in September 2007. Medico Life was renamed Ability Insurance Company in January 2009.

I understand that Ability acquired policies in WA State from the Medical Life Insurance Company per an assumption agreement approved by this office on 10/26/2009, and that pursuant to http://www.gomedico.com/news_pr_0001.htm, Medico Life Insurance was formerly known as Mutual Protective Insurance Company. (The "specimen" policy you provided earlier to this office with your August 23, 2010 letter is a Mutual Protective Insurance Company policy. You have requested a full and complete copy of the actual policy issued to Ms. White, and will send it to me once you receive it.)

Answer: Medico Insurance Company not Medico Life was formerly known as Mutual Protective Insurance Company. It changed its name when it converted to a mutual holding company in 2005.
Ability Insurance Company was formerly known as Medico Life Insurance Company not "Medical" Life. It changed its name as described above. I did request a Duplicate Copy and will send it upon receipt.

Thus, while Ms. White's policy was issued by an insurer *other* than Ability Insurance Company, Ability is responsible for any alleged violations of Washington insurance laws since Ability assumed Ms. White's insurance policy and has been administering her policy since acquiring it from Medico in 2007.

Answer: Correct.
If you have any other questions, please let me know. Thanks!

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
Ability Insurance Company
FKA Medico Life Insurance Company
1515 South 75th Street
Omaha, NE. 68124
(402) 218-4069
(402) 515-4411 cell
(866) 240-2352 FAX
dlawler@abilityre.net

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Ability Insurance Company, 1515 South 75th St., Omaha, NE 68124.

From: Singer, Alan (OIC) [mailto:AlanS@OIC.WA.GOV]
Sent: Monday, December 06, 2010 5:57 PM
To: Don Lawler
Cc: Haworth, John (OIC)
Subject: Gladys White matter
Importance: High

Hi Don,

I would like to make sure I understand this accurately –

My understanding (from http://www.abilityresources.com/company_structure.htm) is that Ability Insurance Company (Ability) is a 100% wholly owned subsidiary of Ability Resources, Inc., which is itself a 100% wholly owned subsidiary of Ability Reinsurance Holdings Ltd. (a "Bermuda Holding Company"), which *it*self owns 100% of Ability Reinsurance (Bermuda) Ltd., a "Bermuda Limited Reinsurer."

Another AbilityResources.com webpage indicates that, in 2007, Ability acquired Medico Life Insurance Company from Medico Insurance Company. According to http://www.abilityresources.com/market_activity.htm, in this transaction Ability assumed the responsibilities for administering the insurance of some 60,000 long term care policyholders it acquired, as well as the $600 million of reserves and $100 million of annual premium it acquired.

I understand that Ability acquired policies in WA State from the Medical Life Insurance Company per an assumption agreement approved by this office on 10/26/2009, and that pursuant to http://www.gomedico.com/news_pr_0001.htm, Medico Life Insurance was formerly known as Mutual Protective Insurance Company. (The "specimen" policy you provided earlier to this office with your August 23, 2010 letter is a Mutual Protective Insurance Company policy. You have requested a full and complete copy of the actual policy issued to Ms. White, and will send it to me once you receive it.)

Thus, while Ms. White's policy was issued by an insurer *other* than Ability Insurance Company, Ability is responsible for any alleged violations of Washington insurance laws since Ability assumed Ms. White's insurance policy and has been administering her policy since acquiring it from Medico in 2007.

If any of the above is not correct, or you take issue with the accuracy of any of the above, I would very much appreciate your immediate clarification. Thank you again for all of your time and attention to this matter.

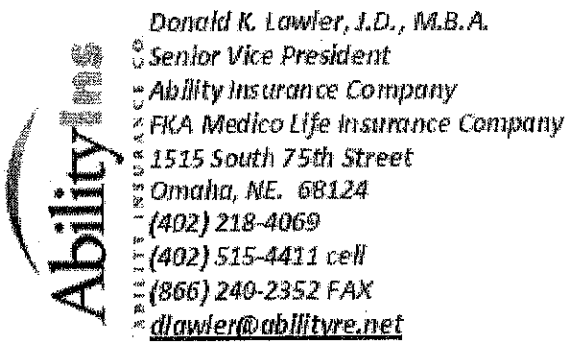
Alan

Alan Michael Singer
Staff Attorney
Legal Affairs
Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255
360-725-7046
360-586-0152 Fax

Singer, Alan (OIC)

From: Don Lawler [dlawler@abilityre.net]
Sent: Tuesday, December 07, 2010 10:53 AM
To: Singer, Alan (OIC)
Subject: Gladys White
Attachments: 120409-White 0S34226.docx; 11052009 - White 0S34226.doc; 01132010 - White 0S34226.doc

Dear Mr. Singer,
The subsequent correspondence you requested is above. If you have any other questions or need additional information, please let me know. Thanks!



Donald K. Lawler, J.D., M.B.A.
Senior Vice President
Ability Insurance Company
FKA Medico Life Insurance Company
1515 South 75th Street
Omaha, NE. 68124
(402) 218-4069
(402) 515-4411 cell
(866) 240-2352 FAX
dlawler@abilityre.net

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Ability Insurance Company, 1515 South 75th St., Omaha, NE 68124.

December 4, 2009

CHERYL SILVERNAIL
13714 143RD AVE E
ORTING WA 98360

RE: Insured: Gladys E. White
Policy No.: 0S34226

Dear Ms. Silvernail:

I am writing in response to your letter of November 30, 2009 and thank you for same.

Your letter confirms that we were not advised of your change of address and that although you were aware that Ms. White could not properly handle her affairs you did not intervene. Again, the policy has a Restoration of Benefits provision in Part M on page 9, but the provision is limited to a five-month period in which to request reinstatement. The five-month period expired in July and we did not receive any contact from you until August.

I am sorry I could not write more favorably. If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

November 5, 2009

CHERYL SILVERNAIL
13714 143RD AVE E
ORTING WA 98360

RE: Insured: Gladys E. White
Policy No.: 0S34226

Dear Ms. Silvernail:

I am writing in response to your letter of September 11, 2009 and thank you for same.

Please be advised that the above contract lapsed for non-payment of premium on February 7, 2009. Notice was given to Ms. White on three occasions at the address on file. Additionally, a Third Party Advisor Notice was sent to you at the Eatonville, Washington address we had on file. This address was given to us on September 10, 2007 by Ms. White.

The policy has a Restoration of Benefits provision in Part M on page 9, but the provision is limited to a five-month period in which to request reinstatement. The five-month period expired in July and we did not receive any contact from you until August.

I am sorry I could not write more favorably. If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

Encs.

January 13, 2010

CHERYL SILVERNAIL
13714 143RD AVE E
ORTING WA 98360

RE: Insured: Gladys E. White
Policy No.: 0S34226

Dear Ms. Silvernail:

Enclosed please find a check from Online Resources, #101603665, in the amount of $5,796.00 made payable to Medico Insurance Company. Pursuant to the check, it was intended for Gladys E. White and Policy #0S34226. As previously explained, that policy has lapsed. I am returning this check to you as Power of Attorney for Ms. White.

If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

Encs.

Singer, Alan (OIC)

From: Singer, Alan (OIC)
Sent: Monday, December 06, 2010 10:08 AM
To: 'Don Lawler'
Subject: RE: Insured Gladys White, consumer complaint of Jack White
Attachments: 8-23-10 Ability Ins Co Don Lawler letter to OIC Bianca Stoner with attached specimen policy and timeline.pdf

Hi Don,

My file has in it your attached 8-23-10 letter to Bianca Stoner of this agency, which attached a "specimen" policy and a timeline, as indicated. As you can see, the "specimen" policy is Mutual Protective Insurance Company MP-LT696(WA), and is 12 pages in all.

As to the "specimen" policy you enclosed, is that a copy of Ms. White's entire policy? If so, will you please confirm that it is and that it includes all of the pages and all the terms in Ms. White's policy? Also, I would like to receive a complete copy of Ms. White's actual policy, not merely a "specimen," if possible. Will you please indicate whether a copy of her actual policy was retained, and if so, I please e-mail it to me as a PDF?

Also, you'll note that your 8-23-10 letter mentioned that you were enclosing some "subsequent correspondence" to Ms. Silvernail. However, as you can see, my copy of your letter does not include this. Will you please also provide me with a PDF copy by e-mail of whatever "subsequent correspondence" to Ms. Silvernail that you were referring to in your letter?

Thank you,

Alan

Alan Michael Singer
Staff Attorney
Legal Affairs
Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255
360-725-7046
360-586-0152 Fax

From: Don Lawler [mailto:dlawler@abilityre.net]
Sent: Monday, November 22, 2010 12:38 PM
To: Singer, Alan (OIC)
Subject: FW: Insured Gladys White, consumer complaint of Jack White

Dear Mr. Singer,

Attached are all four notices:

- Premium Notice #15 - Mailed 1/9/2009
- Past Due Notice #176 - Mailed 2/19/2009
- Advisor Letter (Third Party Notice) #U2462 - Mailed 3/20/2009
- Past Due Notice #480 - Mailed 3/20/2009

If you need anything else, please let me know. Thanks!

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
Ability Insurance Company
FKA Medico Life Insurance Company
1515 South 75th Street
Omaha, NE. 68124
(402) 218-4069
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Ability Insurance Company, 1515 South 75th St., Omaha, NE 68124.

From: Singer, Alan (OIC) [mailto:AlanS@OIC.WA.GOV]
Sent: Monday, November 22, 2010 12:34 PM
To: Don Lawler
Subject: RE: Insured Gladys White, consumer complaint of Jack White
Importance: High

Hi Don,

In addition to sending the "notice of lapse or termination for nonpayment of premium" that was mailed as required by WAC 284-54-253(1), which I requested below, I would also like to ask you to provide some other documents that are referred to in the attached letter you wrote to Bianca Stoner of this agency on September 8, 2010.

In the attached, you can see you wrote that "Ability did mail a letter to Ms. Silvernail. Both Reinstatement Notice and the Third Party Advisor Notice were mailed on March 20, 2009." I am interested in receiving copies of the "letter" you said was mailed to Ms. Silvernail, as well as the "Reinstatement Notice" and the "Third Party Advisor Notice" which were both apparently also sent to her on March 20, 2009. My record does not show that these were included as attachments; please provide them as well.

Will you please tell; me when you can get me these documents?

Thanks,

Alan

Alan Michael Singer
Staff Attorney
Legal Affairs
Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255
360-725-7046
360-586-0152 Fax

From: Don Lawler [mailto:dlawler@abilityre.net]
Sent: Friday, November 19, 2010 6:44 AM
To: Singer, Alan (OIC)
Subject: RE: Insured Gladys White, consumer complaint of Jack White

Will do. Thanks!

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
Ability Insurance Company
FKA Medico Life Insurance Company
1515 South 75th Street
Omaha, NE. 68124
(402) 218-4069
(402) 515-4411 cell
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dlawler@abilityre.net

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Ability Insurance Company, 1515 South 75th St., Omaha, NE 68124.

From: Singer, Alan (OIC) [mailto:AlanS@OIC.WA.GOV]
Sent: Thursday, November 18, 2010 4:42 PM
To: Don Lawler
Subject: Insured Gladys White, consumer complaint of Jack White
Importance: High

Hi Donald,

My file does not contain a copy of the "notice of lapse or termination for nonpayment of premium" that was mailed as required by WAC 284-54-253(1). Will you please kindly e-mail me a copy in PDF as soon as possible?

Thanks,

Alan

Alan Michael Singer
Staff Attorney
Legal Affairs
Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255
360-725-7046
360-586-0152 Fax

AbilityIns

ABILITY INSURANCE CO

August 23, 2010

RECEIVED

AUG 26 2010

INSURANCE DEPT. OLYMPIA
CONSUMER ADVOCACY DIVISION

BIANCA STONER
COMPLIANCE ANALYST L&D
WA OFFICE OF INSURANCE COMMISSIONER
PO BOX 40256
OLYMPIA WA 98504-0256

RE: Your File No.: 1041891
Consumer: Jack R. White
Insured: Gladys White
Policy No.: 0S34226
Policy Type: Individual – Long-Term Care, Form MP-LT696(WA)
NAIC No.: 71471

Dear Ms. Stoner:

Your letter of August 12, 2010 has been forwarded to me for review and response.

Enclosed please find a Specimen copy of the above numbered policy with relevant provisions highlighted for your convenience. As Mr. White's letter indicates, the above numbered policy lapsed for non-payment of premium on February 7, 2009. Also, enclosed please find a Timeline documenting contact with Ms. White's daughter and Power of Attorney, Cheryl Silvernail, and my subsequent correspondence to Ms. Silvernail.

A Premium Notice and Past Notice was sent to Ms. White prior to the policy lapse. Additionally, we sent a Reinstatement Notice to Ms. White and a Third Party Advisor Notice to Ms. Silvernail. Because the policy is lapsed no benefits are payable for the confinement which began on July 25, 2010.

If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

Encs.

MUTUAL PROTECTIVE INSURANCE COMPANY

1515 SOUTH 75TH STREET • OMAHA, NEBRASKA 68124

A Mutual Company

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 is attached to the policy. If your answers are incorrect or untrue, the Company has 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 the address shown above.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company.

Insuring Clause: We agree to provide the benefits set out in this policy for any insured loss. This agreement is subject to all of the provisions of the policy. A "loss" is an expense you incur for care or services this policy covers and that you receive after the Policy Date and while the policy is in force.

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.** Also, read the copy of your application and the policy Schedule. If there is any error or omission, tell us. We will make any needed change.

The first premium you, the Insured, paid before the Policy Date (and the copy of your application, attached hereto), put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

PART A **PLEASE READ — 30-DAY RIGHT TO RETURN**

Please read your policy. If you are not satisfied, send it back to us, or to the agent who sold it to you, within 30 days after you receive it. We will return your money. That will mean your policy was never in force. We will pay a 10% penalty if the requested premium refund is not made within 30 days of our receipt of the returned policy.

PART B **GUARANTEED RENEWABLE FOR LIFE**
SUBJECT TO OUR LIMITED RIGHT TO CHANGE PREMIUMS

We guarantee to renew your policy for life, subject to the Lifetime Maximum Benefits provision, as long as the premium is paid within the allowable time; but, we do have the right to change your premium as stated below.

We can change your premium only if we do the same to all policies of this form and any similar form issued to persons of your class in your state. If a change is made, it will not be based on any physical impairment you might have or any claims you have incurred under this policy, and it will be consistent with the Rate Guarantee provision on page 2. If it is necessary to change the premium for your policy, we will send you notice at least 30 days before your premium is due.

NOTICE TO BUYER: This policy may not cover all of the 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.

A QUALIFIED LONG-TERM CARE POLICY FOR FEDERAL TAX PURPOSES

Rate Guarantee: The premium we charge for this policy is based on the benefit amounts shown in the policy Schedule and the disclosures made in your application. That premium rate is guaranteed for at least a three year period measured from the Policy Date. If subsequent rate increases are needed after that initial three year period, each new rate will be guaranteed for an additional two year period.

ALPHABETICAL GUIDE TO YOUR POLICY

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PART C EXCEPTIONS

We will NOT pay benefits for:

(1) loss that occurs while this policy is not in force;
(2) intentional, self-inflicted injury or attempted suicide;
(3) alcoholism or drug addiction, unless addiction resulted from narcotics prescribed by a Physician;
(4) care provided by a member of your immediate family;
(5) services for which you are not liable or for which no charge normally is made in the absence of insurance; and
(6) loss that occurs outside the United States.

Non-Duplication: This contract will not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance. But it will pay benefits for covered expenses you incur that exceed the amount paid or payable by such governmental plans or laws.

PART D LIFETIME MAXIMUM BENEFITS

The maximum dollar amount for all covered care that we will pay during the lifetime of the policy is shown in the Schedule. That lifetime dollar maximum is determined by multiplying the Daily Benefit amount by the benefit day option, both of which are shown in the Schedule. The lifetime dollar maximum may be greater than the amount shown in the Schedule if the optional inflation shield rider is in force. Coverage under this policy automatically ends after we have paid out the lifetime dollar maximum.

If the Schedule shows your lifetime dollar maximum as Unlimited/Lifetime, there is no lifetime dollar maximum for this policy.

PART E DEFINITIONS

When we use the following words in this policy or in any optional rider, this is what we mean:

Activities of Daily Living: (a) eating; (b) dressing; (c) toileting; (d) transferring; (e) continence and (f) bathing. You are considered to need assistance for each of these activities when:

Eating:	You cannot, without the aid of another person, maintain an adequate food and fluid intake consistent with your dietary needs.
Dressing:	You cannot, without the aid of another person, put on and take off all necessary items of clothing, including medically necessary braces and artificial limbs.
Toileting:	You cannot, without the aid of another person, get to and from the toilet, get on and off the toilet and maintain a reasonable level of associated personal hygiene.
Transferring:	You cannot, without the aid of another person, walk or get in or out of a chair, wheelchair, bed, or other stationary position.
Continence:	You cannot, without the aid of another person, voluntarily control bowel and bladder functions or use an external catheter or other equipment.
Bathing:	You cannot, without the aid of another person, wash yourself by sponge bath in either a tub or shower, including getting into or out of the tub or shower.

Adult Day Health Care: A program of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Adult Day Health Care Center: (a) a facility licensed or certified by the state in which it is located to provide Adult Day Health Care; or (b) if licensing/certification is not required, a part of a facility (or center operated by a facility) that is licensed or certified as a hospital or any type of nursing home by the state in which it is located; or (c) a facility that is approved for Medicaid.

Anniversary Date: The same day and month as the Policy Date in each later year.

Assisted Living Care Facility: A facility that is licensed or certified as an Assisted Living Care Facility in accordance with any applicable state or local laws, with the primary purpose of providing care and services to support needs resulting from Cognitive Impairment or loss of functional capacity. The facility must have a trained employee available at all times to provide that care, and the facility must have established procedures for overseeing the administration of medications. The specific section or unit of the facility where you receive assisted living care must meet all of the above stated requirements.

Benefit Period: A period of covered care for the same or related Conditions, that is not separated by at least 180 days during which you are free of such care.

Case Coordinator: A licensed health care professional, from an agency we will choose, whose training includes managing and arranging for the type of care and services covered under this policy. This person can be a Doctor, Nurse, social worker or other similarly trained and licensed professional. Your Case Coordinator will provide a comprehensive evaluation of your status and will be responsible for developing, implementing and coordinating your Plan of Care. This person will further be responsible for assisting in the selection of providers, making arrangements to initiate services, providing ongoing care monitoring, and revising the Plan of Care as circumstances dictate. The Case Coordinator will work in consultation with your Physician.

Chronically Ill Individual: Any individual who has been certified within the preceding twelve (12) month period by a Licensed Health Care Practitioner as: being unable to perform (without Substantial Assistance from another individual) at least two (2) Activities of Daily Living for a period of at least ninety (90) days due to a loss of functional capacity; having a similar level of disability; or requiring substantial supervision to protect such individual from threats to health and safety due to severe Cognitive Impairment.

Cognitive Impairment: Deterioration of or loss in your intellectual capacity due to organic brain disease or disorder, which requires supervision to protect yourself or others, as measured by clinical evidence and standardized tests that measure your impairment in the following areas:

(a) Your short or long-term memory;

(b) Your orientation as to person (such as who you are), place (such as where you are) and time (such as day, date and year);

(c) Your deductive or abstract reasoning.

Such loss in intellectual capacity can result from Alzheimer's Disease or related degenerative and dementing illnesses.

Condition: Sickness, disease or injury. These include Mental or Nervous Disorders that cause Cognitive Impairment.

Elimination Period: The number of days for which no benefit is payable. The Elimination Period, if any, starts on the date that benefits would otherwise begin and is in effect for the number of days shown in the Schedule. Only one Elimination Period will be applied to any one Benefit Period.

Home Health Agency: An entity that provides home care services and is: (a) certified for participation in the Medicare program; or (b) licensed or certified as a Home Health Agency where required by the state; or (c) is otherwise acceptable to us if licensing or certification is not required. The Home Health Agency must keep records of nursing reports and the Plan of Care. These records must be available to us upon authorized request.

Home Health Aide Services: Assistance with simple health care tasks, personal hygiene, Activities of Daily Living, managing medications, and other related services provided by a Home Health Agency.

Home Health Professional Services: One or more of the following services for your care and treatment that are provided by a Home Health Agency in a noninstitutional setting, under the direction of a Nurse and according to a written diagnosis and Plan of Care:

(a) nursing services;
(b) physical therapy;
(c) speech therapy;
(d) respiratory therapy;
(e) occupational therapy; and
(f) nutritional services provided by a licensed dietician.

Homemaker Services: Assistance provided by a Home Health Agency with managing and maintaining a household, when you can no longer manage those activities and an informal caregiver is not available. This may include preparing meals, doing laundry and incidental household tasks.

Hospice Care: Services (not drugs or other supplies) provided by a Hospice Facility or a Home Health Agency that are designed to provide you with palliative care or to alleviate discomfort during the last phases of life. To be eligible for Hospice Care you must be diagnosed by your Doctor as having no more than 6 months to live.

Hospice Facility: A facility that is primarily engaged in providing care for terminally ill patients whose life expectancy is six months or less. It must be licensed, certified or registered as may be required by the state.

Injury: Accidental bodily Injury that results in loss independent of Sickness and other causes.

Licensed Health Care Practitioner: Any Physician and any registered professional Nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

Maintenance or Personal Care Services: Any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a Chronically Ill Individual (including the protection from threats to health and safety due to severe Cognitive Impairment).

Mental or Nervous Disorder: A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder.

Nurse: A person duly licensed as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Nursing Home: A health care facility that is licensed as a Nursing Home by the state in which it is located and that provides, as its main function, Skilled Nursing Care, Intermediate Nursing Care or Custodial Care. The facility must: (a) provide this care on a continuing inpatient basis as prescribed by a Plan of Care; (b) supervise the care through a nursing staff; (c) maintain clinical records for all patients; (d) maintain control and records of medications given; and (e) have arrangements for the services of a Doctor to furnish medical care in case of an emergency. The specific section or unit of the facility where you receive Nursing Home Care must meet the above described licensing requirements and also must provide, as the main function of that section or unit, care that meets all of the other requirements above. (Items (c) and (d) need not apply when you receive only Custodial Care.)

A Nursing Home is NOT a facility for the treatment of alcoholism, drug addiction or chemical dependency.

Nursing Home Care: Skilled Nursing Care, Intermediate Nursing Care or Custodial Care provided in a Nursing Home.

(a) **Skilled Nursing Care or Intermediate Nursing Care** must be prescribed in your Plan of Care. This care uses professional nursing methods and procedures that are administered by licensed or certified health care personnel. It includes posthospital care, rehabilitation nursing care, maintenance therapy, administration of medication, injections and catheterization.

(b) **Custodial Care** means care that is given to residents of a Nursing Home who, not needing daily nursing care, cannot properly care for themselves due to age or a covered Condition. This care must be prescribed in your Plan of Care.

Physician or Doctor: A licensed practitioner of the healing arts acting within the scope of his/her license.

Plan of Care: A written document prescribing individualized treatment or services that your Condition requires. The plan must be prepared by your Case Coordinator and approved by your Doctor. If case coordination is not used, the plan must be prepared by a Doctor or other licensed medical professional, and must be approved by your Doctor. The Plan of Care must be updated or recertified at least once every 90 days, and the updated or recertified plan must be approved by your Doctor.

Policy Date: The date on which this policy first became effective. That date is shown on the Schedule.

Qualified Long-Term Care Services: Any necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are required by a Chronically Ill Individual or are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Reasonable and Customary Charge: An amount measured by comparing it with charges normally made for similar services and supplies to individuals of similar medical Condition in the locality where the charge is made. All covered charges for which this policy provides benefits are based on the Reasonable and Customary Charges for covered services.

Schedule: Is attached to and is a part of this policy.

Sickness: An illness or disease that you have or acquire.

Substantial Assistance: Physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the Activities of Daily Living.

We, Us or Our: Mutual Protective Insurance Company.

You or Your: The Insured named in the Schedule.

PART F GENERAL BENEFIT INFORMATION

(1) **The Schedule Shows:**

(a) The Daily Benefit which is the basis for our payment of the services we cover. (That amount may be greater if the optional inflation shield rider is in force.)
(b) The Elimination Period that applies to the Benefit Period; and
(c) The dollar maximum for all covered care that we will pay during the lifetime of the policy. (That amount may be greater if the optional inflation shield rider is in force.)

If the Schedule shows your lifetime dollar maximum as Unlimited/Lifetime, there is no lifetime dollar maximum for this policy.

(2) **Receipt of Multiple Covered Services on the Same Day:** If you receive more than one type of covered service on the same day, we will pay the Reasonable and Customary Charge for each service, but in no event shall the total amount paid exceed the Daily Benefit. This is subject to the weekly benefit option under Part K, Care Coordination Benefit.

PART G ELIGIBILITY FOR THE PAYMENT OF BENEFITS

To be eligible for any type of benefit under this policy, your Doctor must show that you are chronically ill. A chronically ill person has been certified by a Licensed Health Care Practitioner as:

(1) Being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to loss of functional capacity;

(2) Having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (1); or

(3) Requiring substantial supervision to protect such individual from threats to health and safety due to severe Cognitive Impairment.

Independent Evaluation: We may, at our expense, have you examined or evaluated by independent medical experts. The studies they perform will be for the purpose of assessing and confirming that you are eligible for care as shown above, and the treatment or services prescribed in the Plan of Care meet all of the requirements of this policy.

PART H NURSING HOME CARE BENEFITS

Limitations or Conditions on Eligibility for Benefits: All of the following conditions apply to receipt of Nursing Home Care benefits.

(1) You must qualify under one of the eligibility requirements set out in Part G.

(2) You must receive Nursing Home Care in a Nursing Home, as defined.

(3) The care received must be prescribed in your Plan of Care.

(4) Your Plan of Care must be updated or recertified at least once every 90 days.

(5) You must receive covered care in excess of the number of days shown in the Schedule as the Elimination Period that applies to each Benefit Period.

Benefit: When you are eligible for and receive Nursing Home Care covered by this policy, we will pay a benefit. That benefit will be the Reasonable and Customary Charges made by the Nursing Home, not to exceed the amount of the Daily Benefit shown in the Schedule or in effect at the time you receive care. It will be paid for each day you receive care in a Nursing Home. This benefit is subject to your lifetime dollar maximum.

PART I HOME CARE BENEFITS

Limitations or Conditions on Eligibility for Benefits: All of the following conditions apply to receipt of home care benefits: (Home care benefits consist of Home Health Professional Services, Home Health Aide Services and Homemaker Services.)

(1) You must qualify under one of the eligibility requirements set out in Part G.

(2) You must receive Home Health Professional Services, Home Health Aide Services or Homemaker Services, as defined.

(3) The care received must be prescribed in your Plan of Care.

(4) Your Plan of Care must be updated or recertified at least once every 90 days.

(5) You must receive covered care in excess of the number of days shown in the Schedule as the Elimination Period that applies to each Benefit Period.

Benefit: When you are eligible for and receive Home Health Professional Services, Home Health Aide Services or Homemaker Services in your home, we will pay a benefit. That benefit will be the Reasonable and Customary Charges for each day of Home Health Professional Services, and 80% of the Reasonable and Customary Charges for each day of Home Health Aide Services or Homemaker Services, not to exceed the amount of the Daily Benefit shown in the Schedule or in effect at the time you receive care. Benefits are subject to your lifetime dollar maximum.

Additional Home Care Benefits: We will also pay a benefit for the following items, which can serve as cost-effective alternatives that allow you to remain in your own home. These benefits are not subject to the Elimination Period, and will not satisfy it. These benefits (except respite care) are not subject to the Daily Benefit, but will count toward your lifetime dollar maximum. These benefits are subject to all other conditions that apply to home care benefits.

(1) **Caregiver Training Benefit:** We will pay a lifetime benefit of up to 5 times the amount of your original Daily Benefit for the reasonable and customary cost of training a friend or family member to help you at home. We will not pay this benefit for anyone who will be paid to care for you.

(2) **Equipment Benefit:** We will pay a lifetime benefit of up to 50 times the amount of your original Daily Benefit for the purchase or rental of supportive equipment or in-home safety devices that allow you to stay in your home for at least 90 days. Such equipment or devices may include ramps, grab bars, a special bed, or an emergency medical alert system.

(3) **Respite Care Benefit:** We will pay the Reasonable and Customary Charge of temporary care in your home, an institution, or community-based program in order to give your primary in-home caregiver a rest. This benefit is subject to the amount of the Daily Benefit for all covered care shown in the Schedule or in effect at the time you receive care, and is further subject to a 21-day maximum per calendar year.

PART J COMMUNITY CARE BENEFITS

Limitations or Conditions on Eligibility for Benefits: All of the following conditions apply to the receipt of community care benefits: (Community care benefits consist of Adult Day Health Care and Hospice Care.)

(1) You must qualify under one of the eligibility requirements set out in Part G.

(2) You must receive Adult Day Health Care or Hospice Care, as defined. Adult Day Health Care must be received in an Adult Day Health Care Center. Hospice Care must be provided by a Hospice Facility or a Home Health Agency.

(3) The care received must be prescribed in your Plan of Care.

(4) Your Plan of Care must be updated or recertified at least once every 90 days.

(5) You must receive covered care in excess of the number of days shown in the Schedule as the Elimination Period that applies to each Benefit Period.

Benefit: When you are eligible for and receive Adult Day Health Care or Hospice Care, we will pay a benefit. That benefit will be the Reasonable and Customary Charges made for each day of Adult Day Health Care or Hospice Care, not to exceed 50% of the Daily Benefit shown in the Schedule or in effect at the time you receive care. Benefits are subject to your lifetime dollar maximum.

PART K CARE COORDINATION BENEFIT

Additional benefits are available under this policy when you agree to and receive coordination of care through a Case Coordinator. When you agree to coordination of care, we will pay for all expenses associated with the services of your Case Coordinator, as well as the following benefits:

(1) **Elimination Period Waiver:** You will receive benefits for the first day of care for any type of care covered under this policy. The policy Elimination Period will not apply.

(2) **Weekly Benefit:** Instead of a Daily Benefit, you will receive a Weekly Benefit. The Weekly Benefit will consist of a weekly (Monday through Sunday) maximum of up to 7 times your Daily Benefit for the Reasonable and Customary Charges for care received during the week. This benefit is subject to your lifetime dollar maximum. The added flexibility of this benefit is valuable because the amount and kind of care you need could exceed your Daily Benefit on any given day.

(3) **Enhanced Home Care Benefit:** Instead of 80%, we will pay 100% of Reasonable and Customary Charges, subject to the Weekly Benefit, for Home Health Aide Services and Homemaker Services provided under the direction of your Case Coordinator. Additionally, we will waive the requirement that Homemaker Services be provided through a Home Health Agency when your Case Coordinator determines that these services may be supplied in a more cost-effective manner by alternate providers. This benefit is subject to your lifetime dollar maximum.

(4) **Assisted Living Care Facility Benefit:** We will pay 80% of the Reasonable and Customary Charge for care in an Assisted Living Care Facility, subject to the Weekly Benefit, when your Case Coordinator recommends this alternative in your Plan of Care. We will not pay home care or community care benefits while you are receiving the Assisted Living Care Facility benefit. This benefit is subject to your lifetime dollar maximum.

PART L BED RESERVATION BENEFIT

Limitations or Conditions on Eligibility for Benefits: To be eligible to receive benefits under this provision, you must meet all of the conditions listed below.

(1) You must be hospitalized temporarily during the course of your covered stay in a Nursing Home or Assisted Living Care Facility.

(2) The Nursing Home or Assisted Living Care Facility must charge you to keep your room available during your hospital stay.

(3) Your hospitalization must be the result of a covered Condition.

(4) You must have satisfied any Elimination Period that applies to the Benefit Period. If you have not, your days in the hospital will apply to the Elimination Period.

Benefit: When you meet the eligibility requirements of this provision we will pay a benefit. It will be equal to the Reasonable and Customary Charge the Nursing Home or Assisted Living Care Facility makes to hold your room during the hospital stay, not to exceed the amount of the Daily Benefit for all covered care shown in the Schedule or in effect at the time you receive care. We will pay this benefit for up to 14 days per calendar year, subject to the Elimination Period and your lifetime maximum dollar amount for all covered care shown in the Schedule or in effect at the time you receive care. Unused benefit days cannot be carried over from one calendar year to the next.

PART M RESTORATION OF BENEFITS IN THE EVENT OF POLICY LAPSE DUE TO COGNITIVE IMPAIRMENT OR LOSS OF FUNCTIONAL CAPACITY

If coverage under this policy ends due to nonpayment of premium, you or any person acting on your behalf will have 5 months to request reinstatement of the policy on the grounds that you suffered from Cognitive Impairment or loss of functional capacity at the time of lapse. We will require the same evidence of Cognitive Impairment or loss of functional capacity that is required for eligibility for benefits under this policy. We also must receive the back premium from the date of default. If these conditions are met, we will reinstate the policy without evidence of insurability. The coverage will be at the same level that existed prior to the date of the lapse. This provision does not apply to a policy that terminated because you requested cancellation or because we paid the maximum dollar amount.

PART N DEFERRED INFLATION PROTECTION OPTION

When you applied for this policy, you were given the opportunity to defer adding an optional Inflation Shield Rider. If you elected that option we will give you the opportunity to add an inflation rider without evidence of insurability within 90 days prior to the third Anniversary Date of the policy, if you have not incurred a claim under the policy. The additional premium required for the inflation rider will be based on your age at the time this benefit is added. Increases will begin to take effect on the first Anniversary Date after the inflation rider is in force.

PART O WAIVER OF PREMIUM

After we have paid benefits for Nursing Home Care for 90 days in a row, we will waive the payment of premiums that come due thereafter during the continuance of consecutive days for which such benefits are paid. This waiver, which includes premiums for any attached rider, will continue until the first day of the month following the date we stop paying benefits for Nursing Home Care.

PART P RIGHT TO REDUCE COVERAGE

You have the right to reduce the benefits of this policy without providing evidence of insurability. Changes may include:

a) a longer Elimination Period;

b) a lower Daily Benefit; or

c) a shorter benefit day option, resulting in a reduced lifetime dollar maximum.

Benefits will not be reduced to a level below the minimum level approved by the Commissioner of Insurance on the date you request reduction.

PART Q HOW TO FILE A CLAIM

(1) **Notice of Claim:** You must give us written notice of a claim within 20 days after loss starts or as soon as you can. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to our Home Office in Omaha, Nebraska, or to one of our agents.

(2) **Claim Forms:** When we receive your notice, we will send you forms for filing proof of loss. If these forms are not sent to you in 15 days, you will have met the proof of loss rule below if, in 90 days after the loss began (or, in the event of a continuing loss, within 90 days after the first month of the loss for which we are liable), you gave us a written statement of what happened.

(3) **Proof of Loss:** You must give us written proof of your loss in 90 days or as soon as you can. In the event of a continuing loss that is eligible for periodic payments, you must give us written proof within 90 days after the end of the period of loss for which we are liable. But proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

PART R PAYMENT OF CLAIMS

(1) **Time of Payment of Claims:** Benefits for continuing care are paid monthly when loss lasts longer than one month. When we receive your proof of loss, benefits that accrued up to the date of the proofs will be paid at the end of each month. All other benefits are paid as soon as we receive your proof of loss. Benefits unpaid when our liability ends are paid when we receive your proof of loss.

(2) **Payment of Claims:** Benefits will be paid directly to you. Benefits unpaid at your death will be paid to your beneficiary or your estate.

If any benefit is payable to your estate, to a minor, or to any person not able to give a valid release, we may pay up to $1,000.00 to any relative by blood or connection by marriage of the Insured or beneficiary that we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

(3) **Claim Review and Appeal Procedure:** In the event of any claim denial with which you do not agree, you have the right to submit a written request to the Company at its Home Office asking for a review of the denial of benefits. That request may include documents from your Physician or care provider that support your basis for the requested review. Within 30 days after we receive that written request, we will notify you or your representative of the results of the review.

PART S POLICY PROVISIONS

(1) **Entire Contract; Changes:** This policy, with any attachments (and the copy of your application), is the entire contract of insurance. No agent may make contracts, determine insurability or change the application or policy in any way. Only an executive officer of ours can approve a change. That change must be shown in the policy.

(2) **Time Limit on Certain Defenses:** After two years from the Policy Date, no misstatements, except knowing and intentional misstatements relating to the Insured's health, can be used to void the policy. If this policy is reinstated on the basis of a health application, the contestable period will be two years from the reinstatement date.

Pre-Existing Conditions: We will not reduce or deny a claim under this policy because a Sickness or Injury existed before the Policy Date.

(3) **Grace Period:** Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period.

(4) **Reinstatement:** Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement and, as may be needed, issue a conditional receipt, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), your policy will be put back in force on that 45th day.

Your reinstated policy will cover only loss due to Injury that begins after the date your policy was put in force. Also, it will cover only loss due to Sickness that begins after the date the policy was put back in force.

In all other respects, you and we will have the same rights under this policy that we had before it lapsed. The premium we accept to reinstate this policy may be used for a period for which premiums had not been paid. But it will not be used for any period more than 60 days before the reinstatement date.

(5) **Physical Examination:** We, at our expense, can have you examined as often as reasonably needed while a claim is pending.

(6) **Legal Action:** You can't bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You can't start such an action more than three years after the date written proof of loss is required.

(7) **Change of Beneficiary; Assignment:** Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.

(8) **Misstatement of Age:** If your age has been misstated, the amount payable will be that which the premium would have bought at the correct age.

(9) **Illegal Occupation:** We will not be liable for any loss to which a contributing cause was your commission of or attempt to commit a felony. Nor will we be liable for any loss to which a contributing cause was your being engaged in an illegal occupation.

(10) **Other Insurance With Us:** You may have only one policy like this one at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.

(11) **Extension of Benefits:** Termination of this policy will be without prejudice to any benefits payable for institutionalization if such institutionalization began while the policy was in force and continues without interruption after termination. "Institutionalization" means Nursing Home Care, as defined in the policy. This extension of benefits beyond the period the policy was in force will be limited to the duration of the Benefit Period, if any, or to the payment of the maximum dollar amount. It will be subject to the policy Elimination Period and all other applicable provisions of the policy.

(12) **Term of Coverage:** Your coverage starts on the Policy Date at 12:01 a.m. standard time where you live. It ends at 12:01 a.m. on the same standard time on the first renewal date. Each time you renew your policy, the new term begins when the old term ends.

(13) **Conformity With State Statutes:** The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

(14) **Annual Meeting:** Our annual meeting is held at 10:00 a.m. on the second Friday of May at our Home Office.

This policy is signed in our behalf by our Chief Executive Officer and Secretary.

Chairman of the Board
Chief Executive Officer

Secretary

Countersigned By_____
Licensed Resident Agent

0S34226 Gladys White 696 Issued 8-8-1999

Lapsed 2-7-2009

Claim 980004 Closed Benefit Qualifier Not Met

Claim 980001 Closed Benefit Qualifier Not Met

It appears that benefits were paid for DOS 9-21-02 to 5-31-07 for a total of 89872.38

8-12-09 Claim Form Received---Added not to doc in OnBase

8-31-09 Sent letter to pi advising them that contract lapsed – copy attached

9-8-09 2nd Claim Form Received along with Invoices

9-15-09 Called Daughter Cheryl explained that policy lapsed on 2-8-09

9-15-09 Inquiry Received from Cheryl

This was handled by Judy and it appears that she referred letter to Tie to discuss with Daughter

10-2-09 Medical Records

10-21-09 referred Medical Records to Don L/Erin to review and handle

10-13-09 Invoice

10-28-09 Another Primary Claim Form along with Invoices

Notes in caps indicated:

10-27-09 Daughter Cheryl called regarding reinstatement

11-10-09 ltr to daughter Cheryl Reinstatement denied

12-12-09 follow up ltr to same daughter regarding denial of reinstatement.

Singer, Alan (OIC)

From: Don Lawler [dlawler@abilityre.net]
Sent: Thursday, December 30, 2010 7:51 AM
To: Singer, Alan (OIC)
Subject: RE: Gladys White
Attachments: White 0S34226.pdf

Dear Mr. Singer,
I have now had a chance to review the file and have the following responses to you questions.

In the 1/13/10 letter you sent attached to the below e-mail, I saw that it indicates that an entity known as "On line Resources" (?)apparently issued a check. What was the purpose of the check?

Answer: As stated in my letter it was apparently meant to pay the premium for Ms. White's policy because it had her name & policy number on it.

It appears there may have been a premium payment that had been tendered to the company. Will you please also answer these additional questions about that 1/13/10 letter:

(1) Was this check sent because your company received a premium payment on Ms. White's policy?
Answer: I believe this was an attempt at premium payment even after reinstatement had been denied.
(2) If so, will you please obtain from the company's bank a copy of whatever form of payment it received, along with any accompanying correspondence?
Answer: We do not know who Online Resources is nor do we have authority to request it banking records. There was no correspondence.
(3) Will you please provide a copy of the "Online Resources" check referenced in the letter? (An e-mailed PDF copy is fine.)
Answer: A copy is above. The original was sent to Ms. Silvernail.
(4) Please explain the reason for this 1/13/10 letter?
Answer: To return the check to Ms. White's Power of Attorney.
(5) Would you happen to know who "Online Resources" is? Please explain why its check was issued to Ms. Silvernail, and what its relationship is with your company.
Answer: I do not know who Online Resources is and we have no relationship with same. The check was issued to Medico Insurance Company not Ms. Silvernail. I sent it to her because she is the Power of Attorney for Ms. White.

I also have questions about the 11/5/09 letter you sent to Ms. Silvernail, which was also attached to the below 12/7/10 e-mail below. Will you please answer these questions about that 11/5/09 letter:

(1) The 11/5/09 letter indicated that "we did not receive any contact from you until August." Please explain what "contact" was received, exactly when, the purpose or the contact, with whom at your company contact was had, in what form the contact occurred (i.e., written, fax, e-mail, etc.), and please provide copies of all documents sent to or received from Ms. Silvernail in regard to such contact.
Answer: Her August 6, 2009 letter and Claimant's Proof of Loss received via facsimile is above. It was date stamped received on August 7th in our Claims Department.
(2) The letter states that "[n]otice was given to Ms. White on three occasions at the address on file." Please provide copies of every such notice and each such copy sent on each of these three occasions, and specify the dates.
Answer: I already provided these in my November 22, 2010 e-mail to you. Please see above.

I am working on the other items you requested. If you have any follow-up questions, please let me know. Thanks!

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
Ability Insurance Company
FKA Medico Life Insurance Company
1515 South 75th Street
Omaha, NE. 68124
(402) 218-4069
(402) 515-4411 cell
(866) 240-2352 FAX
dlawler@abilityre.net

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Ability Insurance Company, 1515 South 75th St., Omaha, NE 68124.

From: Singer, Alan (OIC) [mailto:AlanS@OIC.WA.GOV]
Sent: Thursday, December 16, 2010 5:45 PM
To: Don Lawler
Subject: RE: Gladys White

Hi Don,

In looking over the materials you attached to the 12/7/10 e-mail below, I have a few questions.

In the 1/13/10 letter you sent attached to the below e-mail, I saw that it indicates that an entity known as "On line Resources" (?)apparently issued a check. What was the purpose of the check? It appears there may have been a premium payment that had been tendered to the company. Will you please also answer these additional questions about that 1/13/10 letter:

(6) Was this check sent because your company received a premium payment on Ms. White's policy?
(7) If so, will you please obtain from the company's bank a copy of whatever form of payment it received, along with any accompanying correspondence?
(8) Will you please provide a copy of the "Online Resources" check referenced in the letter? (An e-mailed PDF copy is fine.)
(9) Please explain the reason for this 1/13/10 letter?
(10) Would you happen to know who "Online Resources" is? Please explain why its check was issued to Ms. Silvernail, and what its relationship is with your company.

I also have questions about the 11/5/09 letter you sent to Ms. Silvernail, which was also attached to the below 12/7/10 e-mail below. Will you please answer these questions about that 11/5/09 letter:

(3) The 11/5/09 letter indicated that "we did not receive any contact from you until August." Please explain what "contact" was received, exactly when, the purpose or the contact, with whom at your company contact was had, in what form the contact occurred (i.e., written, fax, e-mail, etc.), and please provide copies of all documents sent to or received from Ms. Silvernail in regard to such contact.
(4) The letter states that "[n]otice was given to Ms. White on three occasions at the address on file." Please provide copies of every such notice and each such copy sent on each of these three occasions, and specify the dates.

Please don't hesitate to call me with any questions about this e-mail.

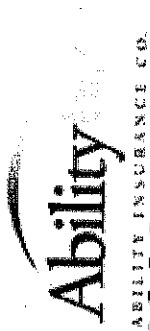
Thanks,

Alan

Alan Michael Singer
Staff Attorney
Legal Affairs
Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255
360-725-7046
360-586-0152 Fax

From: Don Lawler [mailto:dlawler@abilityre.net]
Sent: Tuesday, December 07, 2010 10:53 AM
To: Singer, Alan (OIC)
Subject: Gladys White

Dear Mr. Singer,
The subsequent correspondence you requested is above. If you have any other questions or need additional information, please let me know. Thanks!



Donald K. Lawler, J.D., M.B.A.
Senior Vice President
Ability Insurance Company
FKA Medico Life Insurance Company
1515 South 75th Street
Omaha, NE. 68124
(402) 218-4069
(402) 515-4411 cell
(866) 240-2352 FAX
dlawler@abilityre.net

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Ability Insurance Company, 1515 South 75th St., Omaha, NE 68124.

WARNING: THIS CHECK CONTAINS A SECURITY MARK. DO NOT ACCEPT WITHOUT HOLDING AT AN ANGLE TO VERIFY SECURITY MARK

Online Resources Corporation
4795 Meadow Wood Lane, Suite 300
Chantilly, VA 20151

431595956

Online RESOURCES

101603665

62-188
311

01/07/2010

checks@orcc.com
1-800-788-2550, option 1
fax: 703-653-2227

Acct # 0S34226
Re: Gladys E. White

Paid by: Gladys E White

Five Thousand Seven Hundred Ninety Six and NO/100 Dollars

$*****5,796.00

PAY to the order of

MEDICO INSURANCE COMPANY
Payment Processing
1535 S 75th St
Omaha, NE 68124-1618

Deutsche Bank Trust Company Delaware
Wilmington, Delaware
Void after 90 days

⑈101603665⑈ ⑆031100380⑆ 0059045 0⑈

PS - Inquiry Response - Pol# 0S34226, Clm# - DocID 1494105

08/12/2009 PSB3

August 6, 2009

TO: Claims Department (Fax # - 402-391-6489)

FROM: Cheryl Silvernail (daughter of Gladys White)

RE: New Claim

I spoke with Jerry in the claims department on Tuesday, August 4th. We went over some information regarding my mom's long term care insurance. He advised me to get the claim form on line. If you have any questions or need additional information, please call me at:

Home: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

FAX: 253-840-8819

Thank you.

RECEIVED
AUG 07 2009
CLAIMS DEPARTMENT

08/12/2009 pg001

AbilityIns
ABILITY INSURANCE CO.
Long Term Care Claims Department
P.O. Box 3735 • Omaha, NE 68103
Phone (877) 795-8493 Fax (866) 498-0689 Customersupport@abilityre.net

Claimant's Proof of Loss

Long-Term Care Insurance Claim Request Form

Claimant and Contact Information

Insured's Name:	Date of Birth:	Policy #:
Gladys E. White	7/8/1923	0534226

Home Address: 9223 60th Av. Ct. E Puyallup WA 98371

Daytime Phone #:	Social Security #:

In order for this request to be further processed, a member of our Claims department will need to speak with either the Insured or their representative about this claim. For best service and most timely processing, please provide all of the information requested in the spaces below.

Name of Person to Contact About this Claim:	Relationship to Insured:	Power of Attorney:
Cheryl Silvernail	daughter	☐ Yes ☒ No

Address: 13714 143RD Av. E. Orting WA 98360

Daytime Phone #:	Alternate Phone #:	Best Time to Call:
253-841-8726		

Claimant's Condition

Event (illness, injury, etc...) that led to a need for Long Term Care services:	Date Illness/Injury Started:
fainted - fell - broke her wrist	

Level of Assistance- Please check the box that best describes the assistance the Insured requires with each activity

	Independent	Standby Assist	Hands-On Assist	Date this Assistance Began
Bathing	☐	☐	☒	
Dressing	☐	☐	☒	
Eating	☒	☐	☐	
Toileting	☐	☐	☒	
Transferring	☐	☒	☐	
Continence	☐	☐	☒	
Other:				

RECEIVED
AUG 07 2009
CLAIMS DEPARTMENT

Does the Insured have a diagnosis of Alzheimer's Disease or other type of Dementia? ☒ Yes ☒ No symptoms

If Yes, please describe the Insured's Cognitive Status (memory, judgment, ability to manage medications, safety concerns, etc...):
Doesn't remember to take medications - she's a diabetic insulin high blood pressure

Medical Provider Information

Attending Physician's Name:	Office Phone #:	Office Fax #:
Dr. Rudnick	253-840-4400	253-840-6733

Physician's Address: 4002 9th St. NE Puyallup WA 98372

Has the Insured Been Hospitalized within the past 12 months? ☐ No ☒ Yes, Complete Section Below

Name of Hospital:	Address:	
Good Samaritan Hosp.	407 14th Av. S.E. Puyallup WA 98372	
Phone #:	**Admission Date:**	**Discharge Date:**
253-697-4000	7/25/09	7/28/09

08/12/2009 #8852

Long-Term Care Provider Information

What Type of Care Does the Insured Need?

☐ Nursing Home ☒ Assisted Living ☐ Home Health Care ☐ Hospice ☐ Other:

Does the Insured currently have Long Term Care Services in Place? ☒ No ☒ Yes, Complete Section Below

Name of Facility/Agency:	Phone #:	Type of Care:
Lynden Grove	253-840-4400	

Facility/Agency Address:
400 29th St. N.E. Puyallup WA

Date Care Began:	Date Care Ended:	Name of Contact Person at Facility/Agency:	Fax #:
7/28/09			

Please Note: If you are currently receiving services from more than 1 Long Term Care provider, please provide all of the information requested above for each provider in the white space at the bottom of this form.
If you obtain services from any non-qualified provider, they will not be covered under your policy.
If you obtain services that are not covered under the Policy, we will not be able to reimburse for these services.

Medicare and Other Insurance Information

Are you eligible for or currently enrolled in

Medicare Part A	☒ Yes	☐ No
Medicare Part B	☐ Yes	☐ No
Medicaid	☐ Yes	☐ No

Have any of your Long-Term Care expenses been paid for by Medicare? ☐ No ☐ Yes, Complete Section Below

Start Date:	End Date:	Agency/Facility:
7/28/09		Linden Grove

Do you have any other Long-Term Care Insurance Policies? ☒ No ☐ Yes, Complete Section Below

Insurance Company Name:	Address:	Policy #:	Daily Benefit Amt.:
			$

Signature

My signature below indicates that I understand that the claims processing procedure includes the collection of personal medical information. I also understand that an on-site assessment may also be required. This assessment will be completed at no cost to me by a licensed health care practitioner of Ability Insurance Company's choice.

Signature of the Insured or POA:	Date Signed:

Please return this form and any additional documents to the address at the top of the first page.

Please Remember to Include the Following with this Form:

- ☐ A Copy of the Power of Attorney Document (if applicable)
- ☐ The signed Authorization to Use and Disclose Personal Information form (see page 3 of this form)
- ☐ Copies of invoices for any long term care costs you have incurred thus far
- ☐ A statement of the hourly and/or daily charge for the service you are receiving
- ☐ A copy of the license of the provider you are using and their tax ID number

RECEIVED
AUG. 07 2009
CLAIMS DEPARTMENT

WARNING – Fraud Notice: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as further defined by your state statute.

Don Lawler

From: Don Lawler
Sent: Monday, November 22, 2010 2:38 PM
To: 'Singer, Alan (OIC)'
Subject: FW: Insured Gladys White, consumer complaint of Jack White
Attachments: 0S34226 - Gladys White.pdf

Dear Mr. Singer,

Attached are all four notices:

- Premium Notice #15 - Mailed 1/9/2009
- Past Due Notice #176 - Mailed 2/19/2009
- Advisor Letter (Third Party Notice) #U2462 - Mailed 3/20/2009
- Past Due Notice #480 - Mailed 3/20/2009

If you need anything else, please let me know. Thanks!

Ability

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
Ability Insurance Company
FKA Medico Life Insurance Company
1515 South 75th Street
Omaha, NE. 68124
(402) 218-4069
(402) 515-4411 cell
(866) 240-2352 FAX
dlawler@abilityre.net

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Ability Insurance Company, 1515 South 75th St., Omaha, NE 68124.

From: Singer, Alan (OIC) [mailto:AlanS@OIC.WA.GOV]
Sent: Monday, November 22, 2010 12:34 PM
To: Don Lawler
Subject: RE: Insured Gladys White, consumer complaint of Jack White
Importance: High

Hi Don,

In addition to sending the "notice of lapse or termination for nonpayment of premium" that was mailed as required by WAC 284-54-253(1), which I requested below, I would also like to ask you to provide some other documents that are referred to in the attached letter you wrote to Bianca Stoner of this agency on September 8, 2010.

Medico® Insurance Company

1515 South 75th Street
Omaha, NE 68124
1-800-228-6080
gomedico.com

PREMIUM NOTICE

☐ To change billing address or phone no., check here and see reverse side.

Your telephone number as listed in our records: (253) 845-1228

THIS NOTICE IS FOR ONE POLICY ONLY. OTHER POLICIES YOU MAY HAVE WILL BE BILLED SEPARATELY.

Make check or money order payable to: MEDICO® INSURANCE COMPANY

GLADYS E WHITE
9223 60 AVE CT E
PUYALLUP WA 98371-6155

Policy No. 0S34226

PREMIUM DUE 02/08/2009

PAY THIS AMOUNT

6 MOS	$3,013.92
OR YOU MAY PAY:	
12 MOS	$5,796.00
3 MOS	$1,564.92
2 MOS	$1,053.80

Please return upper portion with payment. Keep lower portion for your records.

15

IMPORTANT

Dear Gladys E White,

As you know, insurance policies become more valuable as they grow older. Health policies have "waiting periods" that disappear after a period of time. Life policies often have cash values that increase with age. You risk losing these advantages — as well as potential benefits — if you allow your policy to lapse.

It's also important to realize that replacing a policy may be costly. As health costs rise, so do insurance premiums. And as you grow older, the premium for coverage may rise based on your age.

If you need information or answers, please call our **TOLL-FREE number, 1-800-228-6080**. Our Customer Service staff is here to help from 7:30 a.m. to 4:45 p.m., Monday through Thursday; and 7:30 a.m. to 11:30 a.m. on Friday, Central Time.

At Medico Insurance Company, prompt and courteous service is more than just a concept — ***it's a practice that comes first!***

Sincerely,

Timothy J. Hall
President

Date Paid _____ Check or M.O. No. _____ Amount _____ Policy # 0S34226
Long-Term Care

Medico® Insurance Company • 1515 So. 75th Street • Omaha, Nebraska 68124 • Website: gomedico.com

At Medico® Insurance Company
we are proud of our commitment to protect your future today.

Medico® Insurance Company

1515 South 75th Street
Omaha, NE 68124
1-800-228-6080
gomedico.com

FINAL PREMIUM NOTICE

☐ To change billing address or phone no., check here and see reverse side.

Your telephone number as listed in our records: (253) 845-1228

THIS NOTICE IS FOR ONE POLICY ONLY. OTHER POLICIES YOU MAY HAVE WILL BE BILLED SEPARATELY.

Make check or money order payable to: MEDICO® INSURANCE COMPANY

GLADYS E WHITE
9223 60 AVE CT E
PUYALLUP WA 98371-6155

Policy No. 0S34226

PREMIUM DUE 02/08/2009

PAY THIS AMOUNT	
6 MOS	$3,013.92
OR YOU MAY PAY:	
12 MOS	$5,796.00
3 MOS	$1,564.92
2 MOS	$1,053.80

Please return upper portion with payment. Keep lower portion for your records.

176

Dear Gladys E White,

At this time we have not received your renewal premium and your policy is in its GRACE PERIOD. Your coverage will lapse if you don't act soon.

You recognized the need for this type of insurance when you applied for your policy.

We want to make it as convenient as possible to continue your coverage. You made a wise decision when you applied and it would be a shame to let it lapse when there are alternative ways of paying. Your premium notice shows the various modes and amounts you may pay —please take a moment to review it. I should mention that we also offer "Automatic Bank Withdrawal," a bank plan for paying premiums. You simply authorize your bank to honor our check each month (or every three months, if you prefer) for the premium. The Automatic Bank Withdrawal method saves time and postage. Of course you can discontinue the bank plan at any time.

If you have any questions or need any help, or if you want to change to our Automatic Bank Withdrawal Plan — please call our **TOLL-FREE number** 1-800-228-6080 between 7:30 a.m. and 4:45 p.m., Monday through Thursday; and 7:30 a.m. and 11:30 a.m. on Friday, Central Time. Our Customer Service Representatives are ready to help you.

Sincerely,

Timothy J. Hall
President

Date Paid _____ Check or M.O. No. _____ Amount _____ Policy # 0S34226
Long-Term Care

Medico® Insurance Company • 1515 So. 75th Street • Omaha, Nebraska 68124 • Website: gomedico.com

At Medico® Insurance Company
we are proud of our commitment to protect your future today.

MEDICO® GROUP
Medico® Insurance Company

March 20, 2009

CHERYL SILVERNAIL
34402 THOMAS RD E
EATONVILLE WA 98328

RE: Gladys E White
Policy No.: 0S34226
Due: 02/08/2009

Dear Cheryl Silvernail,

You have been named as the Advisor to receive notification of this past due premium for Gladys E White.

All of our long-term care/home health care policyholders are given the opportunity to name an Advisor. The Advisor receives a notice from us any time the policyholder's premium is 30 days past due. Our policyholder trusts you to contact him/her to discuss the importance of paying the policy premium.

If the premium is not received within 35 days from the date of this letter, the policy will lapse for nonpayment of premium.

Thank you,

Timothy J. Hall
President

U2462

02162009

Medico® Insurance Company

1515 South 75th Street
Omaha, NE 68124
1-800-228-6080
gomedico.com

PAST DUE PREMIUM NOTICE

☐ To change billing address or phone no., check here and see reverse side.
Your telephone number as listed in our records: (253) 845-1228

THIS NOTICE IS FOR ONE POLICY ONLY. OTHER POLICIES YOU MAY HAVE WILL BE BILLED SEPARATELY.

Make check or money order payable to: **MEDICO® INSURANCE COMPANY**

GLADYS E WHITE
9223 60 AVE CT E
PUYALLUP WA 98371-6155

Policy No. 0S34226

PREMIUM DUE 02/08/2009

PAY THIS AMOUNT

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OR YOU MAY PAY:	
12 MOS	$5,796.00
3 MOS	$1,564.92
2 MOS	$1,053.80

Please return upper portion with payment. Keep lower portion for your records.

480

YOUR POLICY PREMIUM IS PAST DUE!

Dear Gladys E White,

Health care costs are rising along with everyday living costs. I'm sure you agree that should the unexpected happen, you'd want the added financial protection your policy may provide.

We are sending this letter to remind you that your insurance premium is past due. Experience shows that most policies expire inadvertently or the policyholder later decides to regain the policy at a higher cost.

We must receive your premium within the next 30 days or your policy will lapse.

Please mail your premium payment today in the enclosed postage-paid envelope.

You may be able to change your plan benefits and reduce your premium cost but continue your long-term care coverage. Please contact your agent or our Customer Service Department for details.

If you have any questions please call **TOLL-FREE 1-800-228-6080** between 7:30 a.m. and 4:45 p.m., Monday through Thursday; and 7:30 a.m. and 11:30 a.m. on Friday, Central Time.

Policyholder Service Department
Medico Insurance Company

Date Paid _____ Check or M.O. No. _____ Amount _____ Policy # 0S34226
Long-Term Care

At Medico® Insurance Company
we are proud of our commitment to protect your future today.

Singer, Alan (OIC)

From: Don Lawler [dlawler@abilityre.net]
Sent: Thursday, December 30, 2010 8:34 AM
To: Singer, Alan (OIC)
Cc: Sureau, Carol (OIC)
Subject: RE: Gladys White matter -- additional requests
Attachments: White 2.pdf

Dear Mr. Singer,
I have now had a chance to review the file and have the following responses to you questions.

(1) The timeline indicated "copy attached" in reference to an 8/31/09 "letter to pi [sic]," but no such thing was attached to the timeline. Will you please provide a PDF copy of this 8/31/09 "letter to pi" via e-mail?
Answer: Please see above.

(2) The timeline also refers to a "claim form" that was "received," apparently on 8/12/09. Will you please provide a PDF copy of this claim form via e-mail?
Answer: Please see above.

(3) The timeline also refers to a "9-8-09 2nd Claim Form Received along with Invoices." Will you please provide PDF copies via e-mail of this "claim form" and these "invoices" so referenced?
Answer: Please see above.

(4) The timeline also has an entry "11-10-09 ltr to daughter Cheryl Reinstatement denied." Will you please provide a PDF copy of this via e-mail?
Answer: Please see above. The entry is November 11th. The letter is dated November 5th.

(5) The timeline also has the entry "follow up ltr to same daughter regarding denial of reinstatement." Will you please provide a PDF copy of this via e-mail?
Answer: Please see above.

(6) The timeline references "10-13-09 Invoice" and "10-28-09 Another Primary Claim Form along with invoices." Will you please provide PDF copies via e-mail of (a) all such claim forms under the Gladys White policy from 2008 and 2009, and (b) all such invoices under the Gladys White policy from 2008 and 2009?
Answer: Please see above.

(7) Who prepared the timeline?
Answer: Jack Wood the Director of Claims

(8) The timeline mentions "Judy." What is her full name and contact information so I can interview her about this matter?
Answer: Judy Rumsey is a Senior Claim Examiner in this office. You can schedule an interview through me.

(9) The timeline also says "9-15-09 Called Daughter Cheryl explained that policy lapsed on 2-8-09." Who exactly called daughter Cheryl as indicated and what is his or her full name and contact information so I can interview him/her about this matter?
Answer: Sharon Klusaw is a Senior Claim Examiner in this office. You can schedule an interview through me.

If you have any follow-up questions, please let me know. Thanks!

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
Ability Insurance Company
FKA Medico Life Insurance Company
1515 South 75th Street
Omaha, NE. 68124
(402) 218-4069
(402) 515-4411 cell
(866) 240-2352 FAX
dlawler@abilityre.net

This message contains confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this e-mail. Please notify the sender immediately by e-mail if you have received this e-mail by mistake and delete this e-mail from your system. E-mail transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. The sender therefore does not accept liability for any errors or omissions in the contents of this message which arise as a result of e-mail transmission. If verification is required, please request a hard copy version.

Ability Insurance Company, 1515 South 75th St., Omaha, NE 68124.

From: Singer, Alan (OIC) [mailto:AlanS@OIC.WA.GOV]
Sent: Monday, December 20, 2010 3:10 PM
To: Don Lawler
Cc: Sureau, Carol (OIC)
Subject: Gladys White matter -- additional requests

Hi Don,

I do apologize for having had so many questions and requests so far, but I do have some more. My current requests are based on the timeline you supplied with your attached 8/23/10 letter to this agency. Please provide the following information and documents pursuant to WAC 284-54-800(15):

(10)The timeline indicated "copy attached" in reference to an 8/31/09 "letter to pi [sic]," but no such thing was attached to the timeline. Will you please provide a PDF copy of this 8/31/09 "letter to pi" via e-mail?
(11)The timeline also refers to a "claim form" that was "received," apparently on 8/12/09. Will you please provide a PDF copy of this claim form via e-mail?
(12)The timeline also refers to a "9-8-09 2nd Claim Form Received along with Invoices." Will you please provide PDF copies via e-mail of this "claim form" and these "invoices" so referenced?
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(15)The timeline references "10-13-09 Invoice" and "10-28-09 Another Primary Claim Form along with invoices." Will you please provide PDF copies via e-mail of (a) all such claim forms under the Gladys White policy from 2008 and 2009, and (b) all such invoices under the Gladys White policy from 2008 and 2009?
(16)Who prepared the timeline?
(17)The timeline mentions "Judy." What is her full name and contact information so I can interview her about this matter?
(18)The timeline also says "9-15-09 Called Daughter Cheryl explained that policy lapsed on 2-8-09." Who exactly called daughter Cheryl as indicated and what is his or her full name and contact information so I can interview him/her about this matter?

Thanks, and let me know please if you have any questions.

Alan

Alan Michael Singer
Staff Attorney
Legal Affairs
Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255
360-725-7046
360-586-0152 Fax

AbilityIns
ABILITY INSURANCE CO.
Administered on behalf of Medico Insurance Company
Long Term Care Claims Department
PO Box 3735 • Omaha, NE 68103
Phone (877) 795-8493 • Fax (866) 498-0689 • www.gomedico.com

August 31, 2009

GLADYS WHITE
9223 60TH AVE CT E.
PUYALLUP WA 98371

Policy No. 0S34226

This will acknowledge your recent correspondence. According to our records, your contract lapsed effective 2-7-2009; therefore, you have no benefits available.

Please contact us if you have any additional questions concerning this matter.

Sincerely,

Claim Service Department

08/12/2009 PS003

August 6, 2009

TO: Claims Department (Fax # - 402-391-6489)

FROM: Cheryl Silvernail (daughter of Gladys White)

RE: New Claim

I spoke with Jerry in the claims department on Tuesday, August 4th. We went over some information regarding my mom's long term care insurance. He advised me to get the claim form on line. If you have any questions or need additional information, please call me at:

Home: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

FAX: 253-840-8819

Thank you.

RECEIVED
AUG 07 2009
CLAIMS DEPARTMENT

08/12/2009 pg581

AbilityLife
ABILITY INSURANCE CO.
Long Term Care Claims Department
P.O. Box 3735 • Omaha, NE 68103
Phone (877) 795-8493 Fax (866) 498-0689 Customersupport@abilityre.net

Claimant's Proof of Loss

Long-Term Care Insurance Claim Request Form

Claimant and Contact Information

Insured's Name:	Date of Birth:	Policy #:
Gladys E. White	7/8/1923	0534226

Home Address: 9223 60th Av. Ct. E Puyallup WA 98371

Daytime Phone #:	Social Security #:

In order for this request to be further processed, a member of our Claims department will need to speak with either the insured or their representative about this claim. For best service and most timely processing, please provide all of the information requested in the spaces below.

Name of Person to Contact About this Claim:	Relationship to Insured:	Power of Attorney:
Cheryl Silvernail	daughter	☐ Yes ☒ No

Address: 13714 143RD Av. E. Orting WA 98360

Daytime Phone #:	Alternate Phone #:	Best Time to Call:
253-841-8726		

Claimant's Condition

Event (illness, injury, etc...) that led to a need for Long Term Care services:	Date Illness/Injury Started:
fainted - fell - broke her wrist	

Level of Assistance- Please check the box that best describes the assistance the Insured requires with each activity

	Independent	Standby Assist	Hands-On Assist	Date this Assistance Began
Bathing	☐	☐	☒	
Dressing	☐	☐	☒	
Eating	☒	☐	☐	
Toileting	☐	☐	☒	
Transferring	☐	☒	☐	
Continence	☐	☐	☒	
Other:				

RECEIVED
AUG 07 2009
CLAIMS DEPARTMENT

Does the Insured have a diagnosis of Alzheimer's Disease or other type of Dementia? ☒ Yes ☐ No symptoms

If Yes, please describe the Insured's Cognitive Status (memory, judgment, ability to manage medications, safety concerns, etc...): Doesn't remember to take medications - She's a diabetic insulin high blood pressure

Medical Provider Information

Attending Physician's Name:	Office Phone #:	Office Fax #:
Dr. Rudnick	253-840-4400	253-840-6733

Physician's Address: 400 29th St. NE Puyallup WA 98372

Has the Insured Been Hospitalized within the past 12 months? ☐ No ☒ Yes, Complete Section Below

Name of Hospital:	Address:	
Good Samaritan Hosp.	407 14th Av. S.E. Puyallup WA 98372	
Phone #:	**Admission Date:**	**Discharge Date:**
253-697-4000	7/25/09	7/28/09

08/12/2009 pg002

Long-Term Care Provider Information

What Type of Care Does the Insured Need?

☐ Nursing Home ☒ Assisted Living ☐ Home Health Care ☐ Hospice ☐ Other:

Does the Insured currently have Long Term Care Services in Place? ☒ No ☒ Yes, Complete Section Below

Name of Facility/Agency:	Phone #:	Type of Care:
Lynden Grove	253-840-4400	

Facility/Agency Address:
400 29th St. N.E. Puyallup WA

Date Care Began:	Date Care Ended:	Name of Contact Person at Facility/Agency:	Fax #:
7/28/09			

Please Note: If you are currently receiving services from more than 1 Long Term Care provider, please provide all of the information requested above for each provider in the white space at the bottom of this form.

If you obtain services from any non-qualified provider, they will not be covered under your policy.

If you obtain services that are not covered under the Policy, we will not be able to reimburse for these services.

Medicare and Other Insurance Information

Are you eligible for or currently enrolled in

Medicare Part A	☒ Yes	☐ No
Medicare Part B	☐ Yes	☐ No
Medicaid	☐ Yes	☐ No

Have any of your Long-Term Care expenses been paid for by Medicare? ☐ No ☐ Yes, Complete Section Below

Start Date:	End Date:	Agency/Facility:
7/28/09		Linden Grove

Do you have any other Long-Term Care Insurance Policies? ☒ No ☐ Yes, Complete Section Below

Insurance Company Name:	Address:	Policy #:	Daily Benefit Amt.:
			$

Signature

My signature below indicates that I understand that the claims processing procedure includes the collection of personal medical information. I also understand that an on-site assessment may also be required. This assessment will be completed at no cost to me by a licensed health care practitioner of Ability Insurance Company's choice.

Signature of the Insured or POA:	Date Signed:

Please return this form and any additional documents to the address at the top of the first page.

Please Remember to Include the Following with this Form:

- ☐ A Copy of the Power of Attorney Document (If applicable)
- ☐ The signed Authorization to Use and Disclose Personal Information form (see page 3 of this form)
- ☐ Copies of invoices for any long term care costs you have incurred thus far
- ☐ A statement of the hourly and/or daily charge for the service you are receiving
- ☐ A copy of the license of the provider you are using and their tax ID number

RECEIVED
AUG. 07 2009
CLAIMS DEPARTMENT

WARNING – Fraud Notice: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as further defined by your state statute.

NOTE - 09/15/2009 -
Sharon Klusaw 3. 2009 9:57AM
SKLUSAW 9/15/2009
2:26:52 PM
called daughter
explained that
contract lapsed
2-8-2009. daughter
is checking she
didn't feel that
the policy was
lapsed.

TO CF

Ability Ins
ABILITY INSURANCE CO.
Long Term Care Claims Department
P.O. Box 3735 • Omaha, NE 68103
Phone: (877) 795-8493 Fax: (866) 498-0689 Email: Customersupport@abilityre.net

Claimant's Proof of Loss

Long-Term Care Insurance Claim Request Form

Claimant and Contact Information

Insured's Name:	Date of Birth:	Policy #:
Gladys E. White	7/8/1923	0534226

Home Address: 9223 60th Av Ct E

Daytime Phone #:	Social Security #:
253-845-1228	561-36-2379

In order for this request to be further processed, a member of our Claims department will need to speak with either the insured or their representative about this claim. For best service and most timely processing, please provide all of the information requested in the spaces below.

Name of Person to Contact About this Claim:	Relationship to Insured:	Power of Attorney:
Cheryl Silvernail	daughter	☐Yes ☒No

Address: 13714 143RD Av E. Orting, WA 98360

Daytime Phone #:	Alternate Phone #:	Best Time to Call:
253-841-8926	253-446-7190 253-232-2499	day time at work

Claimant's Condition

Event (illness, injury, etc...) that led to a need for Long Term Care services: BROKEN left wrist - after fall at home

Date Illness/Injury Started: 7/25/09

Level of Assistance- Please check the box that best describes the assistance the insured requires with each activity

	Independent	Standby Assist	Hands-On Assist	Date this Assistance Began
Bathing	☐	☐	☒	
Dressing	☐	☒	☐	
Eating	☒	☐	☐	
Toileting	☐	☒	☐	
Transferring	☒	☐	☐	
Continence	☐	☐	☒	

Other: Dementia, HELP WITH MEDICATIONS

Does the insured have a diagnosis of Alzheimer's Disease or other type of Dementia? ☒Yes ☐No

If Yes, please describe the insured's Cognitive Status (memory, judgment, ability to manage medications, safety concerns, etc...): ALL OF the ABOVE - She's fallen several times at home

Medical Provider Information

Attending Physician's Name:	Office Phone #:	Office Fax #:
DR. Rudnick DR Alex Mihali	253-840-4400 253-459-6510	253-840-6733

Physician's Address: 1901 S. Union Ave. Tacoma WA 98405 400 29th St. N.E. Puyallup WA 98372

Has the Insured Been Hospitalized within the past 12 months? ☐No ☒Yes, Complete Section Below

Name of Hospital:	Address:	
Good Samaritan	407 14th Av SE Puyallup	
Phone #:	**Admission Date:**	**Discharge Date:**
253-691-4000	7/25/09	7/28/09

Claimant's POL

Long-Term Care Provider Information

What Type of Care Does the Insured Need?

☐Nursing Home ☒Assisted Living ☐Home Health Care ☐Hospice ☐Other:

Does the Insured currently have Long Term Care Services In Place? ☐No ☒Yes, Complete Section Below

Name of Facility/Agency:	Phone #:	Type of Care:
Franklin House	891-3569	

Facility/Agency Address:			
5713 Parker Road	Sumner	WA	98390

Date Care Began:	Date Care Ended:	Name of Contact Person at Facility/Agency:	Fax #:
8/24/09		Cheryl Hanni	253-891-9433

Please Note: If you are currently receiving services from more than 1 Long Term Care provider, please provide all of the information requested above for each provider in the white space at the bottom of this form.
If you obtain services from any non-qualified provider, they will not be covered under your policy.
If you obtain services that are not covered under the Policy, we will not be able to reimburse for these services.

Medicare and Other Insurance Information

Are you eligible for or currently enrolled in

Medicare Part A	☐Yes	☐No
Medicare Part B	☐Yes	☐No
Medicaid	☐Yes	☒No

Have any of your Long-Term Care expenses been paid for by Medicare? ☐No ☒Yes, Complete Section Below

Start Date:	End Date:	Agency/Facility:
7/28/09	8/24/09	Linden Grove

Do you have any other Long-Term Care Insurance Policies? ☒No ☐Yes, Complete Section Below

Insurance Company Name:	Address:	Policy #:	Daily Benefit Amt.:
			$

Signature

My signature below indicates that I understand that the claims processing procedure includes the collection of personal medical information. I also understand that an on-site assessment may also be required. This assessment will be completed at no cost to me by a licensed health care practitioner of Ability Insurance Company's choice.

Signature of the Insured or POA:	Date Signed:
William White	9-6-2009

Please return this form and any additional documents to the address at the top of the first page.

Please Remember to Include the Following with this Form:

- ☐A Copy of the Power of Attorney Document (if applicable)
- ☐The signed Authorization to Use and Disclose Personal Information form (see page 3 of this form)
- ☐Copies of invoices for any long term care costs you have incurred thus far
- ☐A statement of the hourly and/or daily charge for the service you are receiving
- ☐A copy of the license of the provider you are using and their tax ID number

WARNING -- Fraud Notice: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as further defined by your state statute.

09/08/2009 pg003

September 8, 2009

TO: Claims Department (FAX # 402-391-6489)

FROM: Cheryl Silvernail (daughter of Gladys White)

RE: New claim

Attached is the claim and invoice for my mother, Gladys White. She is now at the Franklin House, an assisted living facility. They are helping her with her prescription medications, insulin, bathing and dressing, etc. If you have any questions or need additional information, please call me at:

Home: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

Address:
13714 143rd Ave. E.
Orting, WA 98360

Thank you,

Cheryl Silvernail

I have also included the front + back of the durable power of attorney.

November 5, 2009

CHERYL SILVERNAIL
13714 143RD AVE E
ORTING WA 98360

FILE COPY

RE: Insured: Gladys E. White
Policy No.: 0S34226

Dear Ms. Silvernail:

I am writing in response to your letter of September 11, 2009 and thank you for same.

Please be advised that the above contract lapsed for non-payment of premium on February 7, 2009. Notice was given to Ms. White on three occasions at the address on file. Additionally, a Third Party Advisor Notice was sent to you at the Eatonville, Washington address we had on file. This address was given to us on September 10, 2007 by Ms. White.

The policy has a Restoration of Benefits provision in Part M on page 9, but the provision is limited to a five-month period in which to request reinstatement. The five-month period expired in July and we did not receive any contact from you until August.

I am sorry I could not write more favorably. If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

DK

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

Encs.

December 4, 2009

CHERYL SILVERNAIL
13714 143RD AVE E
ORTING WA 98360

RE: Insured: Gladys E. White
Policy No.: 0S34226

Dear Ms. Silvernail:

I am writing in response to your letter of November 30, 2009 and thank you for same.

Your letter confirms that we were not advised of your change of address and that although you were aware that Ms. White could not properly handle her affairs you did not intervene. Again, the policy has a Restoration of Benefits provision in Part M on page 9, but the provision is limited to a five-month period in which to request reinstatement. The five-month period expired in July and we did not receive any contact from you until August.

I am sorry I could not write more favorably. If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

DL

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

December 4, 2009

CHERYL SILVERNAIL
13714 143RD AVE E
ORTING WA 98360

RE: Insured: Gladys E. White
Policy No.: 0S34226

Dear Ms. Silvernail:

I am writing in response to your letter of November 30, 2009 and thank you for same.

Your letter confirms that we were not advised of your change of address and that although you were aware that Ms. White could not properly handle her affairs you did not intervene. Again, the policy has a Restoration of Benefits provision in Part M on page 9, but the provision is limited to a five-month period in which to request reinstatement. The five-month period expired in July and we did not receive any contact from you until August.

I am sorry I could not write more favorably. If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

NOTE - 11/07/2009 - 6:48AM
Sharon Klusaw
SKLUSAW 11/07/2009
11:00:14 AM
contract lapsed on
2-7-09 refer to Don
L / Erin to handle

Abilityins
ABILITY INSURANCE CO.
Long Term Care Claims Department
P.O. Box 3735 • Omaha, NE 68103
Phone (877) 795-8493 Fax (866) 498-0689 Customersupport@abilityre.net

Claimant's Proof of Loss

Long-Term Care Insurance Claim Request Form

Claimant and Contact Information

Insured's Name: Gladys E. White
Date of Birth: 7/8/1923
Policy #:
Home Address: 9223 60th Av. Ct. E Puyallup WA 98371
Daytime Phone #:
Social Security #:

In order for this request to be further processed, a member of our Claims department will need to speak with either the Insured or their representative about this claim. For best service and most timely processing, please provide all of the information requested in the spaces below.

Name of Person to Contact About this Claim: Cheryl Silvernail
Relationship to Insured: daughter
Power of Attorney: ☐ Yes ☒ No
Address: 13714 143rd Av. E. Orting WA 98360
Daytime Phone #: 253-841-8726
Alternate Phone #:
Best Time to Call:

Claimant's Condition

Event (illness, injury, etc...) that led to a need for Long Term Care services: fainted - fell - broke her wrist
Date Illness/Injury Started:

Level of Assistance- Please check the box that best describes the assistance the insured requires with each activity

	Independent	Standby Assist	Hands-On Assist	Date this Assistance Began
Bathing	☐	☐	☒	
Dressing	☐	☐	☒	
Eating	☒	☐	☐	
Toileting	☐	☐	☒	
Transferring	☐	☒	☐	
Continence	☐	☐	☒	
Other:				

Does the Insured have a diagnosis of Alzheimer's Disease or other type of Dementia? ☒ Yes ☒ No symptoms
If Yes, please describe the Insured's Cognitive Status (memory, judgment, ability to manage medications, safety concerns, etc...): Doesn't remember to take medications - she's a diabetic - insulin - high blood pressure

Medical Provider Information

Attending Physician's Name: Dr. Rudnick
Office Phone #: 253-840-4400
Office Fax #: 253-840-6733
Physician's Address: 4002 29th St NE Puyallup WA 98372
Has the Insured Been Hospitalized within the past 12 months? ☐ No ☒ Yes, Complete Section Below
Name of Hospital: Good Samaritan Hosp.
Address: 407 14th Av. S.E. Puyallup WA 98372
Phone #: 253-697-4000
Admission Date: 7/25/09
Discharge Date: 7/28/09

ALSF-220 05222009

Long-Term Care Provider Information

What Type of Care Does the Insured Need?

☐ Nursing Home ☒ Assisted Living ☐ Home Health Care ☐ Hospice ☐ Other:

Does the Insured currently have Long Term Care Services in Place? ☐ No ☒ Yes, Complete Section Below

Name of Facility/Agency:	Phone #:	Type of Care:
Lynden Grove	253-840-4400	

Facility/Agency Address: 400 29th St. N.E. Puyallup WA

Date Care Began:	Date Care Ended:	Name of Contact Person at Facility/Agency:	Fax #:
7/28/09			

Please Note: If you are currently receiving services from more than 1 Long Term Care provider, please provide all of the information requested above for each provider in the white space at the bottom of this form.
If you obtain services from any non-qualified provider, they will not be covered under your policy.
If you obtain services that are not covered under the Policy, we will not be able to reimburse for these services.

Medicare and Other Insurance Information

Are you eligible for or currently enrolled in

Medicare Part A	☒ Yes	☐ No
Medicare Part B	☐ Yes	☐ No
Medicaid	☐ Yes	☐ No

Have any of your Long-Term Care expenses been paid for by Medicare? ☐ No ☐ Yes, Complete Section Below

Start Date:	End Date:	Agency/Facility:
7/28/09		Linden Grove

Do you have any other Long-Term Care Insurance Policies? ☒ No ☐ Yes, Complete Section Below

Insurance Company Name:	Address:	Policy #:	Daily Benefit Amt.:
			$

Signature

My signature below indicates that I understand that the claims processing procedure includes the collection of personal medical information. I also understand that an on-site assessment may also be required. This assessment will be completed at no cost to me by a licensed health care practitioner of Ability Insurance Company's choice.

Signature of the Insured or POA:	Date Signed:

Please return this form and any additional documents to the address at the top of the first page.

Please Remember to Include the Following with this Form:

- ☐ A Copy of the Power of Attorney Document (if applicable)
- ☐ The signed Authorization to Use and Disclose Personal Information form (see page 3 of this form)
- ☐ Copies of invoices for any long term care costs you have incurred thus far
- ☐ A statement of the hourly and/or daily charge for the service you are receiving
- ☐ A copy of the license of the provider you are using and their tax ID number

WARNING – Fraud Notice: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as further defined by your state statute.

September 8, 2009

TO: Claims Department (FAX # 402-391-6489)

FROM: Cheryl Silvernail (daughter of Gladys White)

RE: New claim

Attached is the claim and invoice for my mother, Gladys White. She is now at the Franklin House, an assisted living facility. They are helping her with her prescription medications, insulin, bathing and dressing, etc. If you have any questions or need additional information, please call me at:

Home: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

Address:
13714 143rd Ave. E.
Orting, WA 98360

Thank you,

Cheryl Silvernail

I have also included the front + back of the durable power of attorney.

Abilityins
ABILITY INSURANCE CO.
Long Term Care Claims Department
P.O. Box 3735 • Omaha, NE 68103
Phone: (877) 795-8493 Fax: (866) 498-0689 Email: Customersupport@abilityre.net

Claimant's Proof of Loss

Long-Term Care Insurance Claim Request Form

Claimant and Contact Information

Insured's Name: Gladys E. White
Date of Birth: 7/8/1923
Policy #: OS34226
Home Address: 9223 60th Av Ct. E
Daytime Phone #: 253-845-1228
Social Security #: 561-36-2379

In order for this request to be further processed, a member of our Claims department will need to speak with either the insured or their representative about this claim. For best service and most timely processing, please provide all of the information requested in the spaces below.

Name of Person to Contact About this Claim: Cheryl Silvernail
Relationship to Insured: daughter
Power of Attorney: ☐ Yes ☒ No
Address: 13719 143RD Av. E. Orting, WA 98360
Daytime Phone #: 253-841-8726
Alternate Phone #: ~~253-232-2499~~ 253-446-7190
Best Time to Call: day time at work

Claimant's Condition

Event (illness, injury, etc...) that led to a need for Long Term Care services: BROKEN left wrist - after fall at home
Date Illness/Injury Started: 7/25/09

Level of Assistance- Please check the box that best describes the assistance the insured requires with each activity

	Independent	Standby Assist	Hands-On Assist	Date this Assistance Began
Bathing	☐	☐	☒	
Dressing	☐	☒	☐	
Eating	☒	☐	☐	
Toileting	☐	☒	☐	
Transferring	☒	☐	☐	
Continence	☐	☐	☒	

Other: Dementia, HELP WITH MEDICATIONS

Does the Insured have a diagnosis of Alzheimer's Disease or other type of Dementia? ☒ Yes ☐ No

If Yes, please describe the Insured's Cognitive Status (memory, judgment, ability to manage medications, safety concerns, etc...): ALL OF the ABOVE - She's fallen several times at home

Medical Provider Information

253-840-1400 253-840-6138

Attending Physician's Name: DR. Rudnick DR Alex Mihali
Office Phone #: 253-459-6510
Office Fax #:
Physician's Address: 1901 S. Union Ave. Tacoma WA 98405 400 29th St. N.E. Puyallup WA 98372

Has the Insured Been Hospitalized within the past 12 months? ☐ No ☒ Yes, Complete Section Below

Name of Hospital: GOOD SAMARITAN
Address: 407 14th Av SE Puyallup
Phone #: 253-697-4000
Admission Date: 7/25/09
Discharge Date: 7/28/09

Claimant's POL

Long Term Care Provider Information

What Type of Care Does the Insured Need?

☐ Nursing Home ☒ Assisted Living ☐ Home Health Care ☐ Hospice ☐ Other:

Does the Insured currently have Long Term Care Services in Place? ☐ No ☒ Yes, Complete Section Below

Name of Facility/Agency:	Phone #:	Type of Care:
Franklin House	891-3569	

Facility/Agency Address: 5713 Parker Road Sumner WA 98390

Date Care Began:	Date Care Ended:	Name of Contact Person at Facility/Agency:	Fax #:
8/24/09		Cheryl Hanni	253-891-9433

Please Note: If you are currently receiving services from more than 1 Long Term Care provider, please provide all of the information requested above for each provider in the white space at the bottom of this form.
If you obtain services from any non-qualified provider, they will not be covered under your policy.
If you obtain services that are not covered under the Policy, we will not be able to reimburse for these services.

Medicare and Other Insurance Information

Are you eligible for or currently enrolled in

Medicare Part A	☐ Yes	☐ No
Medicare Part B	☐ Yes	☐ No
Medicaid	☐ Yes	☒ No

Have any of your Long-Term Care expenses been paid for by Medicare? ☐ No ☒ Yes, Complete Section Below

Start Date:	End Date:	Agency/Facility:
7/28/09	8/24/09	Linden Grove

Do you have any other Long-Term Care Insurance Policies? ☒ No ☐ Yes, Complete Section Below

Insurance Company Name:	Address:	Policy #:	Daily Benefit Amt.:
			$

Signature

My signature below indicates that I understand that the claims processing procedure includes the collection of personal medical information. I also understand that an on-site assessment may also be required. This assessment will be completed at no cost to me by a licensed health care practitioner of Ability Insurance Company's choice.

Signature of the Insured or POA:	Date Signed:
William White	9-6-2009

Please return this form and any additional documents to the address at the top of the first page.

Please Remember to Include the Following with this Form:

- ☐ A Copy of the Power of Attorney Document (if applicable)
- ☐ The signed Authorization to Use and Disclose Personal Information form (see page 3 of this form)
- ☐ Copies of invoices for any long term care costs you have incurred thus far
- ☐ A statement of the hourly and/or daily charge for the service you are receiving
- ☐ A copy of the license of the provider you are using and their tax ID number

WARNING -- Fraud Notice: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as further defined by your state statute.

10/27/2009

TO: Claims Department (Fax #866-498-0689)

FROM: Cheryl Silvernail (daughter of Gladys White

RE: Claim

Policy #OS34226

I am faxing all correspondence that I have faxed over since August, 2009 to the new fax #. Please respond as soon as possible as we have been waiting since August for information regarding this claim. Thank you.

HOME: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

FAX: 253-840-8819

FAX #: 402-391-6489

September 30, 2009

TO: Sharon, Claims Department

FROM: Cheryl Silvernail

RE: Documentation of Cognitive Impairment

Policy #OS34226

September 30, 2009

To Whom It May Concern:

As per my phone conversation with Sharon in the Claims Department, I am attaching documentation of my mom's cognitive impairment as observed at Good Samaritan Hospital in Puyallup.

From my personal observation, I would also like to include the following:

1. My mother began hiding bills that she didn't understand or didn't want to deal with. Just two examples of this are:

- The Internal Revenue Service notice stating that she owed money. My sister finally found the notices so that we could take care of them.
- Her invoices for Lutheran Community Service (an invoice for her caregiver that was coming in each day for a few hours.) This bill was unpaid for several months, until they contacted me regarding the past due invoices.

2. My mother couldn't remember to take her medications on the days that her caregiver wasn't at her home. She's a diabetic and was not remembering to take her insulin. Because of this, her blood sugar was out of control. She was not taking her high blood pressure medication, which had also soared out of control.

I have also enclosed a letter from her caregiver, Alexandria Farmin, who works for Lutheran Community Services. She wrote about her cognitive impairment and other problems she was encountering in April of 2008.

I'm still a little unsure of why I wasn't contacted when the insurance premiums weren't being paid. My name and phone number have been on all correspondence that was submitted when she had her previous claim. I would think you would still have records of these.

My mother has paid for this insurance since August of 1999. It appears to me that one of the problems of aging, cognitive impairment (dementia), would prevent her from paying the premium notice that would keep her insurance in tact.

Please reconsider your denial of this claim due to non-payment of the premium. Let us know what we would have to pay to put this insurance policy back in force. Thank you.

Cheryl Silvernail
Daughter of Gladys White

August 6, 2009

TO: Claims Department (Fax # - 402-391-6489)

FROM: Cheryl Silvernail (daughter of Gladys White)

RE: New Claim

I spoke with Jerry in the claims department on Tuesday, August 4th. We went over some information regarding my mom's long term care insurance. He advised me to get the claim form on line. If you have any questions or need additional information, please call me at:

Home: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

FAX: 253-840-8819

Thank you.

10/27/2009

TO: Claims Department (Fax #866-498-0689)

FROM: Cheryl Silvernail (daughter of Gladys White

RE: Claim

Policy #OS34226

I am faxing all correspondence that I have faxed over since August, 2009 to the new fax #. Please respond as soon as possible as we have been waiting since August for information regarding this claim. Thank you.

HOME: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

FAX: 253-840-8819

10/27/2009

TO: Claims Department (Fax #866-498-0689)

FROM: Cheryl Silvernail (daughter of Gladys White

RE: Claim

Policy #OS34226

I am faxing all correspondence that I have faxed over since August, 2009 to the new fax #. Please respond as soon as possible as we have been waiting since August for information regarding this claim. Thank you.

HOME: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

FAX: 253-840-8819

FAX #: 402-391-6489

October 12, 2009

TO: Sharon, Claims Department

FROM: Cheryl Silvernail

RE: Invoice for October, 2009

Policy #OS34226

866- 498- 0689

Singer, Alan (OIC)

From: Singer, Alan (OIC)
Sent: Monday, December 20, 2010 1:10 PM
To: 'Don Lawler'
Cc: Sureau, Carol (OIC)
Subject: Gladys White matter -- additional requests
Attachments: 8-23-10 Ability Ins Co Don Lawler letter to OIC Bianca Stoner with attached specimen policy and timeline.pdf

Hi Don,

I do apologize for having had so many questions and requests so far, but I do have some more. My current requests are based on the timeline you supplied with your attached 8/23/10 letter to this agency. Please provide the following information and documents pursuant to WAC 284-54-800(15):

(1) The timeline indicated "copy attached" in reference to an 8/31/09 "letter to pi [sic]," but no such thing was attached to the timeline. Will you please provide a PDF copy of this 8/31/09 "letter to pi" via e-mail?
(2) The timeline also refers to a "claim form" that was "received," apparently on 8/12/09. Will you please provide a PDF copy of this claim form via e-mail?
(3) The timeline also refers to a "9-8-09 2nd Claim Form Received along with Invoices." Will you please provide PDF copies via e-mail of this "claim form" and these "invoices" so referenced?
(4) The timeline also has an entry "11-10-09 ltr to daughter Cheryl Reinstatement denied." Will you please provide a PDF copy of this via e-mail?
(5) The timeline also has the entry "follow up ltr to same daughter regarding denial of reinstatement." Will you please provide a PDF copy of this via e-mail?
(6) The timeline references "10-13-09 Invoice" and "10-28-09 Another Primary Claim Form along with invoices." Will you please provide PDF copies via e-mail of (a) all such claim forms under the Gladys White policy from 2008 and 2009, and (b) all such invoices under the Gladys White policy from 2008 and 2009?
(7) Who prepared the timeline?
(8) The timeline mentions "Judy." What is her full name and contact information so I can interview her about this matter?
(9) The timeline also says "9-15-09 Called Daughter Cheryl explained that policy lapsed on 2-8-09." Who exactly called daughter Cheryl as indicated and what is his or her full name and contact information so I can interview him/her about this matter?

Thanks, and let me know please if you have any questions.

Alan

Alan Michael Singer
Staff Attorney
Legal Affairs
Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255
360-725-7046
360-586-0152 Fax

AbilityIns

ABILITY INSURANCE CO

August 23, 2010

RECEIVED

AUG 26 2010

INSURANCE DEPT. OLYMPIA
CONSUMER ADVOCACY DIVISION

BIANCA STONER
COMPLIANCE ANALYST L&D
WA OFFICE OF INSURANCE COMMISSIONER
PO BOX 40256
OLYMPIA WA 98504-0256

RE: Your File No.: 1041891
Consumer: Jack R. White
Insured: Gladys White
Policy No.: 0S34226
Policy Type: Individual – Long-Term Care, Form MP-LT696(WA)
NAIC No.: 71471

Dear Ms. Stoner:

Your letter of August 12, 2010 has been forwarded to me for review and response.

Enclosed please find a Specimen copy of the above numbered policy with relevant provisions highlighted for your convenience. As Mr. White's letter indicates, the above numbered policy lapsed for non-payment of premium on February 7, 2009. Also, enclosed please find a Timeline documenting contact with Ms. White's daughter and Power of Attorney, Cheryl Silvernail, and my subsequent correspondence to Ms. Silvernail.

A Premium Notice and Past Notice was sent to Ms. White prior to the policy lapse. Additionally, we sent a Reinstatement Notice to Ms. White and a Third Party Advisor Notice to Ms. Silvernail. Because the policy is lapsed no benefits are payable for the confinement which began on July 25, 2010.

If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

Encs.

MUTUAL PROTECTIVE INSURANCE COMPANY

1515 SOUTH 75TH STREET • OMAHA, NEBRASKA 68124

A Mutual Company

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 is attached to the policy. If your answers are incorrect or untrue, the Company has 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 the address shown above.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company.

Insuring Clause: We agree to provide the benefits set out in this policy for any insured loss. This agreement is subject to all of the provisions of the policy. A "loss" is an expense you incur for care or services this policy covers and that you receive after the Policy Date and while the policy is in force.

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.** Also, read the copy of your application and the policy Schedule. If there is any error or omission, tell us. We will make any needed change.

The first premium you, the Insured, paid before the Policy Date (and the copy of your application, attached hereto), put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

PART A **PLEASE READ — 30-DAY RIGHT TO RETURN**

Please read your policy. If you are not satisfied, send it back to us, or to the agent who sold it to you, within 30 days after you receive it. We will return your money. That will mean your policy was never in force. We will pay a 10% penalty if the requested premium refund is not made within 30 days of our receipt of the returned policy.

PART B **GUARANTEED RENEWABLE FOR LIFE**
SUBJECT TO OUR LIMITED RIGHT TO CHANGE PREMIUMS

We guarantee to renew your policy for life, subject to the Lifetime Maximum Benefits provision, as long as the premium is paid within the allowable time; but, we do have the right to change your premium as stated below.

We can change your premium only if we do the same to all policies of this form and any similar form issued to persons of your class in your state. If a change is made, it will not be based on any physical impairment you might have or any claims you have incurred under this policy, and it will be consistent with the Rate Guarantee provision on page 2. If it is necessary to change the premium for your policy, we will send you notice at least 30 days before your premium is due.

NOTICE TO BUYER: This policy may not cover all of the 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.

A QUALIFIED LONG-TERM CARE POLICY FOR FEDERAL TAX PURPOSES

Rate Guarantee: The premium we charge for this policy is based on the benefit amounts shown in the policy Schedule and the disclosures made in your application. That premium rate is guaranteed for at least a three year period measured from the Policy Date. If subsequent rate increases are needed after that initial three year period, each new rate will be guaranteed for an additional two year period.

ALPHABETICAL GUIDE TO YOUR POLICY

	Part
Benefits	H, I, J, K, L & M
Deferred Inflation Protection	N
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Schedule	Last Page
Waiver Of Premium	O

PART C — EXCEPTIONS

We will NOT pay benefits for:

(1) loss that occurs while this policy is not in force;
(2) intentional, self-inflicted injury or attempted suicide;
(3) alcoholism or drug addiction, unless addiction resulted from narcotics prescribed by a Physician;
(4) care provided by a member of your immediate family;
(5) services for which you are not liable or for which no charge normally is made in the absence of insurance; and
(6) loss that occurs outside the United States.

Non-Duplication: This contract will not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance. But it will pay benefits for covered expenses you incur that exceed the amount paid or payable by such governmental plans or laws.

PART D — LIFETIME MAXIMUM BENEFITS

The maximum dollar amount for all covered care that we will pay during the lifetime of the policy is shown in the Schedule. That lifetime dollar maximum is determined by multiplying the Daily Benefit amount by the benefit day option, both of which are shown in the Schedule. The lifetime dollar maximum may be greater than the amount shown in the Schedule if the optional inflation shield rider is in force. Coverage under this policy automatically ends after we have paid out the lifetime dollar maximum.

If the Schedule shows your lifetime dollar maximum as Unlimited/Lifetime, there is no lifetime dollar maximum for this policy.

PART E

DEFINITIONS

When we use the following words in this policy or in any optional rider, this is what we mean:

Activities of Daily Living: (a) eating; (b) dressing; (c) toileting; (d) transferring; (e) continence and (f) bathing. You are considered to need assistance for each of these activities when:

Eating: You cannot, without the aid of another person, maintain an adequate food and fluid intake consistent with your dietary needs.

Dressing: You cannot, without the aid of another person, put on and take off all necessary items of clothing, including medically necessary braces and artificial limbs.

Toileting: You cannot, without the aid of another person, get to and from the toilet, get on and off the toilet and maintain a reasonable level of associated personal hygiene.

Transferring: You cannot, without the aid of another person, walk or get in or out of a chair, wheelchair, bed, or other stationary position.

Continence: You cannot, without the aid of another person, voluntarily control bowel and bladder functions or use an external catheter or other equipment.

Bathing: You cannot, without the aid of another person, wash yourself by sponge bath in either a tub or shower, including getting into or out of the tub or shower.

Adult Day Health Care: A program of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Adult Day Health Care Center: (a) a facility licensed or certified by the state in which it is located to provide Adult Day Health Care; or (b) if licensing/certification is not required, a part of a facility (or center operated by a facility) that is licensed or certified as a hospital or any type of nursing home by the state in which it is located; or (c) a facility that is approved for Medicaid.

Anniversary Date: The same day and month as the Policy Date in each later year.

Assisted Living Care Facility: A facility that is licensed or certified as an Assisted Living Care Facility in accordance with any applicable state or local laws, with the primary purpose of providing care and services to support needs resulting from Cognitive Impairment or loss of functional capacity. The facility must have a trained employee available at all times to provide that care, and the facility must have established procedures for overseeing the administration of medications. The specific section or unit of the facility where you receive assisted living care must meet all of the above stated requirements.

Benefit Period: A period of covered care for the same or related Conditions, that is not separated by at least 180 days during which you are free of such care.

Case Coordinator: A licensed health care professional, from an agency we will choose, whose training includes managing and arranging for the type of care and services covered under this policy. This person can be a Doctor, Nurse, social worker or other similarly trained and licensed professional. Your Case Coordinator will provide a comprehensive evaluation of your status and will be responsible for developing, implementing and coordinating your Plan of Care. This person will further be responsible for assisting in the selection of providers, making arrangements to initiate services, providing ongoing care monitoring, and revising the Plan of Care as circumstances dictate. The Case Coordinator will work in consultation with your Physician.

Chronically Ill Individual: Any individual who has been certified within the preceding twelve (12) month period by a Licensed Health Care Practitioner as: being unable to perform (without Substantial Assistance from another individual) at least two (2) Activities of Daily Living for a period of at least ninety (90) days due to a loss of functional capacity; having a similar level of disability; or requiring substantial supervision to protect such individual from threats to health and safety due to severe Cognitive Impairment.

Cognitive Impairment: Deterioration of or loss in your intellectual capacity due to organic brain disease or disorder, which requires supervision to protect yourself or others, as measured by clinical evidence and standardized tests that measure your impairment in the following areas:

(a) Your short or long-term memory;

(b) Your orientation as to person (such as who you are), place (such as where you are) and time (such as day, date and year);

(c) Your deductive or abstract reasoning.

Such loss in intellectual capacity can result from Alzheimer's Disease or related degenerative and dementing illnesses.

Condition: Sickness, disease or injury. These include Mental or Nervous Disorders that cause Cognitive Impairment.

Elimination Period: The number of days for which no benefit is payable. The Elimination Period, if any, starts on the date that benefits would otherwise begin and is in effect for the number of days shown in the Schedule. Only one Elimination Period will be applied to any one Benefit Period.

Home Health Agency: An entity that provides home care services and is: (a) certified for participation in the Medicare program; or (b) licensed or certified as a Home Health Agency where required by the state; or (c) is otherwise acceptable to us if licensing or certification is not required. The Home Health Agency must keep records of nursing reports and the Plan of Care. These records must be available to us upon authorized request.

Home Health Aide Services: Assistance with simple health care tasks, personal hygiene, Activities of Daily Living, managing medications, and other related services provided by a Home Health Agency.

Home Health Professional Services: One or more of the following services for your care and treatment that are provided by a Home Health Agency in a noninstitutional setting, under the direction of a Nurse and according to a written diagnosis and Plan of Care:

(a) nursing services;
(b) physical therapy;
(c) speech therapy;
(d) respiratory therapy;
(e) occupational therapy; and
(f) nutritional services provided by a licensed dietician.

Homemaker Services: Assistance provided by a Home Health Agency with managing and maintaining a household, when you can no longer manage those activities and an informal caregiver is not available. This may include preparing meals, doing laundry and incidental household tasks.

Hospice Care: Services (not drugs or other supplies) provided by a Hospice Facility or a Home Health Agency that are designed to provide you with palliative care or to alleviate discomfort during the last phases of life. To be eligible for Hospice Care you must be diagnosed by your Doctor as having no more than 6 months to live.

Hospice Facility: A facility that is primarily engaged in providing care for terminally ill patients whose life expectancy is six months or less. It must be licensed, certified or registered as may be required by the state.

Injury: Accidental bodily Injury that results in loss independent of Sickness and other causes.

Licensed Health Care Practitioner: Any Physician and any registered professional Nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

Maintenance or Personal Care Services: Any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a Chronically Ill Individual (including the protection from threats to health and safety due to severe Cognitive Impairment).

Mental or Nervous Disorder: A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder.

Nurse: A person duly licensed as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Nursing Home: A health care facility that is licensed as a Nursing Home by the state in which it is located and that provides, as its main function, Skilled Nursing Care, Intermediate Nursing Care or Custodial Care. The facility must: (a) provide this care on a continuing inpatient basis as prescribed by a Plan of Care; (b) supervise the care through a nursing staff; (c) maintain clinical records for all patients; (d) maintain control and records of medications given; and (e) have arrangements for the services of a Doctor to furnish medical care in case of an emergency. The specific section or unit of the facility where you receive Nursing Home Care must meet the above described licensing requirements and also must provide, as the main function of that section or unit, care that meets all of the other requirements above. (Items (c) and (d) need not apply when you receive only Custodial Care.)

A Nursing Home is NOT a facility for the treatment of alcoholism, drug addiction or chemical dependency.

Nursing Home Care: Skilled Nursing Care, Intermediate Nursing Care or Custodial Care provided in a Nursing Home.

(a) **Skilled Nursing Care or Intermediate Nursing Care** must be prescribed in your Plan of Care. This care uses professional nursing methods and procedures that are administered by licensed or certified health care personnel. It includes posthospital care, rehabilitation nursing care, maintenance therapy, administration of medication, injections and catheterization.

(b) **Custodial Care** means care that is given to residents of a Nursing Home who, not needing daily nursing care, cannot properly care for themselves due to age or a covered Condition. This care must be prescribed in your Plan of Care.

Physician or Doctor: A licensed practitioner of the healing arts acting within the scope of his/her license.

Plan of Care: A written document prescribing individualized treatment or services that your Condition requires. The plan must be prepared by your Case Coordinator and approved by your Doctor. If case coordination is not used, the plan must be prepared by a Doctor or other licensed medical professional, and must be approved by your Doctor. The Plan of Care must be updated or recertified at least once every 90 days, and the updated or recertified plan must be approved by your Doctor.

Policy Date: The date on which this policy first became effective. That date is shown on the Schedule.

Qualified Long-Term Care Services: Any necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are required by a Chronically Ill Individual or are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Reasonable and Customary Charge: An amount measured by comparing it with charges normally made for similar services and supplies to individuals of similar medical Condition in the locality where the charge is made. All covered charges for which this policy provides benefits are based on the Reasonable and Customary Charges for covered services.

Schedule: Is attached to and is a part of this policy.

Sickness: An illness or disease that you have or acquire.

Substantial Assistance: Physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the Activities of Daily Living.

We, Us or Our: Mutual Protective Insurance Company.

You or Your: The Insured named in the Schedule.

PART F

GENERAL BENEFIT INFORMATION

(1) **The Schedule Shows:**

(a) The Daily Benefit which is the basis for our payment of the services we cover. (That amount may be greater if the optional inflation shield rider is in force.)
(b) The Elimination Period that applies to the Benefit Period; and
(c) The dollar maximum for all covered care that we will pay during the lifetime of the policy. (That amount may be greater if the optional inflation shield rider is in force.)

If the Schedule shows your lifetime dollar maximum as Unlimited/Lifetime, there is no lifetime dollar maximum for this policy.

(2) **Receipt of Multiple Covered Services on the Same Day:** If you receive more than one type of covered service on the same day, we will pay the Reasonable and Customary Charge for each service, but in no event shall the total amount paid exceed the Daily Benefit. This is subject to the weekly benefit option under Part K, Care Coordination Benefit.

PART G

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

To be eligible for any type of benefit under this policy, your Doctor must show that you are chronically ill. A chronically ill person has been certified by a Licensed Health Care Practitioner as:

(1) Being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to loss of functional capacity;

(2) Having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (1); or

(3) Requiring substantial supervision to protect such individual from threats to health and safety due to severe Cognitive Impairment.

Independent Evaluation: We may, at our expense, have you examined or evaluated by independent medical experts. The studies they perform will be for the purpose of assessing and confirming that you are eligible for care as shown above, and the treatment or services prescribed in the Plan of Care meet all of the requirements of this policy.

PART H **NURSING HOME CARE BENEFITS**

Limitations or Conditions on Eligibility for Benefits: All of the following conditions apply to receipt of Nursing Home Care benefits.

(1) You must qualify under one of the eligibility requirements set out in Part G.

(2) You must receive Nursing Home Care in a Nursing Home, as defined.

(3) The care received must be prescribed in your Plan of Care.

(4) Your Plan of Care must be updated or recertified at least once every 90 days.

(5) You must receive covered care in excess of the number of days shown in the Schedule as the Elimination Period that applies to each Benefit Period.

Benefit: When you are eligible for and receive Nursing Home Care covered by this policy, we will pay a benefit. That benefit will be the Reasonable and Customary Charges made by the Nursing Home, not to exceed the amount of the Daily Benefit shown in the Schedule or in effect at the time you receive care. It will be paid for each day you receive care in a Nursing Home. This benefit is subject to your lifetime dollar maximum.

PART I **HOME CARE BENEFITS**

Limitations or Conditions on Eligibility for Benefits: All of the following conditions apply to receipt of home care benefits: (Home care benefits consist of Home Health Professional Services, Home Health Aide Services and Homemaker Services.)

(1) You must qualify under one of the eligibility requirements set out in Part G.

(2) You must receive Home Health Professional Services, Home Health Aide Services or Homemaker Services, as defined.

(3) The care received must be prescribed in your Plan of Care.

(4) Your Plan of Care must be updated or recertified at least once every 90 days.

(5) You must receive covered care in excess of the number of days shown in the Schedule as the Elimination Period that applies to each Benefit Period.

Benefit: When you are eligible for and receive Home Health Professional Services, Home Health Aide Services or Homemaker Services in your home, we will pay a benefit. That benefit will be the Reasonable and Customary Charges for each day of Home Health Professional Services, and 80% of the Reasonable and Customary Charges for each day of Home Health Aide Services or Homemaker Services, not to exceed the amount of the Daily Benefit shown in the Schedule or in effect at the time you receive care. Benefits are subject to your lifetime dollar maximum.

Additional Home Care Benefits: We will also pay a benefit for the following items, which can serve as cost-effective alternatives that allow you to remain in your own home. These benefits are not subject to the Elimination Period, and will not satisfy it. These benefits (except respite care) are not subject to the Daily Benefit, but will count toward your lifetime dollar maximum. These benefits are subject to all other conditions that apply to home care benefits.

(1) **Caregiver Training Benefit:** We will pay a lifetime benefit of up to 5 times the amount of your original Daily Benefit for the reasonable and customary cost of training a friend or family member to help you at home. We will not pay this benefit for anyone who will be paid to care for you.

(2) **Equipment Benefit:** We will pay a lifetime benefit of up to 50 times the amount of your original Daily Benefit for the purchase or rental of supportive equipment or in-home safety devices that allow you to stay in your home for at least 90 days. Such equipment or devices may include ramps, grab bars, a special bed, or an emergency medical alert system.

(3) **Respite Care Benefit:** We will pay the Reasonable and Customary Charge of temporary care in your home, an institution, or community-based program in order to give your primary in-home caregiver a rest. This benefit is subject to the amount of the Daily Benefit for all covered care shown in the Schedule or in effect at the time you receive care, and is further subject to a 21-day maximum per calendar year.

PART J

COMMUNITY CARE BENEFITS

Limitations or Conditions on Eligibility for Benefits: All of the following conditions apply to the receipt of community care benefits: (Community care benefits consist of Adult Day Health Care and Hospice Care.)

(1) You must qualify under one of the eligibility requirements set out in Part G.

(2) You must receive Adult Day Health Care or Hospice Care, as defined. Adult Day Health Care must be received in an Adult Day Health Care Center. Hospice Care must be provided by a Hospice Facility or a Home Health Agency.

(3) The care received must be prescribed in your Plan of Care.

(4) Your Plan of Care must be updated or recertified at least once every 90 days.

(5) You must receive covered care in excess of the number of days shown in the Schedule as the Elimination Period that applies to each Benefit Period.

Benefit: When you are eligible for and receive Adult Day Health Care or Hospice Care, we will pay a benefit. That benefit will be the Reasonable and Customary Charges made for each day of Adult Day Health Care or Hospice Care, not to exceed 50% of the Daily Benefit shown in the Schedule or in effect at the time you receive care. Benefits are subject to your lifetime dollar maximum.

PART K

CARE COORDINATION BENEFIT

Additional benefits are available under this policy when you agree to and receive coordination of care through a Case Coordinator. When you agree to coordination of care, we will pay for all expenses associated with the services of your Case Coordinator, as well as the following benefits:

(1) **Elimination Period Waiver:** You will receive benefits for the first day of care for any type of care covered under this policy. The policy Elimination Period will not apply.

(2) **Weekly Benefit:** Instead of a Daily Benefit, you will receive a Weekly Benefit. The Weekly Benefit will consist of a weekly (Monday through Sunday) maximum of up to 7 times your Daily Benefit for the Reasonable and Customary Charges for care received during the week. This benefit is subject to your lifetime dollar maximum. The added flexibility of this benefit is valuable because the amount and kind of care you need could exceed your Daily Benefit on any given day.

(3) **Enhanced Home Care Benefit:** Instead of 80%, we will pay 100% of Reasonable and Customary Charges, subject to the Weekly Benefit, for Home Health Aide Services and Homemaker Services provided under the direction of your Case Coordinator. Additionally, we will waive the requirement that Homemaker Services be provided through a Home Health Agency when your Case Coordinator determines that these services may be supplied in a more cost-effective manner by alternate providers. This benefit is subject to your lifetime dollar maximum.

(4) **Assisted Living Care Facility Benefit:** We will pay 80% of the Reasonable and Customary Charge for care in an Assisted Living Care Facility, subject to the Weekly Benefit, when your Case Coordinator recommends this alternative in your Plan of Care. We will not pay home care or community care benefits while you are receiving the Assisted Living Care Facility benefit. This benefit is subject to your lifetime dollar maximum.

PART L BED RESERVATION BENEFIT

Limitations or Conditions on Eligibility for Benefits: To be eligible to receive benefits under this provision, you must meet all of the conditions listed below.

(1) You must be hospitalized temporarily during the course of your covered stay in a Nursing Home or Assisted Living Care Facility.

(2) The Nursing Home or Assisted Living Care Facility must charge you to keep your room available during your hospital stay.

(3) Your hospitalization must be the result of a covered Condition.

(4) You must have satisfied any Elimination Period that applies to the Benefit Period. If you have not, your days in the hospital will apply to the Elimination Period.

Benefit: When you meet the eligibility requirements of this provision we will pay a benefit. It will be equal to the Reasonable and Customary Charge the Nursing Home or Assisted Living Care Facility makes to hold your room during the hospital stay, not to exceed the amount of the Daily Benefit for all covered care shown in the Schedule or in effect at the time you receive care. We will pay this benefit for up to 14 days per calendar year, subject to the Elimination Period and your lifetime maximum dollar amount for all covered care shown in the Schedule or in effect at the time you receive care. Unused benefit days cannot be carried over from one calendar year to the next.

PART M RESTORATION OF BENEFITS IN THE EVENT OF POLICY LAPSE DUE TO COGNITIVE IMPAIRMENT OR LOSS OF FUNCTIONAL CAPACITY

If coverage under this policy ends due to nonpayment of premium, you or any person acting on your behalf will have 5 months to request reinstatement of the policy on the grounds that you suffered from Cognitive Impairment or loss of functional capacity at the time of lapse. We will require the same evidence of Cognitive Impairment or loss of functional capacity that is required for eligibility for benefits under this policy. We also must receive the back premium from the date of default. If these conditions are met, we will reinstate the policy without evidence of insurability. The coverage will be at the same level that existed prior to the date of the lapse. This provision does not apply to a policy that terminated because you requested cancellation or because we paid the maximum dollar amount.

PART N

DEFERRED INFLATION PROTECTION OPTION

When you applied for this policy, you were given the opportunity to defer adding an optional Inflation Shield Rider. If you elected that option we will give you the opportunity to add an inflation rider without evidence of insurability within 90 days prior to the third Anniversary Date of the policy, if you have not incurred a claim under the policy. The additional premium required for the inflation rider will be based on your age at the time this benefit is added. Increases will begin to take effect on the first Anniversary Date after the inflation rider is in force.

PART O

WAIVER OF PREMIUM

After we have paid benefits for Nursing Home Care for 90 days in a row, we will waive the payment of premiums that come due thereafter during the continuance of consecutive days for which such benefits are paid. This waiver, which includes premiums for any attached rider, will continue until the first day of the month following the date we stop paying benefits for Nursing Home Care.

PART P

RIGHT TO REDUCE COVERAGE

You have the right to reduce the benefits of this policy without providing evidence of insurability. Changes may include:

a) a longer Elimination Period;

b) a lower Daily Benefit; or

c) a shorter benefit day option, resulting in a reduced lifetime dollar maximum.

Benefits will not be reduced to a level below the minimum level approved by the Commissioner of Insurance on the date you request reduction.

PART Q

HOW TO FILE A CLAIM

(1) **Notice of Claim:** You must give us written notice of a claim within 20 days after loss starts or as soon as you can. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to our Home Office in Omaha, Nebraska, or to one of our agents.

(2) **Claim Forms:** When we receive your notice, we will send you forms for filing proof of loss. If these forms are not sent to you in 15 days, you will have met the proof of loss rule below if, in 90 days after the loss began (or, in the event of a continuing loss, within 90 days after the first month of the loss for which we are liable), you gave us a written statement of what happened.

(3) **Proof of Loss:** You must give us written proof of your loss in 90 days or as soon as you can. In the event of a continuing loss that is eligible for periodic payments, you must give us written proof within 90 days after the end of the period of loss for which we are liable. But proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

PART R

PAYMENT OF CLAIMS

(1) **Time of Payment of Claims:** Benefits for continuing care are paid monthly when loss lasts longer than one month. When we receive your proof of loss, benefits that accrued up to the date of the proofs will be paid at the end of each month. All other benefits are paid as soon as we receive your proof of loss. Benefits unpaid when our liability ends are paid when we receive your proof of loss.

(2) **Payment of Claims:** Benefits will be paid directly to you. Benefits unpaid at your death will be paid to your beneficiary or your estate.

If any benefit is payable to your estate, to a minor, or to any person not able to give a valid release, we may pay up to $1,000.00 to any relative by blood or connection by marriage of the Insured or beneficiary that we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

(3) **Claim Review and Appeal Procedure:** In the event of any claim denial with which you do not agree, you have the right to submit a written request to the Company at its Home Office asking for a review of the denial of benefits. That request may include documents from your Physician or care provider that support your basis for the requested review. Within 30 days after we receive that written request, we will notify you or your representative of the results of the review.

PART S **POLICY PROVISIONS**

(1) **Entire Contract; Changes:** This policy, with any attachments (and the copy of your application), is the entire contract of insurance. No agent may make contracts, determine insurability or change the application or policy in any way. Only an executive officer of ours can approve a change. That change must be shown in the policy.

(2) **Time Limit on Certain Defenses:** After two years from the Policy Date, no misstatements, except knowing and intentional misstatements relating to the Insured's health, can be used to void the policy. If this policy is reinstated on the basis of a health application, the contestable period will be two years from the reinstatement date.

Pre-Existing Conditions: We will not reduce or deny a claim under this policy because a Sickness or Injury existed before the Policy Date.

(3) **Grace Period:** Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period.

(4) **Reinstatement:** Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement and, as may be needed, issue a conditional receipt, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), your policy will be put back in force on that 45th day.

Your reinstated policy will cover only loss due to Injury that begins after the date your policy was put in force. Also, it will cover only loss due to Sickness that begins after the date the policy was put back in force.

In all other respects, you and we will have the same rights under this policy that we had before it lapsed. The premium we accept to reinstate this policy may be used for a period for which premiums had not been paid. But it will not be used for any period more than 60 days before the reinstatement date.

(5) **Physical Examination:** We, at our expense, can have you examined as often as reasonably needed while a claim is pending.

(6) **Legal Action:** You can't bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You can't start such an action more than three years after the date written proof of loss is required.

(7) **Change of Beneficiary; Assignment:** Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.

(8) **Misstatement of Age:** If your age has been misstated, the amount payable will be that which the premium would have bought at the correct age.

(9) **Illegal Occupation:** We will not be liable for any loss to which a contributing cause was your commission of or attempt to commit a felony. Nor will we be liable for any loss to which a contributing cause was your being engaged in an illegal occupation.

(10) **Other Insurance With Us:** You may have only one policy like this one at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.

(11) **Extension of Benefits:** Termination of this policy will be without prejudice to any benefits payable for institutionalization if such institutionalization began while the policy was in force and continues without interruption after termination. "Institutionalization" means Nursing Home Care, as defined in the policy. This extension of benefits beyond the period the policy was in force will be limited to the duration of the Benefit Period, if any, or to the payment of the maximum dollar amount. It will be subject to the policy Elimination Period and all other applicable provisions of the policy.

(12) **Term of Coverage:** Your coverage starts on the Policy Date at 12:01 a.m. standard time where you live. It ends at 12:01 a.m. on the same standard time on the first renewal date. Each time you renew your policy, the new term begins when the old term ends.

(13) **Conformity With State Statutes:** The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

(14) **Annual Meeting:** Our annual meeting is held at 10:00 a.m. on the second Friday of May at our Home Office.

This policy is signed in our behalf by our Chief Executive Officer and Secretary.

G W Egermayer Jr

Chairman of the Board
Chief Executive Officer

Evert R Peacock

Secretary

Countersigned By_____

Licensed Resident Agent

0S34226 Gladys White 696 Issued 8-8-1999

Lapsed 2-7-2009

Claim 980004 Closed Benefit Qualifier Not Met

Claim 980001 Closed Benefit Qualifier Not Met

It appears that benefits were paid for DOS 9-21-02 to 5-31-07 for a total of 89872.38

8-12-09 Claim Form Received---Added not to doc in OnBase

8-31-09 Sent letter to pi advising them that contract lapsed – copy attached

9-8-09 2nd Claim Form Received along with Invoices

9-15-09 Called Daughter Cheryl explained that policy lapsed on 2-8-09

9-15-09 Inquiry Received from Cheryl

This was handled by Judy and it appears that she referred letter to Tie to discuss with Daughter

10-2-09 Medical Records

10-21-09 referred Medical Records to Don L/Erin to review and handle

10-13-09 Invoice

10-28-09 Another Primary Claim Form along with invoices

Notes in caps indicated:

10-27-09 Daughter Cheryl called regarding reinstatement

11-10-09 ltr to daughter Cheryl Reinstatement denied

12-12-09 follow up ltr to same daughter regarding denial of reinstatement.

Singer, Alan (OIC)

From: Don Lawler [dlawler@abilityre.net]
Sent: Thursday, March 10, 2011 7:16 AM
To: Singer, Alan (OIC)
Cc: Sureau, Carol (OIC); Terri Tripp
Subject: RE: Your file no.:1041891
Attachments: White 2.pdf

Dear Mr. Singer,

1. A copy of our August 31, 2009 letter to the policyholder was sent with my December 30, 2010 e-mail response. Another copy is above. Please see pages 1, 2 & 3.
2. The letter was produced by the Claim Service Department with no specific person indicated.
3. The letter was directed to the insured because the daughter indicated on the Claimant's Proof of Loss that she did NOT have a Power of Attorney (POA). Please see page 3 above. We would not contact anyone other than the insured if we did not have a POA on file except for providing the Third Party Notice as directed by the insured.

If you have any other questions, please let me know. Thanks!

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
Ability Insurance Company
FKA Medico Life Insurance Company
1515 South 75th Street
Omaha, NE. 68124
(402) 218-4069
(402) 515-4411 cell
(866) 240-2352 FAX
dlawler@abilityre.net

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Ability Insurance Company, 1515 South 75th St., Omaha, NE 68124.

From: Singer, Alan (OIC) [mailto:AlanS@OIC.WA.GOV]
Sent: Monday, March 07, 2011 1:00 PM
To: Don Lawler
Cc: Sureau, Carol (OIC)
Subject: RE: Your file no.:1041891

Hi Don,

I have to ask a few more questions:

Ms. Silvernail tells me that at some point in 2009, when Ms. White was living at Franklin House, Ability mailed a letter to Ms. White's home that apparently was intended for Ms. Silvernail. This letter was apparently dated August 31 and in it, Ability apparently acknowledged Ms. Silvernail's correspondence of August 4 and informed that the contract had lapsed.

(1) Will you please send me a copy of this 8/31/09 letter?
(2) Also, who at Ability would know about the sending of this 8/31/09 letter?
(3) Finally, why did the company attempt to send a letter to Ms. Silvernail at her mother's address, instead of calling Ms. Silvernail? According to the designee form Ms. White completed, the company apparently had Ms. Silvernail's telephone number on file, so I am trying to figure out if the company had no luck trying that number.

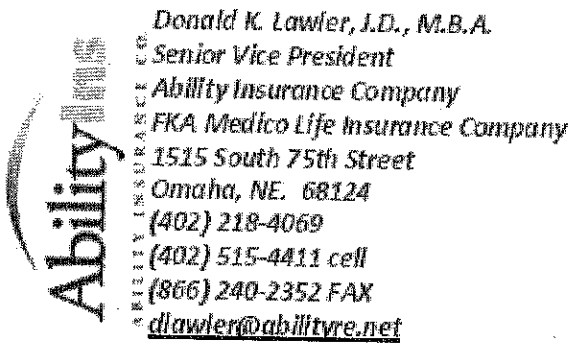
Thanks,

Alan

Alan Michael Singer
Staff Attorney
Legal Affairs
Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255
360-725-7046
360-586-0152 Fax

From: Don Lawler [mailto:dlawler@abilityre.net]
Sent: Friday, January 14, 2011 11:45 AM
To: Singer, Alan (OIC)
Subject: RE: Your file no.:1041891

You, too. Thanks!



Donald K. Lawler, J.D., M.B.A.
Senior Vice President
Ability Insurance Company
FKA Medico Life Insurance Company
1515 South 75th Street
Omaha, NE. 68124
(402) 218-4069
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(866) 240-2352 FAX
dlawler@abilityre.net

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Ability Insurance Company, 1515 South 75th St., Omaha, NE 68124.

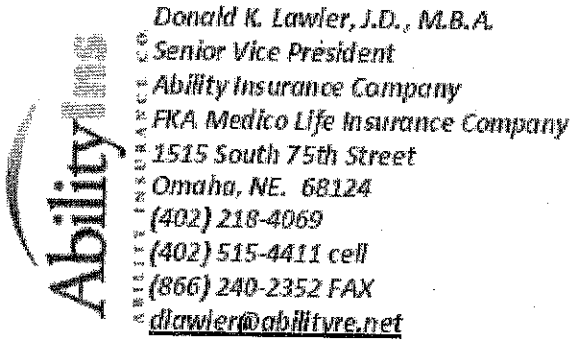
From: Singer, Alan (OIC) [mailto:AlanS@OIC.WA.GOV]
Sent: Friday, January 14, 2011 1:43 PM
To: Don Lawler
Subject: RE: Your file no.:1041891

OK – I'll look for that in the mail, thanks again, and have a good weekend!

Alan Michael Singer
Staff Attorney
Legal Affairs
Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255
360-725-7046
360-586-0152 Fax

From: Don Lawler [mailto:dlawler@abilityre.net]
Sent: Friday, January 14, 2011 11:41 AM
To: Singer, Alan (OIC)
Subject: RE: Your file no.:1041891

Dear Mr. Singer,
Two others besides Ms. White and the details are included in the mailing. Thanks!



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Ability Insurance Company, 1515 South 75th St., Omaha, NE 68124.

From: Singer, Alan (OIC) [mailto:AlanS@OIC.WA.GOV]
Sent: Friday, January 14, 2011 1:28 PM
To: Don Lawler
Subject: RE: Your file no.:1041891

Thanks, Don. Just to be clear, in other words, aside from Ms. White, one other insured was also denied coverage following a request to reinstate his or her coverage under WAC 284-54-253(2)? Will you please provide details about that other insured?

Alan Michael Singer
Staff Attorney
Legal Affairs
Office of the Insurance Commissioner
PO Box 40255

Olympia, WA 98504-0255
360-725-7046
360-586-0152 Fax

From: Don Lawler [mailto:dlawler@abilityre.net]
Sent: Friday, January 14, 2011 10:44 AM
To: Singer, Alan (OIC)
Subject: Your file no.:1041891

Dear Mr. Singer,
I sent to you, via overnight mail, the documents responsive to Question (2) and 3(b) for those policies that lapsed and remained lapsed. To much to e-mail. Only two reinstatement requests were declined.

We are still compiling the notices for those who lapsed and were reinstated and will have them to you early next week. In the meantime, if you have any questions or need additional information, please let me know.

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
Ability Insurance Company
FKA Medico Life Insurance Company
1515 South 75th Street
Omaha, NE. 68124
(402) 218-4069
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dlawler@abilityre.net

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Ability Insurance Company, 1515 South 75th St., Omaha, NE 68124.

AbilityIns
ABILITY INSURANCE CO.
Administered on behalf of Medico Insurance Company
Long Term Care Claims Department
PO Box 3735 • Omaha, NE 68103
Phone (877) 795-8493 • Fax (866) 498-0689 • www.gomedico.com

August 31, 2009

GLADYS WHITE
9223 60TH AVE CT E
PUYALLUP WA 98371

Policy No. 0S34226

This will acknowledge your recent correspondence. According to our records, your contract lapsed effective 2-7-2009; therefore, you have no benefits available.

Please contact us if you have any additional questions concerning this matter.

Sincerely,

Claim Service Department

08/12/2009 pg883

August 6, 2009

TO: Claims Department (Fax # - 402-391-6489)

FROM: Cheryl Silvernail (daughter of Gladys White)

RE: New Claim

I spoke with Jerry in the claims department on Tuesday, August 4th. We went over some information regarding my mom's long term care insurance. He advised me to get the claim form on line. If you have any questions or need additional information, please call me at:

Home: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

FAX: 253-840-8819

Thank you.

RECEIVED
AUG 07 2009
CLAIMS DEPARTMENT

08/12/2009 pg001

Ability Ins
ABILITY INSURANCE CO.
Long Term Care Claims Department
P.O. Box 3735 • Omaha, NE 68103
Phone (877) 795-8493 Fax (866) 498-0689 Customersupport@abilityre.net

Claimant's Proof of Loss

Long-Term Care Insurance Claim Request Form

Claimant and Contact Information

Insured's Name:	Date of Birth:	Policy #:
Gladys E. White	7/8/1923	0534226

Home Address: 9223 60th Av. Ct. E Puyallup WA 98371

Daytime Phone #:	Social Security #:

In order for this request to be further processed, a member of our Claims department will need to speak with either the insured or their representative about this claim. For best service and most timely processing, please provide all of the information requested in the spaces below.

Name of Person to Contact About this Claim:	Relationship to Insured:	Power of Attorney:
Cheryl Silvernail	daughter	☐Yes ☒No

Address: 13714 143RD Av. E. Orting WA 98360

Daytime Phone #:	Alternate Phone #:	Best Time to Call:
253-841-8726		

Claimant's Condition

Event (illness, injury, etc...) that led to a need for Long Term Care services:	Date Illness/Injury Started:
fainted - fell - broke her wrist	

Level of Assistance- Please check the box that best describes the assistance the insured requires with each activity

	Independent	Standby Assist	Hands-On Assist	Date this Assistance Began
Bathing	☐	☐	☒	
Dressing	☐	☐	☒	
Eating	☒	☐	☐	
Toileting	☐	☐	☒	
Transferring	☐	☒	☐	
Continence	☐	☐	☒	
Other:				

RECEIVED
AUG 07 2009
CLAIMS DEPARTMENT

Does the Insured have a diagnosis of Alzheimer's Disease or other type of Dementia? ☒Yes ☒No symptoms

If Yes, please describe the Insured's Cognitive Status (memory, judgment, ability to manage medications, safety concerns, etc...): Doesn't remember to take medications - She's a diabetic insulin high blood pressure

Medical Provider Information

Attending Physician's Name:	Office Phone #:	Office Fax #:
Dr. Rudnick	253-840-4000	253-840-6733

Physician's Address: 4002 39th St NE Puyallup WA 98372

Has the Insured Been Hospitalized within the past 12 months? ☐No ☒Yes, Complete Section Below

Name of Hospital:	Address:	
Good Samaritan Hosp.	407 14th Av. S.E. Puyallup WA 98372	
Phone #:	Admission Date:	Discharge Date:
253-697-4000	7/25/09	7/28/09

08/12/2009 19:52

Long-Term Care Provider Information

What Type of Care Does the Insured Need?

☐ Nursing Home ☒ Assisted Living ☐ Home Health Care ☐ Hospice ☐ Other:

Does the Insured currently have Long Term Care Services In Place? ☒ No ☒ Yes, Complete Section Below

Name of Facility/Agency:	Phone #:	Type of Care:
Lynden Grove	253-840-4400	

Facility/Agency Address: 400 29th St. N.E. Puyallup WA

Date Care Began:	Date Care Ended:	Name of Contact Person at Facility/Agency:	Fax #:
7/28/09			

Please Note: If you are currently receiving services from more than 1 Long Term Care provider, please provide all of the information requested above for each provider in the white space at the bottom of this form.

If you obtain services from any non-qualified provider, they will not be covered under your policy.

If you obtain services that are not covered under the Policy, we will not be able to reimburse for these services.

Medicare and Other Insurance Information

Are you eligible for or currently enrolled in

Medicare Part A	☒ Yes	☐ No
Medicare Part B	☐ Yes	☐ No
Medicaid	☐ Yes	☐ No

Have any of your Long-Term Care expenses been paid for by Medicare? ☐ No ☐ Yes, Complete Section Below

Start Date:	End Date:	Agency/Facility:
7/28/09		Linden Grove

Do you have any other Long-Term Care Insurance Policies? ☒ No ☐ Yes, Complete Section Below

Insurance Company Name:	Address:	Policy #:	Daily Benefit Amt.:
			$

Signature

My signature below indicates that I understand that the claims processing procedure includes the collection of personal medical information. I also understand that an on-site assessment may also be required. This assessment will be completed at no cost to me by a licensed health care practitioner of Ability Insurance Company's choice.

Signature of the Insured or POA:	Date Signed:

Please return this form and any additional documents to the address at the top of the first page.

Please Remember to include the Following with this Form:

- ☐ A Copy of the Power of Attorney Document (If applicable)
- ☐ The signed Authorization to Use and Disclose Personal Information form (see page 3 of this form)
- ☐ Copies of invoices for any long term care costs you have incurred thus far
- ☐ A statement of the hourly and/or daily charge for the service you are receiving
- ☐ A copy of the license of the provider you are using and their tax ID number

RECEIVED
AUG. 07 2009
CLAIMS DEPARTMENT

WARNING – Fraud Notice: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as further defined by your state statute.

NOTE - 09/15/2009 -
Sharon Klusaw 8. 2009 9:57AM
SKLUSAW 9/15/2009
2:26:52 PM
called daughter
explained that
contract lapsed
2-8-2009. daughter
is checking she
didn't feel that
the policy was
lapsed.

TO CF

Abilityins
ABILITY INSURANCE CO.
Long Term Care Claims Department
P.O. Box 3735 • Omaha, NE 68103
Phone: (877) 795-8493 Fax: (866) 498-0689 Email: Customersupport@abilityre.net

Claimant's Proof of Loss

Long-Term Care Insurance Claim Request Form

Claimant and Contact Information

Insured's Name:	Date of Birth:	Policy #:
Gladys E. White	7/8/1923	0S34226

Home Address: 9223 60th Av Ct. E

Daytime Phone #:	Social Security #:
253-845-1228	561-36-2379

In order for this request to be further processed, a member of our Claims department will need to speak with either the insured or their representative about this claim. For best service and most timely processing, please provide all of the information requested in the spaces below.

Name of Person to Contact About this Claim:	Relationship to Insured:	Power of Attorney:
Cheryl Silvernail	daughter	☐Yes ☒No

Address: 13714 143RD Av. E. Orting, WA 98360

Daytime Phone #:	Alternate Phone #:	Best Time to Call:
253-841-8226	253-446-7190 253-232-2499	day time at work

Claimant's Condition

Event (illness, injury, etc...) that led to a need for Long Term Care services: Broken left wrist - after fall at home

Date Illness/Injury Started: 7/25/09

Level of Assistance- Please check the box that best describes the assistance the insured requires with each activity

	Independent	Standby Assist	Hands-On Assist	Date this Assistance Began
Bathing	☐	☐	☒	
Dressing	☐	☒	☐	
Eating	☒	☐	☐	
Toileting	☐	☒	☐	
Transferring	☒	☐	☐	
Continence	☐	☐	☒	

Other: Dementia, Help with medications

Does the insured have a diagnosis of Alzheimer's Disease or other type of Dementia? ☒Yes ☐No

If Yes, please describe the insured's Cognitive Status (memory, judgment, ability to manage medications, safety concerns, etc...): All of the above - she's fallen several times at home

Medical Provider Information

Attending Physician's Name:	Office Phone #:	Office Fax #:
DR. Rudnick DR Alex Mihali	253-840-4400 253-459-6510	253-840-6733

Physician's Address: 400 29th St. N.E. Puyallup WA 98372
1901 S. Union Ave. Tacoma WA 98405

Has the insured Been Hospitalized within the past 12 months? ☐No ☒Yes, Complete Section Below

Name of Hospital:	Address:	
Good Samaritan	407 14th Av SE Puyallup	
Phone #:	**Admission Date:**	**Discharge Date:**
253-697-4000	7/25/09	7/28/09

Claimant's POL

09/08/2009 09:02

Long-Term Care Provider Information

What Type of Care Does the Insured Need?

☐Nursing Home ☒Assisted Living ☐Home Health Care ☐Hospice ☐Other:

Does the Insured currently have Long Term Care Services In Place? ☐No ☒Yes, Complete Section Below

Name of Facility/Agency:	Phone #:	Type of Care:
Franklin House	891-3569	

Facility/Agency Address: 5713 Parker Road Sumner WA 98390

Date Care Began:	Date Care Ended:	Name of Contact Person at Facility/Agency:	Fax #:
8/24/09		Cheryl Henni	253-891-9433

Please Note: If you are currently receiving services from more than 1 Long Term Care provider, please provide all of the information requested above for each provider in the white space at the bottom of this form.

If you obtain services from any non-qualified provider, they will not be covered under your policy.

If you obtain services that are not covered under the Policy, we will not be able to reimburse for these services.

Medicare and Other Insurance Information

Are you eligible for or currently enrolled in

Medicare Part A	☐Yes	☐No
Medicare Part B	☐Yes	☐No
Medicaid	☐Yes	☒No

Have any of your Long-Term Care expenses been paid for by Medicare? ☐No ☒Yes, Complete Section Below

Start Date:	End Date:	Agency/Facility:
7/28/09	8/24/09	Linden Grove

Do you have any other Long-Term Care Insurance Policies? ☒No ☐Yes, Complete Section Below

Insurance Company Name:	Address:	Policy #:	Daily Benefit Amt.:
			$

Signature

My signature below indicates that I understand that the claims processing procedure includes the collection of personal medical information. I also understand that an on-site assessment may also be required. This assessment will be completed at no cost to me by a licensed health care practitioner of Ability Insurance Company's choice.

Signature of the Insured or POA:	Date Signed:
William White	9-6-2009

Please return this form and any additional documents to the address at the top of the first page.

Please Remember to Include the Following with this Form:

☐A Copy of the Power of Attorney Document (if applicable)

☐The signed Authorization to Use and Disclose Personal Information form (see page 3 of this form)

☐Copies of invoices for any long term care costs you have incurred thus far

☐A statement of the hourly and/or daily charge for the service you are receiving

☐A copy of the license of the provider you are using and their tax ID number

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09/08/2009 09:57 FAX 402 391 6489

September 8, 2009

TO: Claims Department (FAX # 402-391-6489)

FROM: Cheryl Silvernail (daughter of Gladys White)

RE: New claim

Attached is the claim and invoice for my mother, Gladys White. She is now at the Franklin House, an assisted living facility. They are helping her with her prescription medications, insulin, bathing and dressing, etc. If you have any questions or need additional information, please call me at:

Home: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

Address:
13714 143rd Ave. E.
Orting, WA 98360

Thank you,

Cheryl Silvernail

I have also included the front + back of the durable power of attorney.

November 5, 2009

CHERYL SILVERNAIL
13714 143RD AVE E
ORTING WA 98360

FILE COPY

RE: Insured: Gladys E. White
Policy No.: 0S34226

Dear Ms. Silvernail:

I am writing in response to your letter of September 11, 2009 and thank you for same.

Please be advised that the above contract lapsed for non-payment of premium on February 7, 2009. Notice was given to Ms. White on three occasions at the address on file. Additionally, a Third Party Advisor Notice was sent to you at the Eatonville, Washington address we had on file. This address was given to us on September 10, 2007 by Ms. White.

The policy has a Restoration of Benefits provision in Part M on page 9, but the provision is limited to a five-month period in which to request reinstatement. The five-month period expired in July and we did not receive any contact from you until August.

I am sorry I could not write more favorably. If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

Encs.

December 4, 2009

CHERYL SILVERNAIL
13714 143RD AVE E
ORTING WA 98360

RE: Insured: Gladys E. White
Policy No.: 0S34226

Dear Ms. Silvernail:

I am writing in response to your letter of November 30, 2009 and thank you for same.

Your letter confirms that we were not advised of your change of address and that although you were aware that Ms. White could not properly handle her affairs you did not intervene. Again, the policy has a Restoration of Benefits provision in Part M on page 9, but the provision is limited to a five-month period in which to request reinstatement. The five-month period expired in July and we did not receive any contact from you until August.

I am sorry I could not write more favorably. If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

DL

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

December 4, 2009

CHERYL SILVERNAIL
13714 143RD AVE E
ORTING WA 98360

RE: Insured: Gladys E. White
Policy No.: 0S34226

Dear Ms. Silvernail:

I am writing in response to your letter of November 30, 2009 and thank you for same.

Your letter confirms that we were not advised of your change of address and that although you were aware that Ms. White could not properly handle her affairs you did not intervene. Again, the policy has a Restoration of Benefits provision in Part M on page 9, but the provision is limited to a five-month period in which to request reinstatement. The five-month period expired in July and we did not receive any contact from you until August.

I am sorry I could not write more favorably. If you have any questions or need additional information, please contact my office.

Very truly yours,

ABILITY INSURANCE COMPANY

Donald K. Lawler, J.D., M.B.A.
Senior Vice President
(402) 218-4069
(866) 240-2352 fax
dlawler@abilityre.net

DKL:tt

NOTE - 11/07/2009 - 6:48AM
Sharon Klusaw
SKLUSAW 11/07/2009
11:00:14 AM
contract lapsed on
2-7-09 refer to Don
L / Erin to handle

ABILITY INSURANCE CO.
Long Term Care Claims Department
P.O. Box 3735 • Omaha, NE 68103
Phone (877) 795-8493 Fax (866) 498-0689 Customersupport@abilityre.net

Claimant's Proof of Loss

Long-Term Care Insurance Claim Request Form

Claimant and Contact Information

Insured's Name:	Date of Birth:	Policy #:
Gladys E. White	7/8/1923	

Home Address: 9223 60th Av. Ct. E Puyallup WA 98371

Daytime Phone #:	Social Security #:

In order for this request to be further processed, a member of our Claims department will need to speak with either the insured or their representative about this claim. For best service and most timely processing, please provide all of the information requested in the spaces below.

Name of Person to Contact About this Claim:	Relationship to Insured:	Power of Attorney:
Cheryl Silvernail	daughter	☐Yes ☒No

Address: 13714 143RD Av. E. Orting WA 98360

Daytime Phone #:	Alternate Phone #:	Best Time to Call:
253-841-8726		

Claimant's Condition

Event (illness, injury, etc...) that led to a need for Long Term Care services:	Date Illness/Injury Started:
fainted - fell - broke her wrist	

Level of Assistance- Please check the box that best describes the assistance the insured requires with each activity

	Independent	Standby Assist	Hands-On Assist	Date this Assistance Began
Bathing	☐	☐	☒	
Dressing	☐	☐	☒	
Eating	☒	☐	☐	
Toileting	☐	☐	☒	
Transferring	☐	☒	☐	
Continence	☐	☐	☒	
Other:				

Does the Insured have a diagnosis of Alzheimer's Disease or other type of Dementia? ☐Yes ☒No symptoms

If Yes, please describe the Insured's Cognitive Status (memory, judgment, ability to manage medications, safety concerns, etc...): Doesn't remember to take medications - she's a diabetic insulin high blood pressure

Medical Provider Information

Attending Physician's Name:	Office Phone #:	Office Fax #:
Dr. Rudnick	253-840-4400	253-840-6733

Physician's Address: 4002 9th st NE Puyallup WA 98372

Has the Insured Been Hospitalized within the past 12 months? ☐No ☒Yes, Complete Section Below

Name of Hospital:	Address:	
Good Samaritan Hosp.	407 14th Av. S.E. Puyallup WA 98372	

Phone #:	Admission Date:	Discharge Date:
253-697-4000	7/25/09	7/28/09

Long-Term Care Provider Information

What Type of Care Does the Insured Need?

☐ Nursing Home ☒ Assisted Living ☐ Home Health Care ☐ Hospice ☐ Other:

Does the Insured currently have Long Term Care Services in Place? ☒ No ☒ Yes, Complete Section Below

Name of Facility/Agency:	Phone #:	Type of Care:
Lynden Grove	253-840-4400	

Facility/Agency Address: 400 29th St. N.E. Puyallup WA

Date Care Began:	Date Care Ended:	Name of Contact Person at Facility/Agency:	Fax #:
7/28/09			

Please Note: If you are currently receiving services from more than 1 Long Term Care provider, please provide all of the information requested above for each provider in the white space at the bottom of this form.
If you obtain services from any non-qualified provider, they will not be covered under your policy.
If you obtain services that are not covered under the Policy, we will not be able to reimburse for these services.

Medicare and Other Insurance Information

Are you eligible for or currently enrolled in

Medicare Part A	☒ Yes	☐ No
Medicare Part B	☐ Yes	☐ No
Medicaid	☐ Yes	☐ No

Have any of your Long-Term Care expenses been paid for by Medicare? ☐ No ☐ Yes, Complete Section Below

Start Date:	End Date:	Agency/Facility:
7/28/09		Linden Grove

Do you have any other Long-Term Care Insurance Policies? ☒ No ☐ Yes, Complete Section Below

Insurance Company Name:	Address:	Policy #:	Daily Benefit Amt.:
			$

Signature

My signature below indicates that I understand that the claims processing procedure includes the collection of personal medical information. I also understand that an on-site assessment may also be required. This assessment will be completed at no cost to me by a licensed health care practitioner of Ability Insurance Company's choice.

Signature of the Insured or POA:	Date Signed:

Please return this form and any additional documents to the address at the top of the first page.

Please Remember to Include the Following with this Form:

- ☐ A Copy of the Power of Attorney Document (if applicable)
- ☐ The signed Authorization to Use and Disclose Personal Information form (see page 3 of this form)
- ☐ Copies of invoices for any long term care costs you have incurred thus far
- ☐ A statement of the hourly and/or daily charge for the service you are receiving
- ☐ A copy of the license of the provider you are using and their tax ID number

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September 8, 2009

TO: Claims Department (FAX # 402-391-6489)

FROM: Cheryl Silvernail (daughter of Gladys White)

RE: New claim

Attached is the claim and invoice for my mother, Gladys White. She is now at the Franklin House, an assisted living facility. They are helping her with her prescription medications, insulin, bathing and dressing, etc. If you have any questions or need additional information, please call me at:

Home: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

Address:
13714 143rd Ave. E.
Orting, WA 98360

Thank you,

Cheryl Silvernail

I have also included the front + back of the durable power of attorney.

AbilityIns
ABILITY INSURANCE CO.
Long Term Care Claims Department
P.O. Box 3735 • Omaha, NE 68103
Phone: (877) 795-8493 Fax: (866) 498-0689 Email: Customersupport@abilityre.net

Claimant's Proof of Loss

Long-Term Care Insurance Claim Request Form

Claimant and Contact Information

Insured's Name:	Date of Birth:	Policy #:
Gladys E. White	7/8/1923	OS34226

Home Address: 9223 60th Av Ct E

Daytime Phone #:	Social Security #:
253-845-1228	561-36-2379

In order for this request to be further processed, a member of our Claims department will need to speak with either the Insured or their representative about this claim. For best service and most timely processing, please provide all of the information requested in the spaces below.

Name of Person to Contact About this Claim:	Relationship to Insured:	Power of Attorney:
Cheryl Silvernail	daughter	☐ Yes ☒ No

Address: 13714 143RD Av. E. Orting, WA 98360

Daytime Phone #:	Alternate Phone #:	Best Time to Call:
253-841-8226	253-232-7499 253-446-7190	day time at work

Claimant's Condition

Event (Illness, Injury, etc...) that led to a need for Long Term Care services:	Date Illness/Injury Started:
Broken left wrist - after fall at home	7/25/09

Level of Assistance- Please check the box that best describes the assistance the insured requires with each activity

	Independent	Standby Assist	Hands-On Assist	Date this Assistance Began
Bathing	☐	☐	☒	
Dressing	☐	☒	☐	
Eating	☒	☐	☐	
Toileting	☐	☒	☐	
Transferring	☒	☐	☐	
Continence	☐	☐	☒	

Other: Dementia, Help with medications

Does the Insured have a diagnosis of Alzheimer's Disease or other type of Dementia? ☒ Yes ☐ No

If Yes, please describe the Insured's Cognitive Status (memory, judgment, ability to manage medications, safety concerns, etc...): All of the above - she's fallen several times at home

Medical Provider Information 253-840-4400 253-840-6733

Attending Physician's Name:	Office Phone #:	Office Fax #:
DR. Rudnick Dr Alex Mihali	253-459-6510	

Physician's Address: 400 29th St. N.E. Puyallup WA 98372
1901 S. Union Ave. Tacoma WA 98405

Has the Insured Been Hospitalized within the past 12 months? ☐ No ☒ Yes, Complete Section Below

Name of Hospital:	Address:	
Good Samaritan	407 14th Av SE Puyallup	
Phone #:	**Admission Date:**	**Discharge Date:**
253-697-4000	7/25/09	7/28/09

Long-Term Care Provider Information

What Type of Care Does the Insured Need?

☐ Nursing Home ☒ Assisted Living ☐ Home Health Care ☐ Hospice ☐ Other:

Does the Insured currently have Long Term Care Services in Place? ☐ No ☒ Yes, Complete Section Below

Name of Facility/Agency:	Phone #:	Type of Care:
Franklin House	891-3569	

Facility/Agency Address: 5713 Parker Road Sumner WA 98390

Date Care Began:	Date Care Ended:	Name of Contact Person at Facility/Agency:	Fax #:
8/24/09		Cheryl Hanni	253-891-9433

Please Note: If you are currently receiving services from more than 1 Long Term Care provider, please provide all of the information requested above for each provider in the white space at the bottom of this form.
If you obtain services from any non-qualified provider, they will not be covered under your policy.
If you obtain services that are not covered under the Policy, we will not be able to reimburse for these services.

Medicare and Other Insurance Information

Are you eligible for or currently enrolled in

Medicare Part A	☐ Yes	☐ No
Medicare Part B	☐ Yes	☐ No
Medicaid	☐ Yes	☒ No

Have any of your Long-Term Care expenses been paid for by Medicare? ☐ No ☒ Yes, Complete Section Below

Start Date:	End Date:	Agency/Facility:
7/28/09	8/24/09	Linden Grove

Do you have any other Long-Term Care Insurance Policies? ☒ No ☐ Yes, Complete Section Below

Insurance Company Name:	Address:	Policy #:	Daily Benefit Amt.:
			$

Signature

My signature below indicates that I understand that the claims processing procedure includes the collection of personal medical information. I also understand that an on-site assessment may also be required. This assessment will be completed at no cost to me by a licensed health care practitioner of Ability Insurance Company's choice.

Signature of the Insured or POA:	Date Signed:
William White	9-6-2009

Please return this form and any additional documents to the address at the top of the first page.

Please Remember to Include the Following with this Form:

- ☐ A Copy of the Power of Attorney Document (if applicable)
- ☐ The signed Authorization to Use and Disclose Personal Information form (see page 3 of this form)
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- ☐ A statement of the hourly and/or daily charge for the service you are receiving
- ☐ A copy of the license of the provider you are using and their tax ID number

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10/27/2009

TO: Claims Department (Fax #866-498-0689)

FROM: Cheryl Silvernail (daughter of Gladys White

RE: Claim

Policy #OS34226

I am faxing all correspondence that I have faxed over since August, 2009 to the new fax #. Please respond as soon as possible as we have been waiting since August for information regarding this claim. Thank you.

HOME: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

FAX: 253-840-8819

FAX #: 402-391-6489

September 30, 2009

TO: Sharon, Claims Department

FROM: Cheryl Silvernail

RE: Documentation of Cognitive Impairment

Policy #OS34226

September 30, 2009

To Whom It May Concern:

As per my phone conversation with Sharon in the Claims Department, I am attaching documentation of my mom's cognitive impairment as observed at Good Samaritan Hospital in Puyallup.

From my personal observation, I would also like to include the following:

1. My mother began hiding bills that she didn't understand or didn't want to deal with. Just two examples of this are:

- The Internal Revenue Service notice stating that she owed money. My sister finally found the notices so that we could take care of them.
- Her invoices for Lutheran Community Service (an invoice for her caregiver that was coming in each day for a few hours.) This bill was unpaid for several months, until they contacted me regarding the past due invoices.

2. My mother couldn't remember to take her medications on the days that her caregiver wasn't at her home. She's a diabetic and was not remembering to take her insulin. Because of this, her blood sugar was out of control. She was not taking her high blood pressure medication, which had also soared out of control.

I have also enclosed a letter from her caregiver, Alexandria Farmin, who works for Lutheran Community Services. She wrote about her cognitive impairment and other problems she was encountering in April of 2008.

I'm still a little unsure of why I wasn't contacted when the insurance premiums weren't being paid. My name and phone number have been on all correspondence that was submitted when she had her previous claim. I would think you would still have records of these.

My mother has paid for this insurance since August of 1999. It appears to me that one of the problems of aging, cognitive impairment (dementia), would prevent her from paying the premium notice that would keep her insurance in tact.

Please reconsider your denial of this claim due to non-payment of the premium. Let us know what we would have to pay to put this insurance policy back in force. Thank you.

Cheryl Silvernail
Daughter of Gladys White

August 6, 2009

TO: Claims Department (Fax # - 402-391-6489)

FROM: Cheryl Silvernail (daughter of Gladys White)

RE: New Claim

I spoke with Jerry in the claims department on Tuesday, August 4th. We went over some information regarding my mom's long term care insurance. He advised me to get the claim form on line. If you have any questions or need additional information, please call me at:

Home: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

FAX: 253-840-8819

Thank you.

10/27/2009

TO: Claims Department (Fax #866-498-0689)

FROM: Cheryl Silvernail (daughter of Gladys White

RE: Claim

Policy #OS34226

I am faxing all correspondence that I have faxed over since August, 2009 to the new fax #. Please respond as soon as possible as we have been waiting since August for information regarding this claim. Thank you.

HOME: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

FAX: 253-840-8819

10/27/2009

TO: Claims Department (Fax #866-498-0689)

FROM: Cheryl Silvernail (daughter of Gladys White

RE: Claim

Policy #OS34226

I am faxing all correspondence that I have faxed over since August, 2009 to the new fax #. Please respond as soon as possible as we have been waiting since August for information regarding this claim. Thank you.

HOME: 253-446-7190

Work: 253-841-8726

Cell: 253-232-7499

FAX: 253-840-8819

FAX #: 402-391-6489

October 12, 2009

TO: Sharon, Claims Department

FROM: Cheryl Silvernail

RE: Invoice for October, 2009

Policy #OS34226

866- 498- 0689

Attachment B

Section 7. Unintentional Lapse

Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

A. (1) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either: a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium; or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's *full name* and *home address*. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended 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 thirty (30) days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice."

The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

(2) When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection A(1) need not be met until sixty (60) days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(3) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection A(1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

B. Reinstatement. In addition to the requirement in Subsection A, a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof of cognitive impairment or the loss of functional capacity. This option shall be available

to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity, if any, contained in the policy and certificate.

Section 8. Required Disclosure Provisions

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

Drafting Note: The last sentence of this subsection is intended to apply to long-term care policies which are part of or combined with life insurance policies, since life insurance policies generally do not contain renewability provisions.

B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

C. Payment of Benefits. A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

D. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

E. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in [insert citation to state law corresponding to Section 6D(2) of the Long-Term Care Insurance Model Act] shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

F. Disclosure of Tax Consequences. With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be

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