

APPLICANT'S EXHIBIT 1

Hearings Unit Case No. 16-0002

Office of the Insurance Commissioner



TIAA-CREF Life Insurance Company

730 Third Avenue
New York, NY 10017-3206
212 490-9000 1 800 223-1200

Policy Number: 09852450

Name of Insured: MR LEO J DRISCOLL

Long-Term Care Insurance Policy

This Policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code.

This Policy is **not a Medicare Supplement Policy**. This Policy is not intended to replace Your present health insurance.

Notice to Buyer: This Policy may not cover all of the costs associated with long-term care incurred by You during the period of coverage. You are advised to **CAREFULLY REVIEW** all policy limitations.

Caution: We issued this insurance Policy based on Your responses to the questions on Your application. A copy of the application is attached to and made a part of this Policy. **If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind Your Policy.** The best time to clear up any question is now, before a claim arises. If, for any reason, any of Your answers are incorrect, write or call Us. Our address and phone number are shown above.

This Policy is **Guaranteed Renewable**. We cannot cancel or refuse to renew this Policy. To keep this Policy in force, You need only pay the premiums on time.

We have a limited right to increase premiums. Your premium will not increase due to a change in Your age or health. We can increase Your premium based on Your premium class, but only if We increase the premiums for all similar policies issued on the same form as this Policy. If the premium increases, the increase will only be made as of an anniversary of the Policy Effective Date. We will give You at least 30 days written notice before We increase Your premium.

60 day right to examine Your Policy. You have 60 days from the day You receive this Policy to examine and return it to Us if You decide not to keep it. You do not have to tell Us Your reason for returning the Policy. Simply return it to Us at the address above. We will refund the full amount of any premium paid, and the Policy will be void from the start. We will add an additional 10 % penalty to any premium refund due which is not paid within 30 days of return of the policy to Us.

President

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POLICY SCHEDULE

GENERAL POLICY INFORMATION

Name of Insured: MR LEO J DRISCOLL
Date of Birth: 11/14/1926
Policy Effective Date: August 1, 2002
(Effective 12:01 AM)

SS#: ~~XXXXXXXXXX~~
Age: 75 Years
Policy Number: 09852450

This Policy was issued in the state of Washington.

BENEFITS

Lifetime Benefit Maximum (as of the Policy Effective Date)	\$200,750.00
Nursing Facility Care Daily Benefit Maximum	\$110.00 per day
Home and Community-Based Care Daily Benefit Maximum	\$55.00 per day
Benefit Waiting Period	90 Days

This policy is sufficient to provide at least 5 years of benefits.

SUPPLEMENTAL BENEFITS

Caregiver Training	Lifetime Maximum of \$550.00
Respite Care	Maximum of 24 Days in any 12 Month Period
Durable Medical Equipment	Lifetime Maximum of \$5,500.00
Emergency Response System Initial Installation Fee	Maximum of up to \$35.00 per Month up to 36 Months Maximum of up to \$75.00

OPTIONAL BENEFITS

Inflation Protection Option	Rider is attached to the Policy
Shared Care Option	Rider is attached to the Policy

PREMIUM SUMMARY

Basic Benefits	\$198.42
Optional Benefit(s):	
Inflation Protection Option	\$109.09
Shared Care Option	\$24.60
Total Monthly Premium	\$332.11
Total Monthly Premium With Spousal Discount	\$298.90
Elected Payment Mode	MONTHLY
Total Modal Premium	\$298.90



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SPECIAL NOTE: Throughout this Policy, the words "We", "Our" or "Us" refer to TIAA-CREF Life Insurance Company ("TIAA-CREF Life"). The words "You" or "Your" refer to the name of the Insured who appears on the Policy Schedule page. For ease of reading, all defined terms, titles of sections, and provisions appear in bold print.

DEFINITIONS

Activities of Daily Living ("ADLs")

Activities of Daily Living are functions which You ordinarily are able to perform without **Substantial Assistance** from another individual. Your ability to perform the following six ADLs is used to determine Your eligibility for benefits:

1. **Bathing:** the ability to wash Yourself in the tub, shower, or by sponge bath including the task of getting into or out of the tub or shower.
2. **Continence:** the ability to voluntarily control bowel and bladder function, or in the event You are incontinent, the ability to maintain a reasonable level of personal hygiene (including caring for a catheter or colostomy bag).
3. **Dressing:** the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn, and to fasten or unfasten them.
4. **Eating(Feeding):** the ability to get nourishment into Your body by any means once it has been prepared and made available to You. It does **NOT** include meal preparation.
5. **Toileting:** the ability to get to and from and on and off the toilet and to maintain a reasonable level of personal hygiene.
6. **Transferring:** the ability to move in and out of a chair or bed, with or without equipment or other support devices.

Adult Day Health Care

Adult Day Health Care means a program of community based 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 individual's home.

Definitions (Continued)

Adult Day Health Care Center

An **Adult Day Health Care Center** is an organization which is appropriately regulated and which provides a program of community based 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 individual's home.

Alzheimer's Facility

An **Alzheimer's Facility** refers to a **Nursing Home/Nursing Facility** or an **Assisted Living Facility**, or any part of such facilities, that is primarily devoted to caring for persons diagnosed with Alzheimer's disease.

Assessment

An **Assessment** is an evaluation(s) done by a **Care Advisor** or, by **Your** personal physician to determine or verify **Your** loss of functional or cognitive ability.

Assisted Living Facility

An **Assisted Living Facility** is a facility that is licensed, if required by the state in which it operates, to provide 24-hour-a-day care and assistance with **Activities of Daily Living**, or ongoing supervision due to **Severe Cognitive Impairment**, for at least 3 or more patients in one location, and:

1. has trained and ready-to-respond employees on duty at all times to provide that care;
2. provides three meals a day and accommodates special dietary needs;
3. has formal arrangements for the services of a physician or nurse to furnish emergency medical care; and,
4. has appropriate methods and procedures for handling and administering drugs and biologicals.

Benefit Waiting Period

The **Benefit Waiting Period** refers to the total number of days in which **You** continuously meet this Policy's eligibility criteria for benefits and **You** incur **Covered Expenses for Nursing Facility Care or Home and Community-Based Care** at least as often as twice every seven days.

We will NOT pay Nursing Facility Care Benefits or Home and Community-Based Care Benefits before the Benefit Waiting Period has been satisfied.

Days of care paid by **Medicare** will count towards satisfying the **Benefit Waiting Period**.

Definitions (Continued)

Home Health Care Agency

A **Home Health Care Agency** is primarily engaged in providing nursing care or **Personal Care** in the home and is licensed or certified by the appropriate licensing authority in that state to provide such services.

Hospice Facility

A **Hospice Facility** is a facility that provides a formal program of care for terminally ill individuals on an in-patient basis and is directed by a physician.

Hospice Services

Hospice Services are in-patient or out-patient services not paid by **Medicare**, that are designed to provide palliative care, and to alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to a terminal disease.

Immediate Family

Immediate Family refers to an insured's spouse, child (natural, step, or adopted), parent, sibling, grandchild, in-law, or anyone who resides in the insured's home.

Lifetime Benefit Maximum

The **Lifetime Benefit Maximum** is the maximum amount that **We** will pay for all **Covered Expenses** under this Policy. The amount of **Your Lifetime Benefit Maximum** will be reduced by all payments made for **Covered Expenses** except for those associated with the **Care Management Benefit**. The **Lifetime Benefit Maximum** is shown in the **Policy Schedule**.

If **You** choose the Lifetime (Unlimited) Benefit Period option, **Your Lifetime Benefit Maximum** will not increase, be reduced or exhausted by **Covered Expenses**. Other limits, such as the Daily Benefit maximums still apply.

Maintenance or Personal Care Services

Maintenance or Personal Care Services means any care for which the primary purpose is to provide needed assistance with any of the disabilities that resulted from an individual being a **Chronically Ill Individual** (including protection from threats to health and safety due to **Severe Cognitive Impairment**).

Medicaid

Medicaid refers to a program provided by the joint federal-state public assistance (welfare) program which provides payment for health care services to those with low incomes or with very high medical bills relative to income and assets. This program was established by Title XIX of the Social Security Amendments and is administered by the states.

Medicare

Medicare refers to the reimbursement system as discussed under Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Definitions (Continued)

Nurse

A **Nurse** is a registered professional nurse (R.N.) or a licensed practical nurse (L.P.N.).

Nursing Home/Nursing Facility

A **Nursing Home/Nursing Facility** is a facility that is licensed or legally authorized to be a **Nursing Home/ Nursing Facility** in accordance with the laws of the state in which it operates. A **Nursing Home/ Nursing Facility** provides 24-hour nursing services; or a distinctly separate part of a hospital and has:

1. a planned program of policies and procedures that is developed with the advice of, and is periodically reviewed and executed by, a professional group of at least one physician and one registered nurse (R.N.);
2. a doctor available to furnish medical care in case of emergency;
3. at least one **Nurse** who is employed there full time (or at least 24 hours per week if the facility has less than 10 beds);
4. a **Nurse** on duty or on call at all times;
5. clinical records for all patients; and,
6. appropriate methods and procedures for handling and administering drugs and biologicals.

Services provided may include: nursing care, personal care, physical therapy, speech therapy, respiratory therapy, nutritional services, or personal hygiene services.

A **Nursing Home/Nursing Facility** does not include: retirement communities; rest homes; homes for the aged; sheltered living accommodations; residence homes; homes for the mentally retarded, the mentally ill, or for the blind or the deaf; a hotel; a domiciliary care home; or a residence or home for alcoholics or drug abusers.

Personal Care

Personal Care means **Standby Assistance with Activities of Daily Living** or providing custodial services for those suffering **Severe Cognitive Impairment**.

Plan of Care

A **Plan of Care** is a written document that is prepared by and signed by a **Care Advisor** or, by **Your** personal physician, that specifies prescribed **Qualified Long-Term Care Services** and treatments that are consistent with an **Assessment of Your** ability to perform **Activities of Daily Living** and basic cognitive functions.

A **Plan of Care** must be prepared in accordance with accepted standards of practice and must contain services or treatments that could not be omitted without adversely affecting the insured's illness or condition.

Qualified Long-Term Care Services

Qualified Long-Term Care Services refers to necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and **Maintenance or Personal Care Services**, that are:

1. required by a **Chronically Ill Individual**; and,
2. provided pursuant to a **Plan of Care** prescribed by a **Care Advisor** or, by **Your** personal physician.

Representative

A **Representative** is a person or entity legally empowered to represent **You**.

Respite Care

Respite Care refers to services **You** need during the time that **Your** primary caregiver (a member of **Your Immediate Family** or an unpaid primary caregiver) is unable to care for **You**.

Respite Care can be received at home or in a nursing home or nursing facility.

Severe Cognitive Impairment

Severe Cognitive Impairment refers to a loss or deterioration in intellectual capacity that is:

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

Standby Assistance

Standby Assistance means having the presence of another person within **Your** arm's reach that is necessary to prevent, by physical intervention, injury to **You** while **You** are performing an **Activity of Daily Living** (such as being ready to catch **You** if **You** fall while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from **Your** throat if **You** choke while eating).

Substantial Assistance

Substantial Assistance means **Standby Assistance**.

Substantial Supervision

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

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Eligibility for the Payment of Benefits

You are eligible for benefits during the time this Policy is force and the following conditions have been met:

1. a **Care Advisor** or, **Your** personal physician has assessed that **You** are a **Chronically Ill Individual**;
2. **You** have completed the **Benefit Waiting Period**, if any; and
3. **Your** expenses for care are **Covered Expenses**.

Limitations

This Policy contains a one-time only **Benefit Waiting Period**. This means that **You** only have to satisfy the **Benefit Waiting Period** once during the lifetime of **Your** policy.

Your Benefit Waiting Period begins on the date **Our Assessment** establishes **Your** inability to perform two or more **Activities of Daily Living** or due to **Severe Cognitive Impairment**.

To satisfy the **Benefit Waiting Period**, **You** are required to incur expenses for **Nursing Facility Care** or **Home and Community-Based Care** at least as often as twice every seven days within **Your** elected **Benefit Waiting Period**.

The **Benefit Waiting Period** does **NOT** apply to **Respite Care**, **Care Management**, **Caregiver Training**, or the **Emergency Response System**.

We will **NOT** pay benefits for expenses incurred on the same day for both **Nursing Facility Care** and **Home and Community-Based Care**.

If **You** are eligible to receive **Nursing Facility Care Benefits** and **Home and Community-Based Care Benefits** on the same day, the maximum daily amount that **We** will pay will be the largest **Daily Benefit Maximum** for:

1. **Nursing Facility Care**; OR
2. **Home and Community-Based Care**.

POLICY BENEFITS

NURSING FACILITY CARE BENEFITS

The maximum amount that **We** will pay for each day of **Covered Expenses** incurred as an overnight resident in:

1. a **Nursing Home/Nursing Facility**; or
2. an **Assisted Living Facility**; or
3. an **Alzheimer's Facility**; or
4. a **Hospice Facility**; and
5. for **Bed Reservation**

will be equal to the lesser of:

1. the **Nursing Facility Care Daily Benefit Maximum**, as shown in the **Policy Schedule**; or
2. the actual daily charge.

BED RESERVATION BENEFIT

This benefit is designed to hold **Your** bed should **Your** stay in a **Nursing Home/Nursing Facility, Assisted Living Facility, Alzheimer's Facility or Hospice Facility** be temporarily interrupted.

The maximum amount that **We** will pay for each day of **Bed Reservation** will be equal to the lesser of:

1. the **Nursing Facility Care Daily Benefit Maximum**; or
2. the actual daily charge.

The maximum number of days that **We** will pay for **Bed Reservation** is 30 days in any 12 month period.

If **Your Policy Schedule** shows a dollar amount for the **Lifetime Benefit Maximum**, **Your** available **Lifetime Benefit Maximum** will be reduced by the amount paid for the **Nursing Facility Care Benefit** and the **Bed Reservation Benefit**.

**HOME AND
COMMUNITY-BASED
CARE BENEFITS**

The maximum amount that **We** will pay for each day that **Covered Expenses** are incurred for **Home Health Care** or **Adult Day Health Care** services will be equal to the lesser of:

1. the Home and Community-Based Care Daily Benefit Maximum, as shown in the **Policy Schedule**; or
2. the actual daily charge.

If **Your Policy Schedule** shows a dollar amount for the **Lifetime Benefit Maximum**, **Your** available **Lifetime Benefit Maximum** will be reduced by the amount paid under this benefit.

NOTE:

1. **Adult Day Health Care** services must be rendered under the direction of an **Adult Day Health Care Center**.
2. **Home Health Care** services may be rendered under the direction of a **Home Health Care Agency** or by a licensed or certified home health care provider (e.g., a home health aide) who is **NOT** affiliated with a **Home Health Care Agency**.

If **You** use a licensed or certified home health care provider who is **NOT** affiliated with a **Home Health Care Agency**, both the provider and the services rendered must be approved by **Us** and a **Care Advisor** and **Your** personal physician.

SUPPLEMENTAL BENEFITS

Care Management

Care Management is completely voluntary. It is an optional service designed to help **You** when **You** are making decisions about long-term care; the care **You** need and **Your** options for meeting those needs. **You** are **NOT** required to use this service or to follow the suggested recommendations.

Services provided under **Care Management** are furnished by **Our Care Advisor**. These services include:

Services provided by **Care Management** are furnished through a **Care Management Organization** and include:

1. designing a **Plan of Care** that will match **Your** long-term care needs with available resources and care providers in **Your** community;
2. periodically reviewing **Your** long-term care needs; and
3. revising, if necessary, the **Plan of Care**.

Expenses for **Care Management** are paid entirely by **Us** and will **NOT** reduce **Your Lifetime Benefit Maximum**.

The **Benefit Waiting Period** does **NOT** have to be met in order to receive this benefit.

Caregiver Training

Caregiver Training is designed to teach a person who is designated by **You** to assist **You** in such areas as:

1. the proper use and care of therapeutic devices;
2. the proper use or disposal of medical aids; and
3. the changing of wound dressings or re-positioning in bed.

The lifetime maximum amount that **We** will pay for **Caregiver Training** is five times the Nursing Facility Care Daily Benefit Maximum.

If **Your Policy Schedule** shows a dollar amount for the **Lifetime Benefit Maximum**, **Your** available **Lifetime Benefit Maximum** will be reduced by the amount paid under this benefit.

Respite Care

The maximum number of days that **We** will pay for **Covered Expenses** for **Respite Care** is 24 days in any 12 month period.

The maximum amount that **We** will pay for each day of **Respite Care** received at home or in an **Adult Day Health Care Center** will be equal to the lesser of:

1. the Home and Community-Based Care Daily Benefit Maximum, as shown in the **Policy Schedule**; or
2. the actual daily charge.

The maximum amount that **We** will pay for each day of **Respite Care** received in a Nursing Home/Nursing Facility will be equal to the lesser of:

1. the Nursing Facility Care Daily Benefit Maximum, as shown in the **Policy Schedule**; or
2. the actual daily charge.

If **Your Policy Schedule** shows a dollar amount for the **Lifetime Benefit Maximum**, **Your** available **Lifetime Benefit Maximum** will be reduced by the amount paid under this benefit.

Durable Medical Equipment

This benefit provides for the rental of **Durable Medical Equipment**; it does **NOT** provide for the purchase of medical supplies or devices; however, if it is more economical to purchase rather than rent the **Durable Medical Equipment**, **We** may pay for such a purchase(s).

To be eligible for this benefit, prior written certification is required by **Your** physician (or by a licensed medical professional) and by a **Care Advisor** stating that:

1. the Equipment is appropriate for **Your** needs; and,
2. the Equipment is expected to allow **You** to continue to stay in **Your** home for at least ninety days with its use.

The lifetime maximum amount that **We** will pay for **Covered Expenses** incurred for **Durable Medical Equipment** is fifty times the Nursing Facility Care Daily Benefit Maximum.

If **Your Policy Schedule** shows a dollar amount for the **Lifetime Benefit Maximum**, **Your** available **Lifetime Benefit Maximum** will be reduced by the amount paid under this benefit.

Emergency Response System

An **Emergency Response System** means a communication system that is: (a) installed in a person's home; and, (b) is used to call for assistance in the event of a medical emergency.

The maximum amount that **We** will pay for **Covered Expenses** incurred for an **Emergency Response System** is \$35 per month, for a maximum of 36 months, and an initial installation fee up to \$75.

We will **NOT** pay for any expenses for normal telephone services or for a home security system.

If **Your Policy Schedule** shows a dollar amount for the **Lifetime Benefit Maximum**, **Your** available **Lifetime Benefit Maximum** will be reduced by the amount paid under this benefit.

Alternate Care Services

Alternate Care Services refers to **Qualified Long-Term Care Services** which are not otherwise defined under **Nursing Facility Care Benefits** or **Home and Community-Based Care Benefits**.

Eligibility for reimbursement of **Alternate Care Services** is subject to the following conditions:

1. A **Care Advisor** or **Your** personal physician has developed and submitted to **Us** a **Plan of Care** that has been agreed to by **You** or **Your Representative**, **Your** physician, and **Us**; and
2. **We** have determined that the **Alternate Care Service(s)** is an appropriate alternative to the benefit(s) otherwise covered under this Policy.

The maximum amount that **We** will pay for **Covered Expenses** for each day of **Alternate Care Services** if **You** are confined as an overnight resident in an approved nursing facility will be equal to the lesser of:

1. the **Nursing Facility Care Daily Benefit Maximum**, as shown in the **Policy Schedule**; or
2. the actual daily charge.

The maximum amount that **We** will pay for **Covered Expenses** for each day of **Alternate Care Services** received at home or in a community-based setting will be equal to the lesser of:

1. the **Home and Community-Based Care Daily Benefit Maximum**, as shown in the **Policy Schedule**; or
2. the actual daily charge.

If **Your Policy Schedule** shows a dollar amount for the **Lifetime Benefit Maximum**, **Your** available **Lifetime Benefit Maximum** will be reduced by the amount paid under this benefit.

POLICY LIMITATIONS AND EXCLUSIONS

Expenses for the following types of care are **NOT Covered Expenses** and are excluded under the terms and conditions of this Policy:

1. care which is provided by a member of **Your Immediate Family**;
2. care which is or usually would be rendered free of charge if this Policy were not in effect;
3. care which is required because of an attempt at suicide or intentionally self-inflicted injury whether sane or insane;
4. care which is required because of war or act of war, whether declared or undeclared;
5. to the extent permissible by law, care for which benefits are provided under:
 - a. **Medicare**;
 - b. Other governmental programs, except Medicaid;
 - c. Mandatory Automobile No-fault Insurance;
 - d. Workers' Compensation;
 - e. Employer's Liability Programs; or,
 - f. Occupational Disease Law;
6. care which is provided in an institution licensed primarily to care for patients with mental illness, to house the mentally retarded, or to treat or rehabilitate individuals with alcohol and drug addictions; and,
7. care received outside of the United States and its possessions.

CLAIMS INFORMATION

Notice of Claim

Notice of claim must be received by **Us** within six months of when **You** incur **Covered Expenses** or as soon after as reasonably possible.

To help facilitate payment of benefits, **You** or **Your Representative** should contact **Us** immediately by calling: 1-800-223-1200; OR by writing to **Us** at: 730 Third Avenue, New York, NY 10017-3206. Written documentation should include:

1. **Your** name and address;
2. **Your** Policy number, as shown in the Policy Schedule page;
3. the occurrence, character, and extent of **Your** loss;
4. the names and addresses of the care providers who are aware of **Your** condition; and
5. the time periods for which **You** are claiming benefits.

Claim Forms

We may require that **You**, **Your Representative**, or a person or organization that is providing care to **You** complete forms that will be used in an **Assessment**. If **We** do not furnish any such forms within fifteen days after receiving **Your** claim, **You** will be deemed to have complied with **Our** requirement for proof of loss by submitting suitable written proof covering the occurrence, character, and extent of the loss for which **Your** claim is being made.

Proof of loss must be furnished as soon as reasonably possible, but no later than two years from the date a **Covered Expense** is incurred.

Assessment

After **We** receive Notice of Claim, an **Assessment** may be required. If the **Assessment** is performed by **Your** personal physician, a copy of that **Assessment** and a **Plan of Care** must be sent to **Us**. If the **Assessment** is performed by a **Care Advisor**, **We** will pay for all expenses.

If **We** require additional information in order to provide evidence of **Your** cognitive or functional status, **We** will request permission to contact **Your** physician or other care providers who are familiar with **Your** condition.

If **You** refuse to cooperate with **Our** request for an **Assessment** or deny permission to contact others familiar with **Your** condition, eligibility for reimbursement of **Covered Expenses** will be denied.

Assessment (Continued)

We will **NOT** reimburse expenses until the **Assessment** is completed and **Your** eligibility to receive benefits is determined.

We reserve the right to request, if necessary, that an additional **Assessment(s)** be performed by a **Care Advisor**.

Periodic Assessment

We will periodically (at least annually) perform an **Assessment** at **Our** expense to determine **Your** benefit eligibility. When **We** have paid benefits to **You** for two continuous years, **We** will not require an **Assessment** more often than once per year.

Payment of Claims

We will notify **You** or **Your Representative** of **Our** decision to confirm or deny payment of benefits. Payment of **Covered Expenses** will be made on a timely basis. Except for direct payments to care providers that are authorized by **You** in writing, reimbursement of **Covered Expenses** will be paid to **You**. Any direct payment **We** make in good faith will fully discharge **Our** liability under this policy for the payment of that benefit.

At **Your** death, any benefits unpaid will be paid according to the following priority: (1) direct payments due to care providers; (2) **Your** spouse, if living; (3) **Your** estate. **We** reserve the right to pay up to \$1,000 of such benefits otherwise payable to **Your** estate to someone related to **You** by blood or marriage who **We** deem to be an appropriate person to receive such payment. **We** will be discharged to the extent of any such payment made in good faith.

How to Appeal a Claim Decision

If **You** believe **Our** claim decision is in error, **You** or **Your Representative** should send **Us** a full explanation (no special form needed) that tells **Us** why **You** feel **We** should change **Our** decision. Include the names, addresses, and phone numbers of any provider(s) who **You** think **We** should contact to learn more about **Your** health and the care **You** received.

Once **We** complete **Our** review, **We** will notify **You** in writing and pay any benefits then due as a result of **Our** reconsideration.

Erroneous Payment(s) of Benefits

If **We** have made payments that are not required by the Policy, such payments must be promptly returned to **Us**. If such payments are not repaid, **We** will reduce future benefit payments otherwise due under this Policy as repayment or take any other legal action **We** deem necessary.

PREMIUMS

When Premiums are Due

The first premium payment is due on the Policy Effective Date. Premiums, after the first, are due annually, semiannually, quarterly, monthly or for any other period which **We** and **You** have agreed upon. The premiums and how often premiums are to be paid are shown in the Policy Schedule page. All premiums are payable at **Our** Home Office or as otherwise instructed by **Us** in writing.

Renewability

This Policy is **Guaranteed Renewable**. **We** cannot cancel or refuse to renew this Policy. To keep this Policy in force, **You** need only pay the premiums on time.

Waiver of Premium

While **Your** policy is in force, **We** will waive premium payments which fall due once **You** have satisfied these conditions:

- (1) **You** have completed the **Benefit Waiting Period**; and,
- (2) **You** are receiving **Nursing Facility Care Benefits** or **Home and Community-Based Care Benefits**.

Once **You** become eligible for the **Waiver of Premium**, **We** will refund premium(s) paid for any period during which the **Waiver of Premium** is in effect.

We will stop waiving **Your** premium(s) when **You** are no longer receiving **Nursing Facility Care Benefits** or **Home and Community-Based Care Benefits** for 30 consecutive days.

To cover the period of time from when the **Waiver of Premium** ends to the due date of **Your** next regularly scheduled premium, **You** will be charged a pro-rata portion of **Your** premium.

NOTE: The **Waiver of Premium** will *NOT* apply during the time **You** are *ONLY* receiving the **Respite Care** benefit, the **Care Management** benefit, the **Caregiver Training** benefit, or the **Emergency Response System** benefit.

Grace Period/Lapse

This Policy has a 31 day Grace Period. If any premium is not paid on or before the date it is due, it may be paid during the following 31 days. The Policy will remain in effect during these 31 days.

If the premium is not paid by the end of the **Grace Period**, the Policy will be terminated (Lapse) as of the due date; except if the **Third Party Notification Option** has been elected.

Third Party Notification Option

To avoid the unintentional **Lapse** of **Your Policy**, **You** may designate a person, in addition to **Yourself**, to be notified by **Us** when **Your** premium is overdue. This designation will extend the 31 day **Grace Period** by an additional 30 days from the date **Your** designee is notified of **Your** late premium. If **Your** premium has **NOT** been received by the end of this additional 30 day period, **Your Policy** will Lapse.

The designee will be deemed to receive the notification five business days after it is mailed. **We** will not extend **Your Grace Period** unless **You** elect this **Third Party Notification Option**. **You** have the right to change **Your** designee at any time by notifying **Us**.

Extension of Benefits

Termination of **Your Policy** shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while **Your Policy** was in force and continues without interruption after termination. The **Extension of Benefits** beyond the period **Your Policy** was in force is limited to the duration of the benefit period, if any, or to payment of the maximum benefits and is subject to the **Benefit Waiting Period**, and all other applicable provisions of the Policy.

Reinstatement

If this policy has Lapsed for non-payment of premium, it may be put back in force (reinstated) within one year of the date of Lapse after **We** receive the following:

1. a properly completed application for **Reinstatement**;
2. proof of insurability satisfactory to **Us**; and,
3. payment of all premiums due.

You will be notified in writing whether **Your** application for **Reinstatement** has been approved. If **We** do not give **You** this notice within 45 days after **We** receive the above items, **Your** insurance will be **Reinstated**.

Merely remitting a premium will not **Reinstate** this Policy. Any premium remitted without an application for **Reinstatement** will be refunded.

The time periods for contesting a **Reinstated Policy** will start from the date **We** approve the **Reinstatement**, not the total time the Policy has been in force (refer to the section entitled "**Incontestability - Time Limit On Certain Defenses**").

NO benefits are payable for **Covered Expenses** that were incurred during a Lapse prior to **Reinstatement**.

Reinstatement Due to Unintentional Lapse

If **Your Policy** was terminated due to non-payment of premiums, **You** or **Your Representative** may request that **Your Policy** be **Reinstated** by providing **Us** with proof that **You** suffered **Severe Cognitive Impairment** during the **Grace Period** and by submitting all past-due premiums. The request for **Reinstatement** must be made within nine months after **Your** coverage has Lapsed. If **Your Policy** is **Reinstated**, **We** will treat this Policy as if there had been no Lapse in coverage.

GENERAL PROVISIONS

The Contract

This Policy, including **Your** application and any attached papers, represents the entire contract between **You** and **Us**. No change in this Policy will be effective unless it is made in writing and is approved by an executive officer or registrar of TIAA-CREF Life.

Any change must also be approved by **You** or be required by law, unless **We** have the right to make the change on **Our** own. This contract is governed by the state in which it was issued as of the Policy Effective Date shown on the **Policy Schedule** page.

Benefit Changes

You may be eligible to make changes to **Your** benefits. All changes must be approved by **Us** in writing and may require proof of insurability satisfactory to **Us**. Changes to benefits may impact **Your** premiums. Contact **Us** for details.

Misstatement of Age

If **Your** age has been misstated in **Your** application, any amounts payable under this Policy will be the amount that the premiums paid would have purchased at the correct issue age. If, based on **Your** true age, **We** would not have issued this Policy, this Policy will be void and **We** will only be liable for the refund of all premiums **You** paid, less any benefits **We** paid.

Incontestability - Time Limit On Certain Defenses

Our right to contest this Policy is limited as follows:

1. If this Policy has been in force for less than six months, **We** may rescind the Policy or deny an otherwise valid claim upon showing of misrepresentation that is material to **Our** acceptance for coverage.
2. If this Policy has been in force for at least six months but less than two years, **We** may rescind the Policy or deny an otherwise valid claim upon showing of misrepresentation that is material to acceptance for coverage and which pertains to the condition for which benefits are sought.
3. After this Policy has been in force for two years, it is not contestable upon grounds of misrepresentation alone; **We** may contest the Policy only upon showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

However, if this Policy is **Reinstated** for any reason other than **Reinstatement Due to Unintentional Lapse**, **We** have the right to contest it (based only on answers to questions in **Your** application for **Reinstatement**). Using the rules above, the time periods for contesting the **Reinstated** Policy will start from the date **We** approve **Reinstatement**, not the total time the Policy has been in force.

General Provisions (Continued)

When Your Coverage Begins

Coverage under this Policy begins on the Policy Effective Date shown in the Policy Schedule page.

When Your Coverage Ends

Your coverage ends when one of the following occurs:

1. **Your Death.** This insurance will automatically terminate on the date of **Your** death. **We** will refund to **Your** estate the pro-rata premium paid for coverage after the date of **Your** death.
2. **Benefits Are Exhausted.** This insurance will automatically terminate if **Your Lifetime Benefit Maximum** has been exhausted.
3. **Lapse Due To Non-payment Of Premium.** This insurance will automatically terminate upon Lapse as indicated in the "**PREMIUMS**" section.

Legal Action Against Us

You cannot sue **Us** to obtain benefits under this Policy before 60 days after written proof of eligibility for benefits has been given as required by this Policy. **You** cannot sue **Us** at all under this Policy unless suit is brought within three years from the time written proof of eligibility for benefits is required to be given.

Cash/Loan Value

This Policy has no cash or loan value.

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TIAA-CREF Life Insurance Company
730 Third Avenue
New York, NY 10017-3206

APPLICATION FOR LONG-TERM CARE INSURANCE

Please fill in all information requested, and answer all questions. This Application must be completed and signed by the individual who is applying for coverage. If you have questions about this long-term care insurance, or if you would like assistance completing this Application, call us TOLL FREE at 1 800 223-1200, weekdays between 8:00 a.m. and 11:00 p.m., Eastern Time.

Application For: New Policy Reinstatement Change of Coverage

SECTION A: Applicant Information

1. Name DRISCOLL Leo J.
Last Name First Name Middle Initial
2. Sex Male Female
3. Social Security No. [REDACTED]
4. Date of Birth 11 / 14 / 1926
Month Day Year
5. Residence 415 EAST 12th Ave Spokane WA
Street City State ZIP
6. Telephone: Day () (509) 747-7468 Evening () same Email address _____
7. Are you employed? Yes Employer _____ Occupation _____ No
8. Are you retired? Yes Date Retired 7-1-97 No
9. Did you retire for any reason related to your health? Yes No If yes, please explain: _____

10. Are you applying for coverage through an employer-sponsored or association plan? Yes No
(If yes, please complete questions 11 & 12.)
11. Name of Sponsoring Employer/Association Plan: (PRIOR EMPLOYER) Gonzaga University TIAA-CREF
12. Who is affiliated with this Employer or Association? Self Spouse Other
If other than self, provide Name _____ Social Security No. _____
13. Marital Status (check one): Married Single Widowed Divorced Other
If married, Name of Spouse MARY THERESE DRISCOLL
Social Security No. _____ Date of Birth 8 / 15 / 1931
Month Day Year
- Does your spouse have, or is he/she applying for, a long-term care policy from TIAA-CREF Life? Yes No
14. Are you or a family member currently or formerly employed by:
 K-12 School College, University or nonprofit education or research institution Other

SECTION B: Initial Screening of Your Insurability

If you answer "YES" to any of the following questions in section B, we regret that we are unable to offer you long-term care insurance at this time.

1. Are you covered by Medicaid (not Medicare)? Note: Medicaid is not the same as Medicare. Yes No
2. Have you had, do you currently have, or have you been medically diagnosed as having:
- | | |
|--|--|
| a. Senility? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | l. More than one transient ischemic attack (TIA)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| b. Dementia? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | m. Combination of stroke and TIA? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| c. Memory loss? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | n. Diabetes in combination with stroke? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| d. Alzheimer's disease? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | o. Diabetes in combination with TIA? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| e. Acquired immune deficiency syndrome (AIDS)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | p. Diabetes in combination with peripheral vascular disease? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| f. AIDS-related complex (ARC)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | q. Post-polio syndrome? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| g. Parkinson's disease? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | r. Chronic kidney disease? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| h. Multiple sclerosis? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | s. Cirrhosis? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| i. Lou Gehrig's disease (ALS)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | t. Metastatic cancer (spread from original site)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| j. Paralysis? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| k. More than one stroke? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
3. Have you been diagnosed or treated for cancer of the:
- | | | | | | |
|---|-----|----|---|-----|----|
| Within the past 12 months: | Yes | No | Within the past 48 months: | Yes | No |
| a. Bladder? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | h. Brain? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| b. Breast? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | i. Esophagus? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| c. Colon? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | j. Liver? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| d. Prostate (with no lymph node involvement)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | k. Pancreas? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| Within the past 36 months: | | | l. Stomach? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| e. Lung? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| f. Ovary? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| g. Uterus (with no lymph node involvement)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |

TIAA-CREF-07-05/02PW1149

[REDACTED]

[REDACTED]

SECTION B: Initial Screening of Your Insurability (continued)

4. In the past 24 months have you:
- | | | | | | |
|--|--------------------------|-------------------------------------|--|--------------------------|-------------------------------------|
| | Yes | No | | Yes | No |
| a. Been confined to a nursing home?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | c. Received home care services?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Been in an assisted living facility?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | d. Used an adult day care facility?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
5. In the past 12 months have you been diagnosed or treated for:
- | | | | | | |
|--|--------------------------|-------------------------------------|-----------------------------------|--------------------------|-------------------------------------|
| | Yes | No | | Yes | No |
| a. Transient ischemic attack (TIA)?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | c. Congestive heart failure?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Stroke?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | | | |
6. In the past 6 months have you had:
- | | | | | | |
|-------------------------|--------------------------|-------------------------------------|------------------------|--------------------------|-------------------------------------|
| | Yes | No | | Yes | No |
| a. A heart attack?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | d. Spine surgery?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Heart surgery?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | e. Hip surgery?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| c. Back surgery?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | | | |
7. Do you currently use:
- | | | | | | |
|-----------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|-------------------------------------|
| | Yes | No | | Yes | No |
| a. A wheelchair?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | c. Oxygen?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. A walker?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | d. Kidney dialysis?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
8. Do you currently require the assistance of another person when performing any of the following daily activities:
- | | | | | | |
|-----------------------------|--------------------------|-------------------------------------|--|--------------------------|-------------------------------------|
| | Yes | No | | Yes | No |
| a. Taking medications?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | e. Dressing?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Walking?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | f. Getting in and out of a bed?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| c. Eating?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | g. Getting in and out of a chair?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| d. Bathing?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | h. Using the toilet?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
9. Do you currently have any surgery planned?..... Yes No

If you answered "NO" to all of the questions in section B, please continue to complete the remainder of this Application so that we can fully evaluate your insurability.

SECTION C: Medical History

1. Height: 5 ft. 10 1/2 in. Weight: 210 lbs.

2. In the past 5 years have you been diagnosed or treated for:
- | | | | | | |
|---|--------------------------|-------------------------------------|---|--------------------------|-------------------------------------|
| | Yes | No | | Yes | No |
| a. Frequent or persistent forgetfulness?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | s. Hodgkin's disease?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Stroke?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | t. Lymphoma?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| c. Transient ischemic attack (TIA)?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | u. Leukemia?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| d. Seizure disorder?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | v. Other blood disorder?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| e. Brain tumor?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | w. Emphysema?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| f. Brain disorder?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | x. Chronic obstructive pulmonary disease (COPD)?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| g. Congestive heart failure?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | y. Asthma?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| h. Heart attack?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | z. Shortness of breath?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| i. Angina?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | aa. Diabetes?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| j. Irregular heartbeat?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | bb. High blood pressure?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| k. Other heart disease?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | cc. Dizziness?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| l. Arthritis?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | dd. Fainting?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| m. Osteoporosis?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | ee. Tremors?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| n. Joint replacement?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | ff. Blackout spells?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| o. Disabling back or spine condition?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | gg. Injuries due to falls, or imbalance?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| p. Hip fracture?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | hh. Depression?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| q. Other fractures?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | ii. Schizophrenia?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| r. Cancer?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | jj. Mental illness?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

SECTION C: Medical History (continued)

3. In the past 36 months have you been treated, hospitalized or counseled for the use of:

- | | | | | | |
|--------------------|--------------------------|-------------------------------------|-----------------------|--------------------------|-------------------------------------|
| | Yes | No | | Yes | No |
| a. Alcohol?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | c. Amphetamines?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Sedatives?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | d. Narcotics?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Please provide all details relating to any "YES" box checked above in Section C, including diagnoses, treatments, hospitalizations, and medications. (If you need more space, please use a separate sheet of paper; sign and date the separate sheet and include it when you mail this Application.)

Question Letter	Dates	Name, Address, and Telephone Number of Attending Physician(s)	Full Details
-----------------	-------	---	--------------

SECTION D: Primary Physician & Medications

1. Please provide the following information about your Primary Physician:

Name DR. Thomas Loselle Address Rockwood Clinic, 400 5th Avenue, Spokane WA 99220 Tele. No. 509-838-2531
 Date Last Consulted Aug. 2001 Reason Back + leg pain - see typewritten sheet attached.

2. Provide the following information about any other physicians consulted in the past two years. (If none, write NONE.)

Physician's Name	Address & Telephone No.	Date	Reason
<u>See typewritten attachment.</u>			

3. What prescription or nonprescription medication do you currently take? (If none, write NONE.)

Medication	Dosage	Frequency	Reason
<u>One Baby Aspirin</u>	<u>81mg.</u>	<u>Daily</u>	<u>Medics tout it as a good idea.</u>

SECTION E: Personal Activities

1. Within the past 12 months has there been any interruption in your regular daily activities due to:

- | | | | | | |
|---------------------|--------------------------|-------------------------------------|---------------------------|-------------------------------------|--------------------------|
| | Yes | No | | Yes | No |
| a. Disability?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | b. Health condition?..... | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

2. Do you currently require assistance with any of the following daily activities:

- | | | | | | |
|-------------------|--------------------------|-------------------------------------|-------------------------------|--------------------------|-------------------------------------|
| | Yes | No | | Yes | No |
| a. Shopping?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | c. Doing housework?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Cooking?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | d. Using transportation?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

3. Do you have any uncorrected impairment of:

- | | | | | | |
|-----------------|--------------------------|-------------------------------------|------------------|-------------------------------------|--------------------------|
| | Yes | No | | Yes | No |
| a. Vision?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | b. Hearing?..... | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

SECTION E: Personal Activities (continued)

4. In the past 3 years have you:
- | | | | | | |
|---|--------------------------|-------------------------------------|---|--------------------------|-------------------------------------|
| | Yes | No | | Yes | No |
| a. Stopped driving because of health problems?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | b. Had your driver's license revoked or suspended for driving under the influence of drugs or alcohol?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
5. Do you currently use:
- | | | | | | |
|-------------------|--------------------------|-------------------------------------|----------------------------------|--------------------------|-------------------------------------|
| | Yes | No | | Yes | No |
| a. A cane?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | c. Other assistive devices?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. Crutches?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> | | Yes | No |
| | | | | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
6. In the past 12 months have you smoked any cigarettes?..... Yes No

Please provide all details relating to any "YES" box checked above in Section E. (If you need more space, please use a separate sheet of paper; sign and date the separate sheet and include it when you mail this Application.)

Section E, para 3 b. I have moderate impairment of hearing high frequency sounds.

Section E, para 1 b. The back and leg pain referenced in the fourth para of the typewritten attachment slowed me down for awhile.

SECTION F: Replacement Questions

Regulations of certain states require that we ask the following questions. You must answer all 5 questions before we can process this form.

1. Do you have another long-term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No
2. Did you have a long-term care insurance policy or certificate in force during the last 12 months? Yes No
 If "YES," Insurance Company Name: _____
 If that policy lapsed, when did it lapse? _____
3. Do you intend to replace any of your medical or health insurance coverage with this policy? Yes No
 If "YES," Insurance Company Name: _____
 Policy # _____
 Insurance Company Address: _____
4. Have you ever applied for life, health, disability or long-term care insurance that has been declined, postponed, or substantially limited by the insurer? Yes No
 If "YES," please indicate type of insurance, date applied for, and reason for declination, postponement, or limitation:

5. Are you receiving disability income, Workers' Compensation, Social Security Disability Income, or any other state or federal disability benefits? Yes No
 If "YES," please state type of benefit(s) being received and cause of disability:

SECTION G: Plan Desired

Please indicate your Plan Option: _____ (Refer to the Benefits Summary & Cost Chart.)

OR

Select Your Own Plan: If you want to customize your coverage, please choose your benefits below by selecting one option under each category. (Refer to the Guide to Benefits & Features. Call 1 800 223-1200 or visit our Web Center for rates.)

Nursing Facility Daily Benefit Maximum	Home Care Daily Benefit Maximum	Benefit Period	Benefit Waiting Period	Inflation Options	Optional Coverage (You may choose more than 1 option.)
<input type="checkbox"/> \$130 <input type="checkbox"/> \$180 <input type="checkbox"/> \$200 Other \$ <u>1100</u> Minimum \$40 Maximum \$300 (in \$10 increments)	<input checked="" type="checkbox"/> 50% of Nursing Facility Daily Benefit Maximum	<input type="checkbox"/> 3 Years <input checked="" type="checkbox"/> 5 Years <input type="checkbox"/> 7 Years <input type="checkbox"/> Lifetime (Unlimited)	<input type="checkbox"/> 30 Days <input checked="" type="checkbox"/> 90 Days <input type="checkbox"/> 365 Days	<input type="checkbox"/> Periodic Inflation Additions (available through age 74) <input checked="" type="checkbox"/> 5% Compound Inflation	<input checked="" type="checkbox"/> Shared Care* 3- and 5-Year Benefit Periods only. <input checked="" type="checkbox"/> Survivor Waiver Premium* <input type="checkbox"/> Nonforfeiture Benefit

*When Shared Care and/or Survivor Waiver are elected, both spouses must elect identical benefit options.

SECTION H: Premium Payments

1. Please check the Payment Method desired:

	Monthly	Quarterly	Semi-Annual	Annual
Electronic Funds Transfer (EFT)	<input checked="" type="checkbox"/>	NA	NA	NA
Annuity Deduction*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Direct Bill	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Payroll Deduction**	<input type="checkbox"/>	NA	NA	NA

*Election must coincide with annuity payment mode.

**If your employer sponsors this plan and offers payroll deduction, please complete the enclosed payroll deduction form.

2. Your Bank Account You must complete this section if you elected to pay premiums by Electronic Funds Transfer (EFT).

Account Type: Checking or Savings Account No. _____ Bank Transit No.* See check attached

Name(s) on Account Leo J. OR MARY Therrell DRISCOLL

Name and Address of Bank _____

Signature of Account Holder Leo J. Driscoll Date June 5, 2002

*Refer to the bottom of your check for the 9-digit number. ATTACH YOUR VOIDED CHECK.

3. TIAA-CREF Annuity Payments Deduction Authorization

You must complete this section if you wish to pay long-term care premiums by having amounts deducted from your TIAA or CREF periodic retirement annuity payments. You must be receiving TIAA or CREF periodic retirement annuity payments in order to use this method of long-term care premium payment.

I AUTHORIZE Teachers Insurance and Annuity Association ("TIAA"); College Retirement Equities Fund ("CREF") to deduct from my TIAA or CREF periodic retirement annuity payments due under the TIAA Annuity Contract or the CREF certificate specified below, the amount necessary to pay the required premiums for this insurance policy issued to me and/or the insurance policy issued to my spouse:

Name of Applicant _____ Name of Contract Holder _____ Check here if same

TIAA Annuity Contract or CREF Certificate No. _____

Signature of Annuity Contract or CREF Certificate Holder _____

This authorization may be cancelled by me at any time, effective upon receipt by TIAA-CREF of my written notice to cancel sent to the following address: TIAA-CREF • 730 Third Ave. • New York, NY 10017-3206.

[REDACTED]

[REDACTED]

4. Third Party Notification Option/Protection Against Unintended Lapse

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

I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium.

Name of Designee MARY T. DRISCOLL Relationship Spouse

Address 415 E. 12th Ave

City Spokane State WA Zip 99202 Telephone 509 838 6131

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

[Signature]
Signature Indicating Waiver of Option

June 5, 2002
Date

SECTION I Authorization

Information in this Application is given to obtain insurance and is true and complete to the best of my knowledge and belief.

I understand and agree that the insurance applied for will not take effect until a Policy is issued by TIAA-CREF Life Insurance Company ("TIAA-CREF Life").

I agree that if any of the above answers and statements become untrue or incomplete prior to the time the insurance applied for becomes effective, I will immediately so notify TIAA-CREF Life.

I AUTHORIZE any licensed physician, medical practitioner, psychiatrist, psychologist, hospital, Veterans Administration clinic or other medical or medically related facility, or mental health facility, insurance company, or employer having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me, or any records or knowledge of me or my health as it relates to underwriting, to give to TIAA-CREF Life or its reinsurers, any such information.

I UNDERSTAND that the information obtained by use of this Authorization will be used by TIAA-CREF Life only to determine my eligibility for insurance. Any information obtained will not be released by TIAA-CREF Life to any person or organization in an individually identifiable form EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my Application for insurance, or as may be otherwise lawfully required or as I may further authorize.

To facilitate rapid submission of such information, I authorize all said sources to give such records or knowledge to any agency employed by TIAA-CREF Life to collect and transmit such information. A photographic copy of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for 2 years from the date shown below, and that upon request I or my authorized representative have a right to receive a copy of this Authorization.

CAUTION: If your answers on this Application fail to include all material medical information as requested, TIAA-CREF Life has the right to deny benefits or rescind your policy.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an Application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

* Signature of Applicant

[Signature]

* Please Print Name

LEO J. DRISCOLL

July 1, 2002

Application of Leo J. Driscoll

Relevant to Section D: Primary Physician & Medications

Paragraphs 1 and 2. Information about any physicians consulted in the past two years:

- July 3, 2000 I had a routine eye examination by Dr. Mark Ryder at the Rockwood Clinic Eye Center, now located at 510 S. Cowley, Spokane, Washington, 99202, telephone (509) 838-2531. I was given an updated prescription for eye-glasses.
- In September, 2000, while vacationing at the Oregon Beach, I experienced persisting pains in the chest and belching causing me concern whether I could possibly be having some sort of heart problem. To be safe, I checked myself into the Emergency facilities at Samaritan North Lincoln Hospital at Lincoln City, Oregon. The attending physician, whose name I do not recall, gave me various tests and concluded that it was unlikely that my problems were related to heart. I later recalled that I had consumed a lot of coffee that day in our motel room. I now avoid caffeine.
- In January, 2001 I had a routine physical exam by my primary physician, Dr. Thomas Laselle, Rockwood Clinic, 400 5th Avenue, Spokane, WA 99220, telephone (509) 838 2531.
- In August, 2001, I visited with Dr. Laselle regarding pain in my back and leg. He gave me back exercises to perform. After doing those exercises for about 2 weeks the pain disappeared and I have been essentially pain free since.
- In April, 2002 I experienced eye discomfort and visited Dr. Mulvilhill at the Rockwood Clinic Eye Center (see address in first para above). He removed some foreign material from my eye, probably resulting from some concrete floor- grinding work that I had been doing at my home. He gave me some medication and the problem went away the next day.

Leo J. Driscoll
June 5, 2002

July 29, 2002

TIAA CREF
730 third Avenue
New York, NY 10017-3206

Attention: Katrina Patterson
LTC Service Representative

TLIAM

SSA

533-20-8482

policy#

09852450

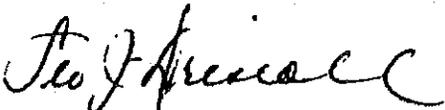
Dear Ms. Patterson:

This answers your letter of July 24, 2002 in which you erroneously state that "Integrated Assessment Services Network has been unable to schedule an assessment interview with you."

Your earlier letter of July 9, 2002 made the same erroneous statement. Promptly after receiving that letter I telephoned you and specifically told you that the nurse from Integrated Assessment Services Network had come to my house and conducted the interview with me on July 3, 2002. She left her card; it identifies her name as Marcella Burau, telephone (208) 661-4151.

I assume that Ms. Burau sent in a report in whatever was the routine manner after she completed her July 3rd interview with me. May I suggest that you pick up your phone, call her, and/or do whatever is necessary to locate her report.

Thank you,



Leo J. Driscoll
415 East 12th Avenue
Spokane, Washington, 99202
(509) 747 7468

[Certified Mail, Return Receipt Requested]

TIAA-CREF 08/01/02 PM 04:38



TIAA-CREF Life Insurance Company

730 Third Avenue

New York, NY 10017-3206

212 490-9000 1 800 223-1200

INFLATION PROTECTION OPTION RIDER
5% Compound Inflation Option

Insured: MR LEO J DRISCOLL
Policy Effective Date: August 1, 2002

Policy Number: 09852450
Rider Effective Date: August 1, 2002

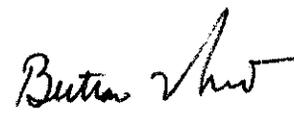
This Rider is attached to and made part of the Policy that was issued to **You** by TIAA-CREF Life Insurance Company. The rights provided by this Rider are subject to the terms and conditions of this Rider and the Policy. This Rider is effective as of the Rider Effective Date indicated above. Premiums for this Rider are shown on the **Policy Schedule** page in **Your Policy**.

On each anniversary of **Your Policy Effective Date** **We** will increase by 5%, compounded annually, all of **Your Daily Benefit Maximums** and **Your Lifetime Benefit Maximum** shown on the **Policy Schedule** page.

Before **We** increase **Your Lifetime Benefit Maximum**, it will be reduced by benefits **We** paid for **Covered Expenses** incurred before the anniversary of **Your Policy Effective Date**.

The amount of the benefit **We** will pay is determined as of the date **You** incur a **Covered Expense**, not as of the date **You** apply for benefits.

If **You** elected the "Lifetime (Unlimited) Benefit Period" option, **NO** adjustments will be made to **Your Lifetime Benefit Maximum**.


President



TIAA-CREF Life Insurance Company

730 Third Avenue
New York, NY 10017-3206
212 490-9000 1 800 223-1200

SPOUSAL DISCOUNT

Insured: MR LEO J DRISCOLL

Policy Number: 09852450

Policy Effective Date: August 1, 2002

Rider Effective Date: August 1, 2002

This Rider is attached to and made part of the Policy that was issued to **You** by TIAA-CREF Life Insurance Company. The rights provided by this Rider are subject to the terms and conditions of this Rider and the Policy. This Rider is effective as of the Rider Effective Date indicated above.

A discount has been applied to **Your** premiums, as reflected on the **Policy Schedule** page, and will remain in effect as long as **You** and **Your** spouse:

1. are members of the same household (i.e., living at the same address);
2. are each issued a Teachers Select Care policy from Teachers Insurance and Annuity Association, and/or a policy with the form number "TCL-LTC.04" from TIAA-CREF Life Insurance Company; and,
3. keep both applicable Policies in force (unless one Policy ends due to death).

This discount will also remain in effect during the time **You** or **Your** spouse are receiving the **Waiver of Premium** benefit.


President



TIAA-CREF Life Insurance Company
730 Third Avenue
New York, NY 10017-3206
212 490-9000 1 800 223-1200

SHARED CARE BENEFIT OPTION RIDER

Insured: MR LEO J DRISCOLL
Policy Effective Date: August 1, 2002
Spouse: MARYTDRISCOLL

Insured's Policy Number: 09852450
Rider Effective Date: August 1, 2002
Spouse's Policy Number: 09852468

Rider Contract

This Rider is attached to and made part of **Your Policy**. The rights provided by this Rider are subject to the terms and conditions of this Rider and of the Policy. However, in the case of any conflict between the provisions of this Rider and of the Policy, the provisions of this Rider shall govern. This Rider is effective as of the **Rider Effective Date** above. Premium for this Rider is shown on the Policy Schedule page of **Your Policy**.

Shared Care Benefit

While **Your Policy** and this Rider are in-force, should **Your spouse** exhaust the **Lifetime Benefit Maximum** under **Your spouse's Policy**, this **Shared Care Benefit Option Rider** will enable **Covered Expenses** incurred by **Your spouse** to be paid under **Your Policy**.

Conditions for Eligibility

Your spouse is eligible for the benefit provided by this Rider after all of the following conditions have been met:

1. **You** are named as the spouse in **Your spouse's Shared Care Benefit Option Rider**;
2. The **Policy Effective Date** in **Your Policy** and in **Your spouse's Policy** is identical;
3. The state where **Your Policy** and **Your spouse's Policy** is issued from is identical;
4. **Your Policy** and **Your spouse's Policy** have the following identical benefit levels and benefit options*:
 - a. Shared Care Benefit Option Rider;
 - b. Benefit Waiting Period;
 - c. Optional Benefit Rider(s);
 - d. **Daily Benefit Maximum** for **Nursing Facility Care** and for **Home and Community-Based Care**;
 - e. **Lifetime Benefit Maximum**;
5. **Your spouse** continues to meet the Benefit Eligibility Requirements under **Your spouse's Policy**;
6. The **Lifetime Benefit Maximum** in **Your spouse's Policy** has been exhausted;
7. The **Lifetime Benefit Maximum** in **Your Policy** has not been exhausted; and
8. **Your Policy** and this Rider are not contestable.

* This does not include the acceptance of benefit increases provided by the **Agreement for Periodic Inflation Additions Rider**, if included in **Your Policy** or in **Your spouse's Policy**.

Covered Expenses

On and after the date that **Your** spouse is eligible for the Shared Care Benefit Option, **We** will pay for **Covered Expenses** incurred by **Your** spouse up to the applicable **Daily Benefit Maximum** under **Your** spouse's Policy.

The **Lifetime Benefit Maximum** in **Your** Policy will be reduced by payments made for **Covered Expenses** incurred by **Your** spouse and paid pursuant to this Rider. Benefits paid for **Covered Expenses** incurred by **You** and **Your** spouse may not exceed the **Lifetime Benefit Maximum** in **Your** Policy.

If the amount of the **Lifetime Benefit Maximum** under **Your** spouse's Policy has not been exhausted but is less than a **Covered Expense**, **We** will pay the remainder of such expense from the **Lifetime Benefit Maximum** under **Your** Policy. The total amount paid for that **Covered Expense** may not exceed the applicable **Daily Benefit Maximum** in **Your** spouse's Policy.

You and **Your** spouse may both receive benefits under **Your** Policy at the same time. If that happens, **Covered Expenses** incurred by **You** will be payable up to the applicable **Daily Benefit Maximum** in **Your** Policy and **Covered Expenses** incurred by **Your** spouse will be payable up to the applicable **Daily Benefit Maximum** in **Your** spouse's Policy.

If **Your** Policy includes an **Agreement For Periodic Inflation Additions Rider**, **We** will continue to offer **You** inflation additions in accordance with the terms of that Rider while **Covered Expenses** incurred by **Your** spouse are being paid.

Waiver of Premium

The Waiver of Premium provision in **Your** Policy will apply only if **You** are receiving benefits under **Your** Policy. Premium payments under **Your** Policy will not be waived due to **Your** spouse receiving benefits under **Your** Policy.

If **Your** Policy's **Lifetime Benefit Maximum** is exhausted, **Your** Policy will remain in-force and premium payments will be waived until:

1. The **Lifetime Benefit Maximum** under **Your** Policy and **Your** spouse's Policy is exhausted; or
2. The death of both **You** and **Your** spouse.

Once **Your** **Lifetime Benefit Maximum** is exhausted, **We** will not offer **You** inflation additions under the **Agreement for Periodic Inflation Additions Rider**, if applicable, and **You** cannot purchase additional amounts of coverage.

Policy Continuation

If **You** die and the **Lifetime Benefit Maximum** under **Your** Policy has not been exhausted, the remaining **Lifetime Benefit Maximum** under **Your** Policy will be available to pay for **Covered Expenses** incurred by **Your** spouse.

Reinstatement

To reinstate this Rider if it has lapsed for non-payment of premium, **You and Your spouse** must satisfy the requirements of the "Reinstatement" provision in each of **Your Policies**.

Change of Spouse

~~You may not change Your spouse on this Rider. You must provide Us with written notice that You elect to terminate this Rider.~~

Termination of this Rider

This Rider will terminate on the earliest of the following:

1. The date **Your Policy** or **Your spouse's Policy** terminates for any reason, except for the death of either spouse; or,
2. The date **We** receive written notice that **You** elect to terminate this Rider; or,
3. The date **Your spouse's Shared Care Benefit Option Rider** terminates for any reason, except for the death of **Your spouse**; or,
4. The date **You** elect to revise **Your Policy** causing the benefit levels or the benefit options under **Your Policy** to no longer be identical to those under **Your spouse's Policy***; or,
5. The date the **Lifetime Benefit Maximum** is exhausted under both **Your Policy** and **Your spouse's Policy**; or,
6. The date **Your Policy** is placed on a nonforfeiture status, if applicable to **Your Policy**.

* This does not include the acceptance of benefit increases provided by the **Agreement for Periodic Inflation Additions Rider**, if included in **Your Policy** or **Your spouse's Policy**.


President

Care Advisor

A **Care Advisor** is a licensed health care practitioner (such as a licensed physician, registered nurse, or licensed social worker) employed by or under contract to, a **Care Management Organization**. This individual is qualified by training and experience to assess and coordinate the overall medical, personal and social service needs of a person who suffers long-term physical or cognitive disability.

Care Management Organization

A **Care Management Organization** is an organization, with whom **We** contract, which is appropriately licensed and legally authorized to engage in providing care management services and:

1. has a staff, including at least one registered nurse (R.N.) and one social worker, who has a master's degree from an accredited school of social work;
2. has a full-time administrator;
3. maintains written records of services provided to each client; and,
4. provides services which include but are not limited to:
 - a. assessing the individual's condition to determine what resources and services are necessary and by whom they might be most appropriately delivered;
 - b. coordinating elements of a **Plan of Care**;
 - c. making referrals to the appropriate medical or social services personnel or agency;
 - d. monitoring such services with respect to utilization and quality; and,
 - e. monitoring and assessing the status and needs of the client.

Chronically Ill Individual

A **Chronically Ill Individual** is defined as a person who has been **Assessed** in the past 12 months by a **Care Advisor** or, by **Your** personal physician as:

1. being unable to perform (without **Substantial Assistance** from another individual) at least 2 out of **6 Activities of Daily Living** for a period of *at least 90 days* due to a loss of functional capacity; or,
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**.

Definitions (Continued)

Covered Expenses

Covered Expenses are charges incurred for **Qualified Long-Term Care Services** that are reimbursed subject to the provisions entitled **Eligibility for the Payment of Benefits, Assessment** and all other applicable terms of this Policy.

Daily Benefit Maximum

The **Daily Benefit Maximum** is the maximum amount that **We** will pay for **Covered Expenses** incurred per day, for Nursing Facility Care or Home and Community-Based Care.

Your Daily Benefit Maximums are shown on the **Policy Schedule** page.

Durable Medical Equipment

Durable Medical Equipment is equipment that meets all of the following tests:

1. it can withstand repeated use;
2. it is designed and used only to assist with **Activities of Daily Living** or to treat a sickness or injury;
3. it has no value, other than incidental value, to **You** or **Your** family in the absence of the condition for which it is intended;
4. it is not an item commonly found in households;
5. it is not sporting or athletic equipment; and,
6. it is not intended solely for the convenience of **You** or **Your** family.

Durable Medical Equipment include:

1. walkers
2. wheelchairs
3. hospital beds
4. infusion pumps
5. ramps to permit movement from one level of the residence to another
6. grab bars

Home Health Care

Home Health Care refers to services that are provided to a patient in his or her home. Services rendered may include:

1. providing assistance with **Activities of Daily Living**;
or
2. providing supervision or safeguarding a patient due to **Severe Cognitive Impairment**; or
3. providing necessary health, medical, or personal care services such as physical therapy, speech therapy, respiratory therapy, home health aide services, nutritional services, personal hygiene services; or
4. providing home **Hospice Services**; or
5. providing homemaker services, including assistance with cleaning; laundry services; food shopping; meal preparation; transportation to accompany the insured to and from medical appointments; and administering medications.