EQUITABLE RELIEF STIPULATION AND AGREEMENT

I. PARTIES

This Equitable Relief Stipulation and Agreement (the "Agreement") is made and entered into this 24th day of August, 2012, by and among the following parties: Plaintiff Dr. WILLIAM HALL ("Plaintiff") and Defendant SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA ("SHIP"). All parties to the Agreement, and no others, are hereafter collectively referred to as the "Parties."

II. RECITALS AND INTRODUCTION

A. WHEREAS, on or about February 7, 2012, Plaintiff, individually and on behalf of a proposed class, instituted an action in the Superior Court of the State of California, County of San Bernardino, entitled *William Hall v. Senior Health Insurance Company of Pennsylvania,* Case Number CIVRS 1200996, alleging SHIP engaged in improper claims procedures and practices;

B. WHEREAS, SHIP denies the allegations in the lawsuit and believes the class action allegations are improper;

C. WHEREAS, Plaintiff is represented by Consumer Watchdog and Shernoff Bidart Echeverria Bentley LLP (collectively, "Plaintiff's Counsel");

D. WHEREAS, as a company that operates without a profit motive, SHIP maintains procedures that allow claims to be efficiently and accurately handled, while protecting SHIP and its policyholders against fraud and false claims;

E. WHEREAS, the Parties agree to accept the procedures and practices as set forth herein;

F. WHEREAS, Plaintiff has settled his individual claims with SHIP as set forth in a separate agreement entitled "Settlement Agreement and Release" to which this Agreement has been appended;

G. WHEREAS, upon execution of this Agreement, including the separate "Settlement Agreement and Release," Plaintiff will file a request for Court approval of the dismissal of the class action claims under California Rules of Court, Chapter 6, Rules 3.770 et seq.;

H. WHEREAS, no consideration has been provided by the proposed class members and no proposed class members' rights are being released pursuant to, or as a result of, this Agreement;

NOW, THEREFORE, it is agreed that, in consideration of the promises and mutual covenants set forth in this Agreement and the separate "Settlement Agreement and Release," the Parties agree to accept the procedures and practices as set forth herein.

III. DEFINITIONS

In addition to any definitions set forth above or elsewhere in this Agreement, the following terms, as used in the Agreement, shall have the meanings set forth below:

1.1. "**Benefits**" means the amount of money due to a Policyholder for payment of Home Care under the terms of a Long-term Care Policy.

1.2. "**Benefit Eligibility Assessment**" or "**BEA**" means an examination performed by SHIP or its agent for the purpose of determining whether a Policyholder qualifies for Benefits under his or her Long-term Care Policy.

1.3. "**Claim**" or "**Claims**" means any submission by a Policyholder to SHIP of a document intended to be a request for Benefits.

1.4. "**Claim Form**" means the form consisting of the "Patient Claim Form," the "Provider Claim Form," and the "Physician Claim Form," which Policyholders are required to submit to SHIP when making a First-time Claim. The Claim Form is attached as Exhibit B.

1.5. "**Claim Packet**" means the packet of informational sheets and forms SHIP will send to Policyholders inquiring about, or submitting, a new claim, which includes the FAQ Sheet, Claim Form, and Daily Visit Notes form. The Claim Packet is comprised of Exhibits A through C.

1.6. "**Claimant**" or "**Claimants**" means a Policyholder in California, or the legal representative of a Policyholder in California, who has submitted a Claim to SHIP for the payment of Benefits.

1.7. "**Court**" means the Superior Court for the State of California for the County of San Bernardino.

1.8. "**Daily Visit Notes**" or "**DVNs**" means the form titled "Daily Visit Notes," which SHIP requires Providers to fill out on a daily basis in order to log Home Care provided to the Claimant. The Daily Visit Notes form is attached as Exhibit C.

1.9. "**Frequently Asked Questions Sheet**" or "**FAQ Sheet**" means the informational sheet listing frequently asked questions and answers that SHIP will enclose with all Claim Packets, attached as Exhibit A.

1.10. "**First-time Claim**" means the form(s) or document(s) submitted to SHIP when a Claimant submits a Claim for Home Care for the first time.

1.11. "**Home Care**" means services provided to a Policyholder in the Policyholder's residence pursuant to the Long-term Care Policy.

1.12. "**License,**" "**Licensed,**" or "**Licensure**" means a state-issued license or certification a Provider receives for undergoing training for the administration of any type of care to the elderly or disabled.

1.13. "**Long-term Care Policy**" or "**Long-term Care Policies**" means an insurance policy held by a Policyholder and owned and/or administered by SHIP, which was originally issued by Conseco Senior Health Insurance Company, American Travelers Life Insurance Company, Transport Life Insurance Company, United General Life Insurance Company, and/or Continental Life Insurance Company.

1.14. "**Patient Claim Form**" means the individual form within the Claim Form that is to be filled out and signed by the Claimant.

1.15. "**Person**" or "**Persons**" means persons and entities, including, without limitation, any individuals, sole proprietorships, associations, companies, partnerships, joint ventures, corporations, trusts, estates, or any other persons or entities.

1.16. "**Physician's Claim Form**" means the individual form within the Claim Form that must be filled out by the Claimant's physician.

1.17. "**Policyholder**" means a Person insured under a Long-term Care Policy administered by SHIP.

1.18. "**Previous Claim Form Instruction Sheet**" means the instructional sheet that accompanied the claim form prior to this Agreement.

1.19. "**Provider**" or "**Providers**" means a Person, other than an immediate member of a Claimant's family, who provides Home Care to a Claimant.

1.20. "**Provider Claim Form**" means individual form within the Claim Form that must be completed by the Provider.

1.21. "**SHIP**" means Senior Health Insurance Company of Pennsylvania, and all of its direct or indirect wholly-owned subsidiaries in the United States, including but not limited to all of its and/or their subsidiary corporations, predecessors and successors in interest, and any of its or their present or former parents, subsidiaries, divisions, affiliates, officers, directors, employees, trustees, principals, attorneys, agents, representatives, sales associates, distributors, vendors, shareholders and partners, as well as any person acting or purporting to act on its and/or their behalf, including but not limited to claims administrators, or on behalf of those in privity with SHIP and the Plaintiff.

1.22. "**Special Master**" means Hon. Herbert Hoffman (Ret.), or a Person appointed by the Parties to monitor the Parties' compliance with this Agreement, as set forth in Section IV.J.2 of this Agreement.

1.23. "**Statement Confirming the Provision of Long-term Care Services**" means the form that a Claimant may substitute for Daily Visit Notes in the event that the Claimant was

not provided with, or otherwise informed of, the Daily Visit Notes form, attached as Exhibit D.

IV. AGREED UPON PRACTICES AND PROCEDURES

A. Documentation Needed to Process a First-time Claim

i. Upon being contacted by a Policyholder who wishes to submit a claim, or receipt of a First-time Claim from a Policyholder who does not submit the required forms and/or documentation, SHIP will mail a Claim Packet to a Policyholder within an average of five days.

ii. SHIP will include in a Claim Packet: a Claim Form, a "Frequently Asked Questions" or FAQ Sheet, and a Daily Visit Notes form.

iii. SHIP will make the Claim Form, FAQ Sheet, and Daily Visit Notes form available on its website, www.shipltc.com.

iv. SHIP will accept from Claimants any claim forms that were in use prior to distribution of the Claim Form required by this agreement and attached as Exhibit B.

v. If SHIP receives a letter from a Claimant's physician that sets forth the Claimant's eligibility for Benefits pursuant to SHIP's Long-term Care Policies and SHIP subsequently confirms the Claimant's eligibility, the date of the Claimant's eligibility will correspond to the date of the letter or the date identified by the physician as when eligibility began, rather than the subsequent date of SHIP's Benefits Eligibility Assessment.

B. Provider Licensure

Plaintiff alleged that SHIP violated California Insurance Code section 10232.9 by sending letters and information forms to California Claimants that improperly state that Home Care providers must be licensed for Claimants to receive Benefits for Home Care services. SHIP alleged it has never required California Home Care Providers to be licensed, a position supported by language contained in its long-term care policies. To avoid confusion to policyholders about licensure requirements in California, the Parties agreed that:

i. SHIP will not use the Previous Claim Form Instruction Sheet in California and will utilize the Claim Form attached as Exhibit B for all claims made in California.

ii. SHIP will include a question and answer in the FAQ Sheet, as set forth in Exhibit A, which states that evidence of Provider Licensure is not required to process Claims for Home Care Benefits.

C. Daily Visit Notes

Plaintiff alleged that SHIP's use of Daily Visit Notes ("DVNs") was unduly burdensome and caused unnecessary delays in the processing of claims. SHIP maintained that DVNs are standard within the long-term care industry and vital to prevent fraud and assess initial and ongoing eligibility determinations. The Parties agreed that SHIP has the right to require

Claimants to provide DVNs, and that:

i. SHIP will utilize the DVNs form attached as Exhibit C.

ii. SHIP will include the DVNs form attached as Exhibit C in the Claim Packet.

iii. SHIP will make the DVNs form attached as Exhibit C available on SHIP's website, www.shipltc.com.

iv. SHIP will accept from Claimants any DVNs forms in use prior to the execution of this agreement.

v. SHIP will include a question and answer in the FAQ Sheet, as set forth in Exhibit A, which states that DVNs must be filled out by a Provider on a daily basis, and signed by both the Claimant and the Provider on a weekly basis.

D. Statement Confirming the Provision of Long-term Care Services

i. In instances where a Claimant has received care *prior to* receiving the Claim Packet required by this Agreement, and does not have DVNs for that care, or was otherwise unaware of the DVN requirement, SHIP may accept a statement from the Claimant's Provider, pursuant to the form attached as Exhibit D.

ii. SHIP will continue to require Claimants to provide DVNs as proof of loss, unless otherwise agreed, for care received *after* the Claim Packet required by this Agreement is provided, or after the Claimant is otherwise informed of the DVN requirement.

iii. SHIP will include a question and answer in the FAQ Sheet, as set forth in Exhibit A, which states that SHIP may accept the Statement Confirming the Provision of Long-term Care Services from a Provider for past care instead of DVNs in instances where the Provider did not complete DVNs.

iv. SHIP will make the Statement Confirming the Provision of Long-term Care Services form attached as Exhibit D available on its website, www.shipltc.com.

E. Benefit Eligibility Assessment

SHIP continues to have the right to require Claimants to undergo a Benefits Eligibility Assessment ("BEA"), and nothing in this Agreement shall be construed as eliminating or affecting SHIP's right to require BEAs.

i. Notwithstanding the foregoing, if the BEA reveals a conflict with the opinions of the Policyholder's doctor, a claims representative will make reasonable efforts (at least one phone call, including leaving a voicemail with a call-back number) to contact the Policyholder's doctor in an attempt to resolve the matter before rejecting any claim based on the BEA.

ii. SHIP will also include a question and answer in the FAQ Sheet, as set forth in

Exhibit A, which states that SHIP may require a BEA.

F. Procedure When Information is Needed to Process Claims

SHIP will make reasonable efforts (at least one phone call, including leaving a voicemail with a call-back number) to verbally contact Policyholders or their designee if additional information is needed.

G. Appeals

SHIP will continue to maintain its current appeal process for Policyholders whose Claims have been denied or rejected.

H. Compliance

1. Reporting

For a period of eighteen (18) months after this stipulation goes into effect, SHIP, by and through its general counsel, Patrick Carmody, will provide reports to the Special Master demonstrating compliance with this Agreement. Those reports, which shall be privileged and confidential, shall detail (1) whether SHIP implemented and continues to maintain the procedures and forms detailed in subsections "A" through "G" of this Section; (2) the number of claims received during the reporting time period; (3) the number of appeals received; and (4) the outcome of those appeals.

The reports shall be provided every six months. The first report shall be due six months after the execution of this Agreement. The Special Master shall review the reports and issue within thirty days a written finding of compliance, non-compliance, or the need for additional information, which shall be provided to all Parties. If there is a finding of non-compliance, the Parties will be advised of the basis for a finding of non-compliance, and upon request, the Special Master shall set a hearing date relating to such non-compliance. The Parties agree that each Party's obligations under this Agreement shall not cease upon expiration of the reporting period.

2. Special Master

The Parties hereby appoint Hon. Herbert Hoffman (Ret.) as a Special Master to oversee compliance with this Agreement. In addition to receiving and reviewing the semi-annual reports set forth above, all disputes arising out of this Agreement, including motions to enforce the Agreement, shall be submitted to Judge Hoffman. If any Party or their counsel wishes to bring a dispute before Judge Hoffman, the Party or their counsel shall provide written notice to Judge Hoffman and other Parties and their counsel. Judge Hoffman shall set an expedited briefing schedule to hear such disputes, and issue a binding ruling on such disputes. However, before any Party requests a hearing before Judge Hoffman, other than relating to non-compliance under Section IV.H.1, the Party must make a good faith effort to resolve the matter with the other Party. As to SHIP, the meet and confer shall be conducted with general counsel Pat Carmody, or his designee or successor.

In the event of any such dispute, Judge Hoffman may award sanctions against SHIP in the form of reasonable attorneys' fees and/or other costs incurred as a result of such dispute. In the event that either SHIP violates this Agreement through "willful misconduct" (defined as clear and convincing evidence demonstrating an intentional violation of this Agreement or a pattern of three or more of the same violations of this Agreement during any six-month reporting period), Judge Hoffman may award monetary sanctions up to $15,000.00. If, after being sanctioned due to three or more of the same violations, SHIP violates the Agreement through three more of the same violations of this Agreement during a consecutive six-month reporting period, Judge Hoffman may award monetary sanctions up to $25,000.00. If, after being sanctioned twice due to same violations of this Agreement, SHIP violates the Agreement through three more of the same violations of this Agreement during a consecutive six-month reporting period, Judge Hoffman may award monetary sanctions up to $50,000.00. Judge Hoffman shall also have the power to order equitable relief to the extent necessary to gain compliance with this Agreement.

If Judge Hoffman is unavailable or unable to hear any dispute, the Parties shall select a mutually agreeable retired judge to hear the dispute. If the Parties are unable to mutually agree, Judge Hoffman shall designate an alternate retired judge to hear the dispute. If Judge Hoffman determines he is unable to designate an alternate, the Court shall appoint a retired judge to hear the dispute. The costs of the Special Master will be paid by SHIP. However, in the event a dispute arises and the Special Master deems SHIP to be the prevailing party, the Special Master may, in his discretion, shift some or all of the costs of the Special Master to another Party to the dispute.

All parties agree that Plaintiff's Counsel may enforce this Agreement based on reports provided by the Special Master or information independently gathered by Plaintiff's Counsel.

I. Regulatory Compliance

It is understood and agreed among the Parties that this Agreement shall not apply to the extent it conflicts with any California statute, regulation, or any order or directive imposed on SHIP by the California Department of Insurance or any other California or federal regulatory body or governmental entity.

VI. GENERAL PROVISIONS

A. NO ADMISSION

This Agreement is not to be construed or deemed as an admission of liability, culpability, negligence, or wrongdoing on the part of SHIP. SHIP has entered into this Agreement as part of its ongoing desire to improve the level of service provided to its policyholders. This Agreement is a settlement document and shall, pursuant to California Evidence Code section 1152, be inadmissible as evidence in any proceeding to establish liability, except in any action or proceeding to enforce the terms of this Agreement.

B. GOVERNING LAW & JURISDICTION

This Agreement shall be governed by, construed, and enforced in accordance with the

laws of the State of California.

C. AMENDMENT

This Agreement may be amended only by a written agreement executed by the Parties in interest at the time of the modification.

D. INDIVIDUAL AND PARTNERSHIP AUTHORITY

Any individual signing this Agreement on behalf of another individual, a corporation or partnership represents and/or warrants that he has full authority to do so.

E. GENDER AND TENSE

Whenever required by the context hereof, the singular shall be deemed to include the plural, and the plural shall be deemed to include the singular, and the masculine, feminine and neuter genders shall each be deemed to include the other.

F. ENTIRE AGREEMENT

This Agreement, along with the separately executed agreement entitled "Settlement Agreement and Mutual Release," constitute the entire agreement between the Parties hereto pertaining to the subject matter hereof, and fully supersedes any and all prior understandings, representations, warranties and agreements between the Parties hereto, or any of them, pertaining to the subject matter hereof, and may be modified only by written agreement signed by all of the Parties hereto.

G. COUNTERPARTS

This Agreement may be executed in counterparts, each of which shall be an original but all of which shall constitute one and the same instrument.

H. BENEFIT AND BURDEN

This Agreement shall be binding upon and inure to the benefit of the Parties and their respective representatives, successors and assigns.

I. CONSTRUCTION

The Parties agree that the terms and conditions of this Agreement are the result of arms-length negotiations between the Parties, and that the Agreement shall not be construed in favor of or against any Party by reason of the extent to which any Party or their counsel participated in the drafting of this Agreement.

J. CAPTIONS

Paragraph titles or captions are inserted as a matter of convenience and for reference, and

in no way define, limit, extend or describe the scope of this Agreement or any of its provisions. Each term of this Agreement is contractual and not merely a recital.

THE UNDERSIGNED HEREBY ACKNOWLEDGE THEY HAVE READ, UNDERSTAND AND AGREE TO THE TERMS AND CONDITIONS SET FORTH IN THIS AGREEMENT. THE UNDERSIGNED FURTHER WARRANT THAT THEY HAVE AUTHORITY TO EXECUTE THIS AGREEMENT AS PROPER OFFICERS OR DULY AUTHORIZED REPRESENTATIVES FOR THE ENTITY ON WHOSE BEHALF THEY ARE SIGNING.

PLAINTIFF

DATED: _____

_____
WILLIAM HALL

DEFENDANT

DATED: _____

_____
BY: Patrick L. Caumody
SENIOR HEALTH INSURANCE
COMPANY OF PENNSYLVANIA

APPROVED AS TO FORM AND CONTENT

DATED: _____

_____
BY: Samuel Bruchey Esq.
SHERNOFF BIDART ECHEVERRIA
BENTLEY LLP
Counsel for Plaintiff,
WILLIAM HALL

DATED: _____

_____
BY: Harvey Rosenfield, Esq.
CONSUMER WATCHDOG
Counsel for Plaintiff,
WILLIAM HALL

DATED: 8/31/12

_____
BY: Christian W. Schmitthenner, Esq.
Counsel for Defendant,
SENIOR HEALTH INSURANCE
COMPANY OF PENNSYLVANIA

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PLAINTIFF

DATED: 8/28/12

WILLIAM HALL

DEFENDANT

DATED: _____

BY:
SENIOR HEALTH INSURANCE
COMPANY OF PENNSYLVANIA

APPROVED AS TO FORM AND CONTENT

DATED: 8/30/12

BY: Samuel Bruchey Esq.
SHERNOFF BIDART ECHEVERRIA
BENTLEY LLP
Counsel for Plaintiff,
WILLIAM HALL

DATED: _____

BY: Harvey Rosenfield, Esq.
CONSUMER WATCHDOG
Counsel for Plaintiff,
WILLIAM HALL

DATED: _____

BY: Christian W. Schmitthenner, Esq.
Counsel for Defendant,
SENIOR HEALTH INSURANCE
COMPANY OF PENNSYLVANIA

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PLAINTIFF

DATED: _____

_____
WILLIAM HALL

DEFENDANT

DATED: _____

_____
BY:
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

APPROVED AS TO FORM AND CONTENT

DATED: _____

_____
BY: Samuel Bruchey Esq.
SHERNOFF BIDART ECHEVERRIA BENTLEY LLP
Counsel for Plaintiff,
WILLIAM HALL

DATED: 6/21/12

_____
BY: Harvey Rosenfield, Esq.
CONSUMER WATCHDOG
Counsel for Plaintiff,
WILLIAM HALL

DATED: _____

_____
BY: Christian W. Schmitthenner, Esq.
Counsel for Defendant,
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

EXHIBIT A

FREQUENTLY ASKED QUESTIONS

1. How do I submit a claim under my policy?

You must complete and submit a **claim form**, which includes: (1) a patient claim form to be filled out by you, (2) a provider claim form to be filled out by your care provider, and (3) a physician claim form to be filled out by your physician. You can obtain a copy of the claim form on our website at www.shipltc.com/forms/ or by calling 1-877-451-5824. You will also need to provide **Daily Visit Notes**, an **itemized bill for care**, and **your doctor's signed plan of treatment**. A claims representative may contact you for additional information if necessary.

2. Does my home care provider need to be licensed?

If you are receiving care in California, your home care provider does not need to have a license.

3. Does my home care provider need to complete Daily Visit Notes?

Yes, Daily Visit Notes must be filled out by your care provider and signed by both you and your care provider. If you are unable to sign the form, an authorized representative can sign on your behalf. A blank Daily Visit Note form will be provided with your claim form packet. Or, you can obtain a copy of the Daily Visit Note form on our website at www.shipltc.com/forms/ or by calling 1-877-451-5824.

4. What if I already received home care but my provider did not complete Daily Visit Notes?

If you already received home care but your provider did not complete Daily Visit Notes, we may accept a statement from your care provider for the past care instead of Daily Visit Notes. However, for future care your provider will need to complete Daily Visit Notes. You can obtain a copy of the statement form on our website at www.shipltc.com/forms/ or by calling 1-877-451-5824.

5. Will I need to have a Benefit Eligibility Assessment?

A Benefit Eligibility Assessment ("BEA") is a visit by a nurse in your home to assess your needs. We may require a BEA to confirm eligibility for benefits. If we determine a BEA is necessary, we will contact you to schedule the assessment at your convenience at your home. The need for a BEA will not delay your eligibility for benefits.

6. Who can I contact if I have questions about the claims process?

If you have any questions about the claims process, please call our customer service representatives at 1-877-451-5824. All such calls will be handled by a person knowledgeable of your claim and dealt with in a reasonable time frame.

7. Is there an appeal process if my claim is denied or rejected?

Yes, if your claim is denied or rejected, you are entitled to a "management review" of the claim. We will be glad to consider additional facts you may wish to submit. You may request a management review by mailing a letter setting forth additional information to the following address:

Long Term Care Claims
Attention: Claims Manager
P.O. Box 64913
St. Paul, MN 55164

EXHIBIT B

POLICYHOLDER'S CLAIM FORM

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

1. LIST ALL POLICY NUMBERS:

POLICY NUMBER: _____ _____ _ ☐ I DO ☐ I DO NOT WANT TO FILE CLAIM ON THIS POLICY

POLICY NUMBER: _____ ☐ I DO ☐ I DO NOT WANT TO FILE CLAIM ON THIS POLICY

POLICY NUMBER: _____ ☐ I DO ☐ I DO NOT WANT TO FILE CLAIM ON THIS POLICY

2. POLICYHOLDER'S NAME: _____

SOCIAL SECURITY NUMBER: _____

POLICYHOLDER'S CURRENT ADDRESS: _____

POLICYHOLDER'S PHONE NUMBER: (___) ____ - _____

WHAT TYPE OF RESIDENCE IS THIS?

☐ PRIVATE RESIDENCE ☐ NURSING HOME ☐ ASSISTED LIVING FACILITY

☐ OTHER: _____

3. ADDRESS TO WHICH YOU WANT ALL POLICY CORRESPONDENCE, INCLUDING CLAIM PAYMENTS SENT:

☐ SAME AS ABOVE ☐ TO ADDRESS SHOWN BELOW:

ADDRESS: _____

4. ILLNESS OR ACCIDENT CAUSING YOU TO OPEN THIS CLAIM:

_____

_____

DATE OF ONSET FOR THIS ILLNESS OR ACCIDENT

MO _____ DAY _____ YEAR _____

5. DATE YOU FIRST SAW ANY DOCTOR FOR THIS CONDITION:

MO _____ DAY _____ YEAR _____

DOCTOR'S NAME: _____

DOCTOR'S ADDRESS:

_____

_____

DOCTOR'S PHONE NUMBER:

(____) ____ - _____

6. IS THIS CLAIM RELATED TO AN ACCIDENT AND SOMEONE ELSE APPEARS TO BE AT FAULT FOR YOUR INJURY? ☐ YES ☐ NO

7. FAMILY OR PRIMARY CARE DOCTOR'S NAME: _____

IF SAME DOCTOR AS ABOVE CHECK BOX ☐ IF DIFFERENT PLEASE LIST BELOW:

ADDRESS: _____

PHONE NUMBER: (____) ____-_____

8. PRIVACY LAWS RESTRICT THE INFORMATION WE CAN RELEASE TO ANYONE OTHER THAN THE POLICYHOLDER.

NOTE: IF YOU HAVE DESIGNATED A POWER OF ATTORNEY, PLEASE ATTACH THE DOCUMENTATION.

HAVE YOU DESIGNATED A POWER OF ATTORNEY? ☐ *YES* ☐ *NO*

PRIMARY PERSON TO WHOM YOU HAVE GIVEN POWER OF ATTORNEY: _____

HOME NUMBER: (____) _____ - _____ OFFICE: (_____) _____ - _____

MOBILE: (____) _____ - _____

IF YOU HAVE DESIGNATED SOMEONE TO ACT ON YOUR BEHALF IN FILING CLAIM PLEASE COMPLETE THE HIPAA AUTHORIZATION, SECTION B ON PAGE 2.

HAVE YOU DESIGNATED SOMEONE TO ACT ON YOUR BEHALF? ☐ *YES* ☐ *NO*

PERSON DESIGNATED TO ACT ON YOUR BEHALF FOR FILING THIS CLAIM: _____

HOME NUMBER: (____) _____ - ____ OFFICE: (_____) _____ - _____ MOBILE: (____) ____-_____

Note: Providing claim form information does not guarantee approval of a claim payment. All determinations will be based upon claim information, policy language and rider(s), if applicable. Additional information may be requested in order for a claim determination to be made.

YOU MAY SUBMIT FORMS INDIVIDUALLY AS THEY ARE FULLY COMPLETED OR YOU MAY SUBMIT THEM TOGETHER. COMPLETED FORMS AND REQUESTED ATTACHMENTS FROM YOUR PHYSICIAN AND/OR PROIVDER SHOULD BE MAILED TO:

Senior Health Insurance Company of Pennsylvania
P.O. Box 64913
St. Paul, MN 55164
OR Fax to: (952) 983-5256

POLICYHOLDER'S CLAIM FORM

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

AUTHORIZATIONS FOR USE OR DISCLOSURE OF HEALTH-RELATED INFORMATION
(These authorizations comply with the HIPAA Privacy Rule)

Name of Insured	Date of Birth
Policy Number	Address

If either Section A or B are completed by a legal representative, valid Power of Attorney documentation must accompany this form

Section A: Use of Health Related Information *to* Senior Health Insurance Company of Pennsylvania

I authorize any licensed physician, medical practitioner, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer having information available as a diagnosis, treatment and prognosis with respect to any physical or mental condition and or treatment of me, and any non-medical information about me, to give any and all such information to particular company to which I am submitting a claim, or its legal representative. I understand that the information obtained by use of this authorization will be used only to evaluate my claim and may be transferred to any organization or person employed by or representing Senior Health Insurance Company of Pennsylvania to assist with this purpose.

This authorization includes information about drugs, alcoholism, mental illness, sexually transmitted disease, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

This authorization is valid while my claim is pending, while it remains active or in order for us to process your appeal. Except in the case of an appeal, this authorization shall expire on the date my claim ends. I understand that my authorized representative or I have the right to request and receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

Failure to sign this authorization may impair our ability to evaluate your non-health claim and may be a basis for denying a non-health claim for benefits. You have the right to revoke this authorization by notifying us in writing at *Senior Health Insurance Company of Pennsylvania, Attn: Claim Review, P.O. Box 64913, St. Paul, MN 55164.* Such revocation may be the basis for denying benefits.

Claimant Signature (or legal Representative) _____ Date: _____

IMPORTANT – PATIENT (or LEGAL REPRESENTATIVE) PLEASE SIGN HERE X _____ Date: _____

Section B: Health Information to be Disclosed *by* Senior Health Insurance Company of Pennsylvania

I authorize Company to disclose my Protected Health Information to the following (Person/Organization Receiving Information)

_____, The Relationship of this person/organization to me is: _____.

This recipient may use the health information authorized on this form for the following purpose

_____.

I would like this authorization to EXPIRE on: _____ OR as long as the policy is in force or until the policyholder changes the authorization. This authorization shall be effective as of the date of my signature below. I understand that I can revoke this authorization at any time, except to the extent it has already been relied upon, by given written notice at: *Senior Health Insurance Company of Pennsylvania, Attn: Claim Review, P.O. Box 64913, St. Paul, MN 55164.*

I understand that Company may not deny me benefits due to refusal to sign this "Section B" authorization. I further understand that my signature on this authorization does not authorize any changes to my policy information or to my policy or change the way Company communicates with me. I also understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by the HIPAA Privacy Rule. The undersigned is entitled to receive a copy of this form. A copy of this authorization shall be valid as the original.

Signature of Insured _____ Effective Date: _____

Your name: _____ Describe authority to act on behalf of insured, (e.g., power of attorney, legal guardian, etc.) _____

ATTENDING PHYSICIAN'S CLAIM FORM

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

THIS INFORMATION NEEDS TO BE COMPLETED BY THE PHYSICIAN OR PRACTITIONER MOST KNOWLEDGEABLE ABOUT THE ILLNESS OR ACCIDENT RELATED TO THIS CLAIM

PLEASE ANSWER ALL QUESTIONS AND SIGN BELOW

2

1. POLICYHOLDER NAME: _____
2. POLICY NUMBER(S): _____
3. PRIMARY CONDITION(S) CAUSING THIS LOSS:
   _____
   _____
   _____
4. DATE OF FIRST TREATMENT FOR PRIMARY CONDITION:
   MO _____ DAY _____ YEAR _____
   BY WHOM? DOCTOR'S NAME: _____
   ADDRESS: _____
5. DATE OF PRIOR HOSPITAL STAY: MO _____ DAY _____ YEAR _____
   DIAGNOSIS: _____
   HOSPITAL NAME: _____
   ADDRESS: _____
6. ANY NURSING HOME STAY OR IN-HOME CARE WITHIN THE LAST 5 YEARS? ☐YES ☐NO
   IF YES, DATES: MO _____ DAY _____ YEAR _____ ; MO _____ DAY _____ YEAR _____
   NAME OF PROVIDER OF CARE: _____
   ADDRESS: _____
7. IS THERE A DIAGNOSIS OF COGNITIVE IMPAIRMENT? ☐YES ☐NO
   IF YES, LIST DIAGNOSIS _____, COGNITIVE TESTING RESULTS _____, DATE _____ AND ATTACH ANY TEST RESULTS

I CERTIFY THAT THE INFORMATION ABOVE IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

PHYSICIAN'S SIGNATURE _____ **DATE SIGNED** _____

PHYSICIAN'S NAME _____ **TAX ID#** _____

ADDRESS _____ **TELEPHONE# ( )** _____

CITY _____ **STATE**_____ **ZIP**_____ **FAX# ( )** _____

YOU MAY SUBMIT FORMS INDIVIDUALLY AS THEY ARE FULLY COMPLETED OR YOU MAY SUBMIT THEM TOGETHER. COMPLETED FORMS AND REQUESTED ATTACHMENTS FROM YOUR PHYSICIAN AND/OR PROIVDER SHOULD BE MAILED TO:

Senior Health Insurance Company of Pennsylvania
P.O. Box 64913
St. Paul, MN 55164
OR Fax to: (952) 983-5256

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SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

PROVIDER CLAIM FORM

PLEASE SUBMIT A SEPARATE FORM FOR EACH PROVIDER

PLEASE ANSWER ALL QUESTIONS AND SIGN BELOW

1. POLICYHOLDER NAME: _____
2. POLICY NUMBER(S): _____
3. AGENCY/FACILITY/PROVIDER NAME: _____
4. TAX ID/SOCIAL SECURITY NUMBER: _____
5. ADDRESS: _____ _____ _____
6. PHONE NUMBER: OFFICE: (____) ____ - _____ MOBILE: (____) ____ - ____
7. FAX NUMBER: (____) ____ - _____
8. TYPE OF LICENSE OR CERTIFICATION HELD BY THE AGENCY/FACILITY/PROVIDER OF CARE, IF APPLICABLE:

   _____

   DATE LICENSE OR CERTIFICATION EXPIRES: MO ____ DAY _____ YEAR ____

   PLEASE ATTACH A COPY OF THE LICENSE OR CERTIFICATION (IF AVAILABLE)
9. START OF CARE DATE: _____ END OF CARE DATE: _____
10. WAS ANY PERIOD OF THE PATIENT'S CARE COVERED BY MEDICARE? ☐YES ☐NO
    IF YES, PLEASE LIST DATES: _____
    _____
11. WAS THE CARE PRECEDED BY A HOSPITAL STAY? ☐YES ☐NO
    IF YES, DATES: _____
    _____
    HOSPITAL NAME: _____
    ADDRESS: _____
    _____

    SINCE DATE CARE STARTED HAVE THERE BEEN ANY SUBSEQUENT BREAKS IN CARE?
    ☐YES ☐NO
    IF YES, REASON: _____
    _____
    IF YES, DATES: _____
    _____

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

PROVIDERS NAME: _____ **Position** _____

PROVIDERS Signature _____ **Date**_____

Phone Number (____) _____ **Fax Number (____)** _____

YOU MAY SUBMIT FORMS INDIVIDUALLY AS THEY ARE FULLY COMPLETED OR YOU MAY SUBMIT THEM TOGETHER. COMPLETED FORMS AND REQUESTED ATTACHMENTS FROM YOUR PHYSICIAN AND/OR PROIVDER SHOULD BE MAILED TO:

Senior Health Insurance Company of Pennsylvania
P.O. Box 64913
St. Paul, MN 55164
OR Fax to: (952) 983-5256

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

AK, DE, RESIDENTS: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ RESIDENTS: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
AR RESIDENTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CA RESIDENTS: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO RESIDENTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DC RESIDENTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL RESIDENTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

ID RESIDENTS: Any person who knowingly and with intent to defraud or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

IN RESIDENTS: A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony.

KY RESIDENTS: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

LA RESIDENTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MD RESIDENTS: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MN RESIDENTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NM RESIDENTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NH RESIDENTS: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ RESIDENTS: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NY RESIDENTS: Any person who knowingly and with intent to defraud any insurance company or other person files a 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 and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH, OR RESIDENTS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OK RESIDENTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA RESIDENTS: 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 and subjects such person to criminal and civil penalties.

PR RESIDENTS: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand (5,000) dollars no more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

EXHIBIT C

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

CAREGIVER WEEKLY TIMESHEET

Return Forms to:
SHIP
PO Box 64913
St. Paul, MN 55164-0913

Insured:

Policy Number:

If you have any questions, please call 877-451-5824

CHARTING KEY

X = Required to be performed by caregiver
S = Supervise/ Standby Assist within arm's reach
A =Hands-on Assistance required to complete task

CAREGIVER INSTRUCTIONS

1. Complete a new timesheet each week.
2. Using the **CHARTING KEY** to the right, indicate in EVERY box EACH day the level of assistance provided ON THAT DAY (blank means no assistance). For example, if you fed patient, place an "x" in the "Feed" box.
3. Enter the start & end times, number of hours worked, and total pay EVERY day along with a weekly total pay at the end.
4. Use the "Note" section to record anything you feel is significant as to required level of care. For example: care increased today because.....Or care decreased because.....Leave blank if no change.
5. Print your name, relationship to insured, sign, and date the completed form.
6. The insured or the insured's legal representative must also print his or her name, sign, and date the completed form.

Activity Date	Reimbursement Rate $____/ Hour or Day	Feed	Bath	Dress	Toilet / Continent	Walk / WC	Transfer	Meds	Meal Prep	Clean & Laundry	Shop & Transport
Monday	Time In										
Mo/day/yr	Time Out	Note									
__/___/___	Total # Hrs										
Tuesday	Time In										
	Time Out	Note									
__/___/___	Total #Hrs										
Wednesday	Time In										
	Time Out	Note									
__/___/___	Total #Hrs										
Thursday	Time In										
	Time Out	Note									
__/___/___	Total #Hrs										
Friday	Time In										
	Time Out	Note									
__/___/___	Total #Hrs										
Saturday	Time In										
	Time Out	Note									
__/___/___	Total #Hrs										
Sunday	Time In										
	Time Out	Note									
__/___/___	Total #Hrs										

TOTAL WEEKLY HOURS_____ TOTAL WEEKLY PAY $_____

Caregiver relationship to Insured: _____ Caregiver SSN#:_____

BY SIGNING I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT UNDER PENALTY OF PERJURY

Caregiver Name (Print) _____ Signiture_____ Date_____

Insured / Legal Representative Name (Print) _____ Signature _____ Date _____

EXHIBIT D

SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA
P.O. Box 64913 • St. Paul, MN 55164
Telephone: 1-877-450-5824

STATEMENT CONFIRMING PROVISION OF LONG TERM CARE SERVICES

I, _____, certify that I provided the below listed long term care services to _____ and that I did not maintain records of, or no longer have the records documenting the care during the time I provided it. Further, I certify that I was paid $_____ by _____ for my services. I understand that proof of that payment may be required for these service dates and that future claims may not be paid without daily service records.

Service dates: _____ (enter a range of dates starting from the first date of service to the most recent date of service)

Frequency with which services were provided: _____ (hours per day, days per week)

All locations in which services were provided: _____ (claimant's home, a hospital, a nursing facility, etc.)

Services provided on a regular (daily or every visit) basis:

- ☐ Standby assistance to bathe
- ☐ Standby assistance to dress
- ☐ Standby assistance to toilet
- ☐ Standby assistance to transfer
- ☐ Standby assistance to manage incontinence
- ☐ Standby assistance to ambulate
- ☐ Hands-on assistance to bathe
- ☐ Hands-on assistance to dress
- ☐ Hands-on assistance to toilet
- ☐ Hands-on assistance to transfer
- ☐ Hands-on assistance to manage incontinence
- ☐ Hands-on assistance to ambulate
- ☐ Supervision due to cognitive impairment
- ☐ Other: _____

- ☐ Meal preparation
- ☐ Medication management or medication reminders
- ☐ Housekeeping
- ☐ Transportation (i.e. to and from medical appointments)

During the time I provided services to _____, I ☐ did ☐ did not provide services to anyone else in the household. If services provided to another person, name that person:

_____

This document does not guarantee benefit approval or payment of a claim

NOTE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement for a claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading any insurance company, commits a fraudulent insurance act, which is a crime and may also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Caregiver Name (printed): _____ Signature: _____ Date: _____

Claimant name: _____ Policy #: _____