Clear Form Data
FILLABLE FORM

**Attachment C**

DHS-5426B-ENG 8-08



Case number: _____

Case name: _____

Worker name: _____

Worker phone number: _____

Fax number: _____

Agency name: _____

Agency address: _____

_____

# Long-Term Care Partnership Insurance Policy Evaluation

Date: _____

To: _____

_____

_____

Minnesota has implemented the Long-Term Care Partnership. State and federal law establish criteria required for long-term care insurance policies to qualify for the Long-Term Care Partnership. Long-term care insurance that qualifies for the Long-Term Care Partnership is known as a Partnership policy.

Minnesota law allows a person with a Partnership policy to designate a certain amount of assets to disregard when eligibility is determined for Minnesota Medical Assistance for Long-Term Care. These assets are also protected from estate recovery.

The amount of assets that a person can protect is equal to the amount of benefits paid by the person's Partnership policy.

Information you provide on the enclosed Insurance Policy Evaluation Form will be used to determine if the person listed below qualifies for asset protection under the Long-Term Care Partnership. A signed Permission to Share Long-Term Care Insurance Information (DHS-5426A) providing authorization for state and county agencies to exchange health information with insurance companies in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) is also enclosed.

Complete the Insurance Policy Evaluation Form about the person named below. Return the form within 30 days to the agency contact named above:

| NAME OF INSURED PERSON | | | DATE OF BIRTH |
|---|---|---|---|
| STREET ADDRESS | CITY | STATE | ZIP CODE |
| NAME OF INSURANCE COMPANY | | | INSURANCE POLICY NUMBER |

**Group policy information, if applicable.**

| INSURANCE CERTIFICATE NUMBER | NAME OF EMPLOYER OR ASSOCIATION |
|---|---|
| | |

This information is available in alternative formats to individuals with disabilities by calling your agency at (651) 431-2670 or (800) 657-3739. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services benefits, contact your agency's ADA coordinator.

Minnesota Department of **Human Services**

MINNESOTA Long Term Care Partnership™

Insured person: _____

Case number: _____

Case name: _____

Worker name: _____

# Insurance Policy Evaluation Form

Medical Assistance for Long-Term Care may not be determined until you complete and return this form. **Return this form within 30 days to the agency listed on the cover letter.**

## A. Was the insured person a Minnesota resident on the date this long-term care policy was issued?

☐ No – go to question B. ☐ Yes – answer the questions below

1. Is the policy certified as having met the consumer protection requirements of the Long-Term Care Partnership in Minnesota? ☐ YES ☐ NO
2. Is the policy tax qualified under Section 7702(B)(b) of the IRS Code of 1986? ☐ YES ☐ NO
3. Has the policy continuously met the inflation protection requirements for the Long-Term Care Partnership? ☐ YES ☐ NO

## B. Was the insured person a resident of a state other than Minnesota on the date this policy was issued?

☐ No – go to Signature Section ☐ Yes – answer the questions below

In which state was the policy issued? _____

1. Was the insured person a resident of that state on the date the policy was issued? ☐ YES ☐ NO
2. Is the policy certified as having met the consumer protection requirements of the Long-Term Care Partnership in the state in which it was issued? ☐ YES ☐ NO
3. Is the policy tax qualified under Section 7702(B)(b) of the IRS Code of 1986? ☐ YES ☐ NO
4. Has the policy continuously met the inflation protection requirements for the Long-Term Care Partnership in the state in which it was issued? ☐ YES ☐ NO

## C. Did you answer "Yes" to all questions in A or B above?

☐ No – go to Signature Section ☐ Yes – answer the questions below

1. Have policy benefits been exhausted? ☐ YES ☐ NO

   Note: Exhaustion of benefits occurs on the date your company paid the person's final long-term care claim.

   **Yes:** Amount of benefits paid after July 1, 2006? $_____.

   Date of the final payment? _____.

   **No:** Amount of benefits paid after July 1, 2006? $_____.

   Through what date have claims been paid? _____.

   Approximate amount of benefits remaining? $_____

| COMPLETED BY (PLEASE PRINT) | TITLE | |
|---|---|---|
| SIGNATURE OF INSURANCE COMPANY REPRESENTATIVE | DATE | PHONE NUMBER |

**Questions about insurance issues should be directed to the Insurance Division of the Minnesota Department of Commerce at (651) 296-2488.**