Asian Development Bank

Memorandum

Budget, Personnel, and Management Systems Department
Staff Development and Benefits Division

1 April 2009

To: ADB Staff and Retirees

From: Ikuko Matsumoto
Director, Staff Development and Benefits Division

Subject: **Long Term Care Insurance**

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1. We wish to announce that Long Term Care Insurance coverage is now available to all Staff[1], Retirees[2], and their spouses. Participation is voluntary and every applicant is subject to medical underwriting. Premiums are fully paid by the Insured. Please address questions and interest to Cristina Keppler, Compensation and Benefits Specialist at ckeppler@adb.org, insurance@adb.org, asaludo@adb.org or at extension 4115. The salient features of the Plan are provided below.

LONG TERM CARE INSURANCE PLAN (LTCP)

2. Long term care insurance (LTCP) helps provide for the cost of care over extended periods not normally covered by health insurance. This coverage complements our Group Medical Insurance Plan (GMIP) which covers medical expenses but not the cost for care. LTCP is underwritten by Les Assurances Generales de France and administered by Vanbreda International.

3. LTCP guarantees an allowance for an Insured when the Insured is recognized by the Insurer as being in a state of dependence as defined below:

a) the Insured whose medical condition has stabilized and who is in a situation of permanent inability to perform at least four (4) out of the six (6) activities of daily living (ADLs).

1) Washing: Ability to maintain a satisfactory level of personal hygiene in accordance with customary standards.

2) Feeding: Ability to take and eat the food that was prepared beforehand and put at one's disposal.

3) Dressing: Ability to dress and undress oneself taking into account, if necessary, specially adapted clothes.

4) Mobility: Ability to move about on level surfaces, taking into account the help of an adapted aid.

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[1] Board members, Management, Professional Staff, National Officers and Administrative Staff
[2] Retirees who elected immediate pension and receiving monthly pension

5) Continence: Ability to control bowel and bladder function and to ensure hygienic urinary and fecal secretions, taking into account the availability of sanitary protection or surgical devices.

6) Transferring: Ability to move from a bed to a chair or an armchair and vice versa.

b) the Insured suffering from a neuropsychiatric disease such as Alzheimer's disease or senile dementia, which has been medically assessed by a psychiatrist or a neurologist and for whom the psychiatrist or neurologist has recorded a score of less than fifteen (15) on Folstein's "Mini Mental State Examination".

4. The most common reasons that people need this type of long term care insurance are prolonged illnesses, degenerative conditions, permanent disabilities and cognitive disorders, such as Alzheimer's and Parkinson's diseases.

Eligibility

5. Eligible applicants are ADB Staff and Retirees, and their spouses. The ADB Staff/Retiree needs to be enrolled in LTCP for his/her spouse to be eligible in this Plan. Age limit upon approval is 75.

6. For Staff appointed after 30 June 2009 and their spouses, the eligibility date to apply for LTCP coverage is the Staff's appointment date or date of marriage (for spouse, whichever is later).

7. Staff members on sick leave, on permanent disability or have already filed a request for disability can apply for coverage from the 31st day following the return to work at ADB.

Conditions for Enrollment

8. Enrollment is always subject to the Insurer's medical underwriting and approval. The applicant should submit the following completed forms to the Staff Development and Benefits Division (BPDB):

a) Long Term Care Enrollment Form (Attachment 1);

b) Health Statement (Attachment 2); and

c) Additional Health Questionnaire (Attachment 3) - If the answer to one of the questions in the Health Statement is YES, then applicant should also complete this form. Applicants aged 65-74 should also complete both the Health Statement and the Additional Health Questionnaire.

9. If applicant enrolls on or before 30 June 2009 then coverage, if approved, will become effective on 1 April 2009.

10. If enrolling from 1 July 2009 or three (3) months after eligibility date, a waiting period[3] is applied and fixed at:

a) 0 months in case of dependence resulting from of an accident (defined as sudden and violent action caused by an external force, without the Insured's deliberate intention);

b) 12 months in case of dependence resulting from illness other than neuro-cognitive;

c) 36 months in case of dependence resulting from a neuro-cognitive disorder.

11. There will be no exceptional approvals. The insurer will either accept or reject applications for enrollment after evaluating the medical questionnaire and supporting documents submitted.

Coverage Options

12. Applicants may elect a monthly allowance of US$300, US$500, US$1,000 or US$2,000. Based on the framework established by Vanbreda, NOAS (SS) active Staff and Retirees residing in Afghanistan, Cambodia, East Timor, India, Indonesia and Pakistan may choose either the US$300 or US$500 monthly allowance. The allowance should not exceed the Staff's gross monthly salary or Retiree's gross monthly pension.

13. There is no option to change coverage election after approval of coverage. The LTCP allowance already being paid is increased by 2% every 1 January.

Premium

14. The premium will be deducted from payroll for ADB Staff and from monthly pension for Retirees. For National Officers and Administrative Staff and Retirees whose salaries/pensions are not in US$, premiums will be converted based on the applicable exchange rate at the time of payroll/pension processing.

Monthly premiums in US$

Age	Monthly allowance of US$300		Monthly allowance of US$500	
	Male	Female	Male	Female
< 20	0.58	0.42	0.94	0.70
20 – 30	0.64	0.44	1.06	0.72
31 – 40	0.88	0.56	1.46	0.92
41 – 50	1.26	1.06	2.10	1.76
51 – 60	2.12	1.92	3.54	3.20
61 – 65	5.08	4.82	8.48	8.02
66 – 70	10.46	9.94	17.42	16.56
71 – 75	19.74	18.84	32.88	31.40

[3] This is the period after the Insured's affiliation date. If the risk is realized during this waiting period, the Insured is not covered and is not entitled to benefits.

Monthly premiums in US$

Age	Monthly allowance of US$1,000		Monthly allowance of US$2,000	
	Male	Female	Male	Female
< 20	1.90	1.38	3.78	2.78
20 – 30	2.12	1.44	4.26	2.88
31 – 40	2.92	1.84	5.86	3.68
41 – 50	4.18	3.54	8.36	7.06
51 – 60	7.10	6.38	14.18	12.76
61 – 65	16.94	16.04	33.88	32.08
66 – 70	34.84	33.10	69.68	66.20
71 – 75	65.76	62.82	131.52	125.62

15. Payment of premium will be waived once the Insured is recognized and declared by the Insurer as being in a state of dependence.

Procedures to Apply for Recognition of Dependence

16. The Insured or any other person in his/her environment must provide the following:

a) documentary evidence on the Insured's state of health;

b) request for payment of allowance with a certificate from the treating physician or hospital physician that shows (i) the Insured's state of dependence, (ii) the date of occurrence, and (iii) the accidental or pathological origin of the disorder or disorders;

c) Medical questionnaire (for Evaluation of Loss of Autonomy) completed by the person or persons who are actually looking after the Insured and by the treating physician or hospital physician. The treating physician will be asked to provide a medical file containing the hospital reports and the results of complementary tests performed. In case of cognitive impairment, precise descriptive elements will be required: assessment test(s) of the cognitive functions, specifically the M.M.S. examination of Folstein.

d) If the Insured is looked after in his/her home and is entitled to home care or home nursing services, the notification of approval for this care delivered by the Insured's Health Insurance (public or private), must be provided.

e) If the Insured is hospitalized in a long-stay facility, a rehabilitation unit or a specialized establishment, the date of entry, type of establishment, type of service and, if applicable, nature of the approval given by the Health Insurance (public or private), must be specified in the hospital physician's medical certificate.

17. Upon review of the medical questionnaire and the medical file, the Insurer's medical advisor may:

a) contact the treating or hospital physician for clarification and further information, and/or;

b) have the state of dependence of the Insured verified by a physician of the Insurer's choice; and/or

c) conduct any medical examinations that may be deemed necessary.

18. If the application for dependence is not approved, the request may be reassessed under the following conditions:

a) At least three months have elapsed since the last evaluation.

b) The documentary evidence must be resubmitted with updates including new aspects implying a deterioration of the Insured's state of health.

Conditions for Payment of Long Term Care Allowance

19. Once the Insurer's medical advisor recognizes an Insured to be in a state of dependence in accordance with the Contract, a monthly allowance as elected upon enrollment will be paid to the Insured. The following conditions apply:

a) The allowance will be paid after the 3-month deductible period which starts on the day after the Insurer's date of recognition of the state of dependence.

b) The allowance is paid monthly in arrears on the first day of the following month, for as long as the state of dependence lasts.

c) The allowance will be paid pro-rata in arrears, based on count of thirty (30) days per month, from the start date of the allowance until the last day of that month.

d) During the period of entitlement to the allowance, the Insured must inform the Insurer the history of his/her state of health and inform, within thirty (30) days, if:

- the approval (for reimbursement of expenses) granted earlier by the Insured's Health Insurance (public or private) has been revoked;
- there is a change of (care) institution;
- Insured decides to return to his/her home or that of a relative/friend.

e) Every six (6) months, the Insured must send to the Insurer a proof of being alive. This evidence may be:

- A settlement note of the Health Insurance (public or private); or
- An invoice from the institution where the Insured is staying indicating the expenses incurred during the elapsed period; or
- Recent official record of civil status.

f) The Insurer may, at any time, require the Insured who is receiving allowance to:

- undergo a medical check and to have him/her examined by a physician of the Insurer's choice.
- disclose and/or provide each document that may be deemed necessary for evaluation of the Insured's state of health.

g) If the Insured refuses to undergo a medical check or to disclose the necessary documents, the payment of the allowance will be suspended.

h) If the condition of the Insured ceases to meet the requirements for recognition of the state of dependence, the allowance will be suspended on the last day of the month when the state of dependence ended and to restart on the day the state of dependence is approved again.

20. In case of late affiliation and if the state of dependence starts during the waiting period, this state of dependence will not entitle the Insured for payment of long term care allowance.

Exclusions

21. Excluded from this cover is the state of dependence as a consequence of:

a) voluntary or intentional act of the Insured, an attempt to commit suicide, self-mutilation, use of non-prescribed drugs, chronic alcoholism, drunkenness;

b) civil or foreign war, uprising, scuffle, terrorist acts in which the insured participated actively, but cases of legal self-defense and assistance to a person in danger remain guaranteed under the coverage;

c) transmutation of the atomic nucleus; or

d) congenital diseases

Termination of Enrollment

22. For Staff who is not eligible or will not elect immediate pension upon retirement, coverage ends at the end of employment.

23. An Insured has a one-time possibility to voluntarily end his/her coverage and may only re-enroll upon submission of proof of equivalent long term care coverage.

24. Any false declaration of the Insured will render the Insured's enrollment null and void.

Attachment 1: Enrollment Form
Attachment 2: Health Statement
Attachment 3: Additional Health Questionnaire

Long Term Care Insurance Plan (LTC) Enrollment Form

Asian Development Bank ADB

IMPORTANT:

1) NOAS (SS) active staff and retirees residing in Afghanistan, Cambodia, East Timor, India, Indonesia and Pakistan may only choose either the US$300 or US$500 monthly allowance.

2) Submit this form to Staff Development and Benefits Division (BPDB) together with the completed medical questionnaire enclosed in a sealed envelope.

3) Enrollment is subject to Insurer's medical underwriting and approval.

Staff/Retiree *(Family Name)*	*(First Name)*	(Middle Initial)	ID Number

Department/Office (for Staff) / Postal Address (for Retiree) *(Mnemonic Code)*	Sex	Marital Status	Date of Birth			Appointment Date		
			DD	*MM*	*YY*	*DD*	*MM*	*YY*
	☐ Male ☐ Female							

Type of Enrollment *(please mark appropriate box)*

☐ Enrollment of Self only ☐ Enrollment of Self and Spouse ☐ Enrollment of Spouse *(staff/retiree should be enrolled)* ☐ Termination of Coverage

Staff/Retiree Category*(please mark appropriate box)*

☐ Active Staff PS ☐ Active Staff NOAS (SS) ☐ Retiree PS ☐ Retiree NOAS (SS)

Monthly Allowance in US$*(please mark coverage option)*

☐ US$ 300 ☐ US$ 500 ☐ US$ 1,000 ☐ US$ 2,000

Family Name	First Name	Middle Initial	Date of Birth			Dependent Code
			DD	*MM*	*YY*	

I hereby authorize the ASIAN DEVELOPMENT BANK to make the necessary deductions from my salary/pension in payment of the applicable insurance premium, in connection with my enrollment in the Long Term Care Insurance Plan.

I understand that I am fully responsible and accountable for claims submitted under the Plan on behalf of myself and/or my spouse and that if I and/or my spouse provide incomplete, inaccurate, false or misleading information or claims, I may be subject to disciplinary action, suspension/termination of my and/or my spouse's coverage under the Plan, and/or termination of my employment pursuant to Administrative Order 2.04, as appropriate. The insurer and/or the administrator may also take legal action against me and/or my spouse or anyone who would file fraudu claims on my and/or my spouse's behalf. I authorize the release of any documents/records/information to the Insurer, the ADB or their duly authorized representatives as may be required to validate and process my and/or my spouse's claim.

I understand that ADB may change the terms, conditions and premiums of this Plan not more than annually during the period of my and/or my spouse's enrollment under this Plan. However, may terminate my and/or my spouse's enrollment at any time upon submission of my written requ for termination.

Signature	Date: *(DD/MM/YY)*

FOR BPCB's USE ONLY

Annual Salary/Pension	Coverage *(monthly allowance)*	Effective Coverage Date
Processed by:	Semi-monthly Premium:	Remarks *(if any)*
Verified and Approved by:	Staff - Spouse - Total -	

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LONG-TERM CARE INSURANCE (LTC)
Health Statement

NAME - FIRST NAME _____

DATE OF BIRTH (D - M - Y) _____ SEX ☐ M ☐ F

		YES	NO
1.	Do you need the help of a third party or a technical device to wash yourself, to walk, to get dressed, to eat, to stand up, to lie down, to sit, to ensure your urinary and/or faecal hygiene?	☐	☐
2.	Are you on sick leave or unable to work or suffering from a disability over 33%?	☐	☐
3.	Are you on early retirement for health reasons or is there a request in progress?	☐	☐
4.	Do you have any special social benefits due to your state of health? Is there a request in progress?	☐	☐
5.	Are you suffering from a handicap, a disability, the consequences of an accident, a chronic disease, (a) recurring complaint(s) or any other illness?	☐	☐
6.	Do you suffer from Alzheimer's disease, Parkinson's disease, multiple sclerosis, the consequences of a cerebral vascular accident or a psychological, nervous, mental, cancer related or rheumatoid condition, or of a visual or hearing impairment that cannot be corrected by a technical device?	☐	☐
7.	Is your height (in cm) minus your weight (in kg) smaller than 80 or larger than 120? _____ cm - _____ kg = _____ (e.g. 180 cm - 70 kg = 110 = No)	☐	☐
8.	a) Are you currently receiving a continuous treatment for a period longer than 3 months in a row? b) Are you currently receiving nursing care at home? c) Have you been informed that in the near future you will have to be hospitalised, undergo a surgery, consult a specialist doctor or be admitted to a specialised institute?	☐ ☐ ☐	☐ ☐ ☐
9.	In the past five years: a) have you been hospitalised, did you undergo a surgery or did you stay in a specialised environment for more than fifteen consecutive days? b) did you have a temporary working incapacity lasting more than 30 consecutive days?	☐ ☐	☐ ☐

If you answered one (or more) question(s) by 'Yes', please fill in the additional health questionnaire.

The person to be insured acknowledges (s)he declared all information in his/her knowledge to allow for an assessment of the scope of the risks. (S)he acknowledges that any information with regard to his/her state of health that is deliberately withheld or omitted can lead to the cancellation of this contract. This declaration is an integral part of the insurance contract.

DATE _____ PLACE _____

SIGNATURE OF THE PERSON TO BE INSURED, PRECEDED BY THE HANDWRITTEN STATEMENT 'READ AND APPROVED'

In view of a smooth administration of the contract and/or settlement of the insurance claim, and only for that purpose, I hereby give my specific and informed consent regarding the processing of the medical data concerning myself and/or the members of my family (article 7 of the Belgian law of December 8, 1992 concerning the private life).

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LONG-TERM CARE INSURANCE
Additional health questionnaire

TO BE COMPLETED BY THE PERSON TO BE INSURED

NAME - FIRST NAME

DATE OF BIRTH (D - M - Y) SEX ☐ M ☐ F

CURRENT PROFESSIONAL ACTIVITY PREVIOUS

HEIGHT (CM) WEIGHT (KG)

BLOOD PRESSURE TREATED? ☐ YES ☐ NO

DO YOU SMOKE? ☐ YES, QUANTITY PER DAY ☐ NO

DO YOU DRINK ALCOHOL? ☐ YES, QUANTITY PER DAY ☐ NO

1) Living conditions

DO YOU LIVE ☐ IN A HOUSE WITH STAIRS? ☐ YES ☐ NO HOW MANY FLOORS?

☐ IN A FLAT WITH A LIFT? ☐ YES ☐ NO HOW MANY FLOORS?

DISTANCE TO SHOPS: ON FOOT MIN. DO YOU NEED TRANSPORTATION? ☐ YES ☐ NO

DISTANCE TO YOUR DOCTOR: ON FOOT MIN. DO YOU NEED TRANSPORTATION? ☐ YES ☐ NO

DO YOU LIVE ☐ ALONE ☐ WITH YOUR SPOUSE ☐ OTHER

2) Medical history of the past 10 years and current state of health

DO OR DID YOU HAVE A DISEASE, AN ACCIDENT OR ANY OTHER HEALTH PROBLEMS OR ANOMALIES?

☐ NO ☐ YES, EXACT NATURE / DATE / DURATION

HAVE YOU BEEN INFORMED THAT YOU HAVE AN AGE RELATED CEREBRAL, NEUROLOGICAL OR PSYCHOLOGICAL CONDITION?

☐ NO ☐ YES, WHICH ONE?

HAVE YOU BEEN UNABLE TO WORK FOR MORE THAN 30 CONSECUTIVE DAYS?

☐ NO ☐ YES, WHY? / START DATE / END DATE

ARE YOU SEEING A GENERAL PRACTITIONER?

☐ NO ☐ YES, HOW MANY TIMES A YEAR?

REASON(S)

ARE YOU SEEING A SPECIALIST?

☐ NO ☐ YES, WHO? / SPECIALTY?

WHY? HOW OFTEN?

DO YOU RECEIVE ANY OTHER PARAMEDICAL CARE (SUCH AS SPEECH THERAPY, PSYCHOLOGICAL HELP, PHYSIOTHERAPY,...)?

☐ NO ☐ YES, WHICH CARE?

DATE / DURATION / REASON(S)

DO YOU HAVE ANY SPECIAL SOCIAL BENEFITS DUE TO YOUR STATE OF HEALTH? IS THERE A REQUEST IN PROGRESS?

☐ NO ☐ YES, SINCE WHEN? / WHAT KIND?

3) Treatment(s) (please attach the prescriptions)

ARE YOU RECEIVING OR DID YOU RECEIVE MEDICAL TREATMENT FOR MORE THAN ONE MONTH?

☐ NO ☐ YES, DATE / EXACT NATURE / REASON / DOSE

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4) Hospitalisation(s) (please attach the medical report(s))

HAVE YOU BEEN OR ARE YOU BEING HOSPITALISED?

☐ NO ☐ YES, EXACT DATE / REASON / RESULT

DID YOU OR DO YOU HAVE TO UNDERGO A SURGERY (INCLUDING AN ENDOSCOPY, A FIBROSCOPY, A CELIOSCOPY)?

☐ NO ☐ YES, EXACT DATE / REASON / RESULT

5) Analysis and tests (please attach copies of the results)

IN THE LAST 5 YEARS, HAVE YOU HAD ANY COMPLEMENTARY MEDICAL TEST (RADIOLOGY, SCANNER, IRM, LABORATORY TEST, ECG, ...) LEADING TO ABNORMAL RESULTS?

☐ NO ☐ YES, EXACT NATURE / DATE / REASON / RESULTS

ARE YOU SCHEDULED FOR SUCH A TEST OR MEDICAL EXAMINATION?

☐ NO ☐ YES, EXACT NATURE / DATE / REASON

6) Eyes/Ears

DO YOU WEAR GLASSES OR CONTACT LENSES? ☐ NO ☐ YES

ACUITY OF VISION: BEFORE CORRECTION RIGHT EYE /10 LEFT EYE /10

WITH CORRECTION RIGHT EYE /10 BY DIOPTRIES

LEFT EYE /10 BY DIOPTRIES

DO YOU HAVE A VISUAL DEFICIT NOT CORRECTED BY GLASSES OR CONTACT LENSES?

☐ NO ☐ YES: ☐ UNILATERAL ☐ BILATERAL EXACT NATURE / TREATMENT

DO YOU SUFFER FROM AN EYE DISORDER SUCH AS RETINOPATY DISEASE, CATARACT, GLAUCOMA OR MACULAR DEGENERATION RELATED TO AGE?

☐ NO ☐ YES: ☐ UNILATERAL ☐ BILATERAL EXACT NATURE / TREATMENT

DO YOU NEED OR DO YOU WEAR A HEARING DEVICE?

☐ NO ☐ YES: ☐ UNILATERAL ☐ BILATERAL EXACT NATURE / TREATMENT

7) Autonomy

DO YOU HAVE A CONGENITAL DISEASE OR A HANDICAP, A DISABILITY, A MALFORMATION?

☐ NO ☐ YES, DETAILS

DO YOU NEED THE HELP OF A THIRD PARTY TO

- SIT DOWN	☐ NO	☐ YES	- WASH YOURSELF	☐ NO	☐ YES
- STAND UP/TO LIE DOWN	☐ NO	☐ YES	- SHOP	☐ NO	☐ YES
- WALK	☐ NO	☐ YES	- DO THE HOUSEKEEPING	☐ NO	☐ YES
- EAT/TO DRINK	☐ NO	☐ YES	- COOK	☐ NO	☐ YES
- GET DRESSED/UNDRESSED	☐ NO	☐ YES	- KEEP YOUR BUDGET	☐ NO	☐ YES
- USE THE TOILET	☐ NO	☐ YES	- DO ANYTHING ELSE	☐ NO	☐ YES

DETAILS

DO YOU NEED OR DO YOU USE

- A WHEELCHAIR	☐ NO	☐ YES	- DIAPERS OR PROTECTIONS	☐ NO	☐ YES
- CANES/CRUTCHES	☐ NO	☐ YES	- ANY OTHER TECHNICAL AIDE/DEVICE	☐ NO	☐ YES
- A WALKER	☐ NO	☐ YES			

DETAILS

The person to be insured acknowledges (s)he declared all information in his/her knowledge to allow for an assessment of the scope of the risks. (S)he acknowledges that any information with regard to his/her state of health that is deliberately withheld or omitted can lead to the cancellation of this contract. This declaration is an integral part of the insurance contract.

DATE PLACE SIGNATURE OF THE PERSON TO BE INSURED, PRECEDED BY 'READ AND APPROVED'

In view of a smooth administration of the contract and/or settlement of the insurance claim, and only for that purpose, I hereby give my specific and informed consent regarding the processing of the medical data concerning myself and/or the members of my family (article 7 of the Belgian law of December 8, 1992 concerning the private life).