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SAMPLE DOCUMENT

LONG TERM CARE INSURANCE PLAN

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PURPOSE: To satisfy ERISA's plan document requirements and to provide an administrative structure for the Plan.

NOTES:

(1) See definition in Section 2.1(c) of the document.

(2) If an amendment and restatement, add the following language: "This Plan replaces and supersedes any and all similar plans or programs sponsored or maintained by the Company, in whole or in part, for the benefit of Eligible Individuals."

(3) The drafter should identify if spouses, domestic partners, or dependents are to be covered under the plan, keeping in mind the taxation issues involved (*e.g.*, domestic partners must qualify as federal tax dependents for premiums paid by an employer to receive tax preferred status). If spouses, domestic partners or dependents are to be covered by the plan, appropriate references should be added. If the Company wants to cover domestic partners, the parameters for recognizing an individual as a domestic partner should be specified in the Plan's definitions. See discussion regarding dependent status and tax treatment in Part Three, Section II.E, entitled "Dependents," with accompanying footnotes.

(4) If this is not intended to be an ERISA plan, delete references to ERISA but not to the Internal Revenue Code. See Part Four of this Study.

(5) Insert a description of the class of eligible individuals here. See Parts Three and Five of the Study for issues that may arise in determining the eligible class. The term "Eligible Individual" should be defined in the Plan to include partners and other owners, as appropriate. Independent contractors or others should be specifically excluded, as appropriate.

This sample document is intended only as guidance for the client's own legal counsel. The document is general in nature and does not reflect the specific circumstances of any individual or situation. The document does not constitute tax or legal advice and cannot be used to avoid any penalties that may be imposed on a taxpayer. It is intended that the client's legal counsel will modify the document where necessary to satisfy the client's objectives and the requirements of any applicable federal, state or local law. Northwestern Mutual does not guarantee the effectiveness of this document and is not responsible for any tax or legal consequences resulting from use.

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(6) This generally should be the Company's fiscal year. This date will determine when annual reports, if required, for the Plan are due. See Part Four, Section III.D.2 entitled, "The Annual Report."

(7) Delete if there is no spousal coverage.

If domestic partners or dependents are covered under the plan, the plan language needs to be changed. See Note 3.

(8) Delete if the plan is paid by employer contributions only.

(9) Describe how employee and employer contributions are paid.

(10) The summary claims procedures described herein are based on the claims procedures regulations issued November 21, 2000, and effective for claims filed on or after January 1, 2002. 65 Fed. Reg. 70246. The claims requirements differ according to the type of plan, with additional requirements and shorter timeframes applying to group health plans and disability plans. For purposes of this Study, we have assumed that the long-term care insurance plan is *not* a group health plan or disability plan. See *Form 3*, Notes 4 and 11 for more information regarding this issue.

For plans that are exempt from the requirement that an SPD be provided (see Part Four, Section III.C of the Study), this claims section of the Plan may be copied and provided to employees upon request.

(11) The named fiduciary may be an individual designated by name or office held (*e.g.*, President, Human Resources Director, etc.) or may be the Company or its Board of Directors. This form assumes that the Company is designated as the named fiduciary.

(12) As discussed in the Board Resolution comments, the validity and scope of indemnification will depend on local law and will have to be determined by the employer's legal counsel. Indemnification is permitted under ERISA. 29 C.F.R. § 2509.75-4.

(13) It may be useful to delegate amendment authority to an officer to avoid the need to have all amendments brought to the Board.

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Form 2
Annotated Sample Plan Document

This plan document assumes the plan is subject to ERISA.

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[COMPANY NAME]
LONG-TERM CARE INSURANCE PLAN

[Effective _________, 20__]
[Amended and Restated _________, 20__]

Article I. Establishment and Interpretation of the Plan

Section 1.1 Establishment. _________________________ (the "Company")*(NOTE 1)* hereby [adopts][amends and restates],*(NOTE 2)* effective as of _________, 20__, the ________________ Long-Term Care Insurance Plan (the "Plan") which is a welfare benefit plan providing long-term care insurance for the exclusive benefit of Eligible Individuals of the Company [and their Spouses].*(NOTE 3)*

Section 1.2 Purpose. The purpose of the Plan is to provide to Participants and [their Spouses] certain welfare benefits described herein. The Plan is intended to meet all applicable requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and the Internal Revenue Internal Revenue Code of 1986, as amended ("I.R.C."), as well as rulings and regulations issued or promulgated thereunder.*(NOTE 4)*

Article II. Definitions, Gender and Number

Section 2.1 Definitions. Whenever used in the Plan, the following words and phrases shall have the meanings set forth below unless the context plainly requires a different meaning, and when the defined meaning is intended, the term is capitalized:

(a) "Board" means the Board of ___________ of the Company as constituted at the relevant time.

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(b) “Code” or “Internal Revenue Code” means the Internal Revenue Code of 1986, as amended from time to time, and any successor statute. References to an Internal Revenue Code section shall be deemed to be that section or to any successor to that section.

(c) “Company” means [insert name], and its successors.

(d) “Effective Date” means ____________, 20__.

(e) “Eligible Individual” means ________________. *(NOTE 5)*

Comment: *This section 2.1(e) should refer to the group of persons the employer intends to cover. Selected Options, from most restrictive to least restrictive, are as follows:*

Option 1: Select Group – by the Individuals’ Names

“Eligible Individual” means an individual providing services to the Company whose name appears on Appendix A. [If this option is used, add an appendix to this document.]

Option 2: Select Group by Class

“Eligible Individual” means an employee of the Company who is classified as the President or a Vice President.

Option 3: Larger Classes

“Eligible Individual” means all individuals providing services to the Company and classified by the Company as [Partners][Associates] [Define terms.]

Option 4: All Full-Time Employees

“Eligible Individual” means all employees who are regularly scheduled to work ___ hours per week for the Company.

(f) “ERISA” means the Employee Retirement Income Security Act of 1974, as amended from time to time.

(g) “Insurer” means the insurance company issuing the policy or policies providing benefits under the Plan.

(h) “Participant” means an Eligible Individual [or an Eligible Individual’s Spouse] who has satisfied the participation requirements of Article III.

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(i) "Plan" means the _________________ Long-Term Care Insurance Plan, as set forth herein and as may be amended or restated from time to time.

(j) "Plan Administrator" means the Company, unless another entity or person is appointed by the Company to administer the Plan pursuant to Section 7.4.

(k) "Plan Year" means the twelve (12) consecutive month period ending each __________. *(NOTE 6)*

(l) "Policy" means a long-term care insurance policy issued by the Insurer and providing benefits to Participants.

[(m) "Spouse" means a person who is legally married to an Eligible Individual. *(NOTE 7)*]

Section 2.2 Gender and Number. Pronoun references in the Plan shall be deemed to be of any gender relevant to the context, and words used in the singular may also include the plural.

Article III. Eligibility and Participation

Section 3.1 Commencement of Participation. An Eligible Individual [and Spouse] shall become a Participant[s] in the Plan as of [the Eligible Individual's date of hire] [or, specify elimination period, if applicable, *e.g*., first day of the month after [one month] [one year] of the Eligible Individual's employment] provided the conditions set forth in Section 3.2 are satisfied by the Eligible Individual [and Spouse].

Section 3.2 Participation Conditions. As a condition to participation and receipt of benefits under the Plan, an Eligible Individual [and Spouse] agree[s] to:

(a) Furnish to the Insurer any required application to participate provided for in Section 3.3 within [thirty (30)] days of becoming eligible to participate in the Plan;

(b) Observe all rules and regulations implementing the Plan and satisfy any requirements of an Insurer, including any underwriting criteria, as a condition of issuing the Policy;

(c) Consent to inquiries by the Insurer as provided under the Policy; [and]

(d) Submit to the Company or such other agents as the Company may designate, all reports, bills and other information which the Company may reasonably require[.] [;] [; and]

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[(e) Provide identification of Spouse to Company and Insurer if spousal coverage is available and being sought by the Eligible Individual] [; (See NOTE 7) and][. (See NOTE 7)]

[(f) Agree to make required contributions to the Plan as described in Section 4.1. (NOTE 8)]

Section 3.3 Application to Participate. Each Eligible Individual [and Spouse] shall execute and deliver to the Insurer, a written application by which the Eligible Individual [and Spouse] applies to participate in the Plan and supplies any other pertinent information that the Insurer reasonably requires.

Section 3.4 Termination of Participation. In the event an Eligible Individual terminates employment for whatever reason, or otherwise ceases to be an Eligible Individual, the Eligible Individual [and Spouse] shall cease to be a Participant in the Plan as of that date consistent with the Policy. [In addition, a Spouse's participation in the Plan will cease upon dissolution of marriage as of the date consistent with the Policy.] Former Participants may continue to receive long-term care coverage by paying any required premium directly to the Insurer.

Article IV. Funding and Benefits

Comment: Select and customize these alternatives based upon plan design decisions. (NOTE 9)

Option 1: Employer Pay All

Section 4.1 Company Contributions. The Company pays the entire cost of coverage under the Plan. Participant contributions are neither required nor accepted.

Option 2: Employee Pay All

Section 4.1 Participant Contributions. The Participant pays the entire cost of coverage under the Plan through [direct payment to the Insurer] [after-tax payroll deductions].

Option 3: Contributory Approach

Section 4.1 Contributions.

(a) Participant Contributions. The Participant pays the cost of coverage under the Plan to the extent not paid for by the Company.

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(b) Company Contributions. The Company may, in its discretion, pay all or a portion of the premiums for coverage under the Plan. As of the Effective Date, the Company shall pay [describe percentage of premium or dollar amount of premium]. This amount may be changed at any time by action of the Company provided that the Company provides written notice to all Participants.

Section 4.2 Funding. The Plan is funded by [Participant] [and] [Company] contributions. Benefits are provided exclusively through individual qualified long-term care insurance policies. [The Company shall pay to the Insurer when due all premiums required to maintain such insurance in force.] [The Participant shall pay to the Insurer when due all premiums required to maintain such insurance in force.] [The Company shall pay to the Insurer when due all premiums required to maintain such insurance in force for those Participants who have made any required Participant contributions]. Nothing herein requires the Company or the Plan Administrator to contribute to the Plan, or to maintain any fund or segregate any amount for the benefit of any Participant, except to the extent specifically required hereunder. No Participant shall have any right to, or interest in, the assets of the Company.

Article V. Benefits

The Plan provides for long-term care benefits as described in the Policy provided to the Participant which Policy is incorporated herein by reference and made a part hereof. Benefits to be provided hereunder will be provided solely under such Policy. All benefits are subject to the terms and conditions of the Policy.

Article VI. Claims Procedure*(NOTE 10)*

Section 6.1 Written Claim for Insured Benefits. No benefit shall be paid until the Insurer has received a claim for benefits that satisfies all requirements set forth in the Policy.

Section 6.2 Claims Procedure for Insured Benefits (Policy Claims). The claims procedure and appeals procedure for insured benefits shall be as set forth in the Policy. The Insurer shall decide the claim within a reasonable period of time after it is received. If the Insurer denies the claim, in whole or in part, a written notification will be provided, setting forth the reason(s) for the denial. If a claim is denied, the Participant may appeal to the Insurer for a review of the denied claim, in accordance with the procedures and within the time period set forth in the Policy. Refer to the Policy for complete information on the claims and appeals processes. In the event of an adverse determination on appeal, the claimant may pursue other remedies as provided for under ERISA § 502.

Section 6.3 Other Claims Under the Plan (Non-Policy Claims). For other claims under the Plan (other than for benefits under the Policy), the Participant must make a claim by delivering a written

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request to the Plan Administrator. Upon receipt of such request the Plan Administrator may require the Participant to complete such forms and provide such additional information as may be reasonably necessary to establish the Participant's rights under the Plan.

If a claim is wholly or partially denied, the Plan Administrator shall furnish to the Participant a notice of the decision, within ninety (90) days after receipt of the claim by the Plan. If special circumstances require more than ninety (90) days to process the claim, this period may be extended for up to an additional ninety (90) days by giving written notice to the Participant before the end of the initial 90-day period stating the special circumstances requiring the extension and the date by which a final decision is expected. Failure to provide a notice of decision in the time specified shall constitute a denial of the claim and the Participant shall be entitled to require a review of the denial under the review procedures.

The notice to be provided to every Participant who is denied a claim shall be in writing and shall set forth, in a manner calculated to be understood by the Participant, the following:

(1) The specific reason(s) for the adverse determination;

(2) Reference to the specific Plan provision(s) on which the denial is based;

(3) A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary; and

(4) An explanation of the Plan's claim review procedure describing the steps to be taken by a Participant who wishes to submit his or her claim for review.

The purpose of the review procedure is to provide a procedure by which a Participant may have a reasonable opportunity to appeal a denial of a claim to the Plan Administrator for a full and fair review. To accomplish that purpose, the Participant or his or her duly authorized representative:

(1) May request a review upon written application to the Plan Administrator;

(2) May review and obtain copies of relevant Plan documents, upon request and free of charge; and

(3) May submit for consideration: written comments, documents, records and other information related to the claim.

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A Participant (or his duly authorized representative) shall request a review by filing a written application for review with the Plan Administrator at any time within sixty (60) days after receipt by the Participant of written notice of the denial of his or her claim.

The decision on review of a denied claim shall be made in the following manner:

(1) The decision on review shall be made by the Plan Administrator, who may in his or her discretion hold a hearing on the denied claim. The Plan Administrator shall make a decision promptly, which shall ordinarily be not later than sixty (60) days after the Plan's receipt of the request for review, unless special circumstances (such as the need to hold a hearing) require an extension of time for processing. In that case a decision shall be rendered as soon as possible, but not later than one hundred twenty (120) days after receipt of the request for review. If an extension of time is required due to special circumstances, written notice of the extension shall be furnished to the Participant prior to the time the extension commences.

(2) The decision on review shall be in writing and shall include specific reason(s) for the decisions, written in a manner calculated to be understood by the Participant, as well as reference to the specific plan provisions on which the decision is based.

(3) The Participant may review and obtain copies of relevant Plan documents, upon request and free of charge.

(4) In the event the decision on review is not furnished to the Participant within the time required, the claim shall be deemed denied on review.

In the event of an adverse determination on appeal, the Participant may pursue other remedies as provided for under ERISA § 502. Failure to follow this claims procedure may prevent the Participant from challenging an adverse decision in court.

Article VII. Administration and Finances

Section 7.1 Named Fiduciary. The Company shall be the named fiduciary of the Plan. *(NOTE 11)*

Section 7.2 Administration. The Company shall be the Plan Administrator, and, as such, has total and complete discretionary authority to determine conclusively for all parties all questions arising in the administration of the Plan and all relevant facts, except where such authority may have been delegated to another individual or entity pursuant to Section 7.4. It is understood that the Insurer has total and complete discretionary authority to determine conclusively for all parties all questions arising in the administration of the Policy and all relevant facts.

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Section 7.3 Powers of the Company. The Company, or any agent to whom it has delegated its authority, shall have all powers necessary to administer the Plan, including, without limitation, powers:

(a) to interpret the provisions of the Plan;

(b) to establish rules for the administration of the Plan and to prescribe any forms required to administer the Plan; and

(c) to change plans, contracts or policies and/or insurers or other providers of benefits described Article V of the Plan.

Section 7.4 Delegation. The Company shall have the power, by resolution of the Board, to delegate specific duties and responsibilities. Any delegation by the Company, if specifically stated, may allow further delegations by such individual or entity to whom the delegation has been made. The Company may rescind any delegation at any time. Each person or entity to whom a duty or responsibility has been delegated shall be responsible for the exercise of those duties or responsibilities and shall not be responsible for any act or failure to act of any other individual or entity.

Section 7.5 Reports and Records. The Company and those to whom the Company has delegated duties and authority under the Plan shall keep records of all their proceedings and actions, and shall maintain all books of account, records, and other data necessary for the proper administration of the Plan and for compliance with applicable laws.

Section 7.6 Actions of the Company. The Company (including any person or persons to whom the Company has delegated duties), has discretionary authority to interpret and construe the terms of the Plan and to determine all questions of eligibility and status of employees, Participants, and beneficiaries under the Plan and their respective interests. All determinations, interpretations, rules and decisions of the Company (including those made or established by any person or persons to whom the Company has delegated duties) are conclusive and binding upon all persons having or claiming to have any interest or right under the Plan.

Section 7.7 Costs. Except as provided to the contrary, the costs of administering the Plan shall be borne by the Company.

Section 7.8 Indemnification. To the extent permitted by law, the Company shall indemnify the members of the Company's Board, and others to whom the Company has delegated duties and authority pursuant to Section 7.4 who are either employees, officers, or directors of the Company

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against any and all claims, losses, damages, expenses, and liabilities, arising from their responsibilities in connection with the Plan which are not covered by insurance (without recourse) paid for by the Company, unless due to gross negligence or intentional misconduct. *(NOTE 12)*

Article VIII. Amendments and Termination

Section 8.1 Amendments. The Company shall have the right at any time and from time to time, by resolution of the Board, to amend the Plan, in full or in part, including changing eligibility requirements and the amount of any Participant contributions, such amendment to be effective at the time stated therein. *(NOTE 13)*

Section 8.2 Benefits Provided through Third Parties. In the case of any benefit provided pursuant to an insurance policy or other contract with a third party, the Company may amend the Plan by changing insurers, policies, or contracts without changing the language of the Plan, provided that copies of the contracts or policies are filed with the Plan documents and the Participants are informed of the effects of any changes.

Section 8.3 Termination. The Company expects the Plan to remain in force, but necessarily must, and hereby does, reserve the right to terminate the Plan at any time. Upon termination of the Plan, all Participant and Company contributions will cease and no future Participant or Company contributions will be made. Any such termination shall be evidenced by a resolution of the Board or by action of such other person(s) to whom such action has been delegated by the Board pursuant to Sections 7.4. Neither the Company nor any of its respective officers, directors or employees shall have any further financial obligations under the Plan from and after termination of the Plan except those that have accrued up to the date of termination and have not been satisfied.

Article IX. Miscellaneous

Section 9.1 No Guaranty of Employment. The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the Company and any Participant. Nothing contained herein shall give any Participant the right to be retained in the employ of the Company or to interfere with the right of the Company to discharge any Participant at any time, nor shall it give the Company the right to require any Participant to remain in its employ or to interfere with the Participant's right to terminate his or her employment at any time.

Section 9.2 Limitation on Liability. The Company does not guarantee benefits payable under any Policy, and any benefits payable thereunder shall be the exclusive responsibility of the Insurer that is obligated under the Policy.

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Section 9.3 Nonalienation. No benefit payable at any time under the Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, levy, attachment, or encumbrance of any kind by any Participant or beneficiary.

Section 9.4 Applicable Law. The Plan and all rights under it shall be governed by and construed according to the laws of the State of _________, except to the extent those laws are preempted by the laws of the United States of America.

Section 9.5 Benefits Provided Through Insurer. In the case of any benefit provided under a Policy, if there is any conflict or inconsistency between the description of benefits contained in the Plan and the Policy, the terms of the Policy shall control.

Section 9.6 Captions. Article and section headings and captions are provided for purposes of reference and convenience only and shall not be relied upon in any way to construe, define, modify, limit, or extend the scope of any provision of the Plan.

IN WITNESS WHEREOF, the Company has caused this Plan to be executed by its duly authorized [officers][partners] effective as of the ____ day of ____________, 20____.

COMPANY:

____

By: ___________________________

Its: ___________________________

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