

Long-Term Care Insurance Health Screening Questionnaire

Agent: _____
Client: _____

*Long-Term Care Insurance is about protecting the things that are important to your clients.
When considering long-term care for your client, you must think about their health.
It is their health, not their pocketbook, that determines if long-term care insurance makes sense.*

Date of Birth: _____ Height: _____ Weight: _____
Do you use tobacco products: _____ Type: _____
In past 12 months: _____ How often: _____

Have you previously been declined for long-term care insurance?: Yes No

Have you seen a doctor in the last 2 years?: Yes No

Are you receiving Social Security Disability Income?: Yes No

Reason for Disability: _____

List all prescription medications taken over the past 12 months:

1. Medication: _____ Amount: _____ Currently Taking: _____
How long: _____ Reason Prescribed: _____

2. Medication: _____ Amount: _____ Currently Taking: _____
How long: _____ Reason Prescribed: _____

3. Medication: _____ Amount: _____ Currently Taking: _____
How long: _____ Reason Prescribed: _____

4. Medication: _____ Amount: _____ Currently Taking: _____
How long: _____ Reason Prescribed: _____

5. Medication: _____ Amount: _____ Currently Taking: _____
How long: _____ Reason Prescribed: _____

Do you use a cane, crutches, braces, hospital bed, lift chair, walker, wheelchair, oxygen or kidney dialysis? Yes No

Do you need assistance with: shopping, walking, using transportation, housekeeping or cooking? Yes No

Do you currently need the assistance or supervision of another person in performing any of the following activities: moving in/out of bed or chair, bathing, dressing, toileting, bowel/bladder control or eating? (Circle all that apply) Yes No

Have you ever been diagnosed by a licensed physician as having any of the following conditions?
PLEASE NOTE THESE ARE ALL AUTOMATIC DECLINES.

AIDS/HIV Positive	ALS (Lou Gehrig's Disease)
Alzheimer's Disease	Crest
Mental Retardation	Metastatic Cancer
Multiple Myeloma	Cystic Fibrosis
Multiple Strokes or TIAs	Muscular Dystrophy
Multiple Sclerosis	Neurogenic Bladder
Scleroderma	Parkinson's Disease
Post Polio Paralytic Syndrome	Dementia/Confusion/Memory Loss
Spinal Cord Injury	Cerebral Atrophy
Kidney Failure	Liver Cirrhosis
Schizophrenia	

**Within the last 10 years have you received medical advice, diagnosis or treatment for any of the following?
(Circle all that apply)**

- | | |
|--|------------------------------------|
| Amputation | Anemia |
| Autoimmune Disorder | Angioplasty/Bypass Surgery |
| Dizziness | Back Disorder/Surgery |
| Arthritis (Gold Steroid/Chronic Steroid) | Epilepsy/Seizures |
| Blindness/Macular Degeneration | Drug or Alcohol Abuse |
| Falls | Blood Disorder |
| High Blood Pressure | Heart Problems |
| Bronchitis/Asthma | Joint Replacement/Fractures |
| Fibromyalgia | Cancer |
| Mental/Nervous Disorder | Neurological Disorder |
| COPD/Emphysema | Peripheral Vascular Disease |
| Urinary Incontinence | Ulcerative Colitis/Crohn's Disease |
| Depression | Respiratory Disorders |
| Stroke/TIA | Hepatitis |
| Aneurysm | Lupus |
| Diabetes Mellitus (What type _____ & Insulin units per day _____) | |
| Elevated PSA or Prostrate Disorders (PSA levels _____) | |
| Osteoporosis with fractures (Bone density test t-scores _____) | |

If you answered "YES" to any of the previous questions, please provide full details here:

Diagnosis: _____ Date: _____
Treatments: _____ Prognosis: _____
Medications: _____

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Give details on any surgery or procedure in the last 10 years? (Please explain) (i.e. angioplasty, bypass surgery)

Reason: _____ Date: _____
Treatment or therapy: _____
Residual Problems: _____

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Treatment or therapy: _____
Residual Problems: _____

Do you have any scheduled surgery?: _____

If your care costs \$50,000 per year, how much of the cost could/would you want to pay and for how long?: _____

List additional medications, diagnosis or procedures on a separate page and attach to this document.