LONG-TERM CARE INSURANCE INTAKE FORM

Submit Form

A. Client Data

Married ☐ Single ☐

Client Name: _____ Spouse/Partner: _____

Sex: ☐ Male ☐ Female Sex: ☐ Male ☐ Female

Street Address: _____

City: _____ State/Zip: _____ /

Client's Birth Date: _____ Spouse's Birth Date: _____

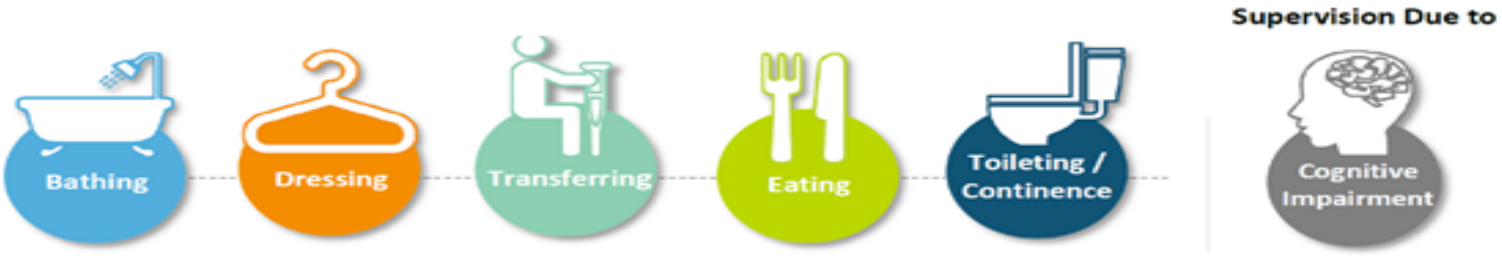
Client's Height: _____ Spouse's Height: _____

Client's Weight: _____ Spouse's Weight: _____

B. Health Data

	Client	Spouse
Do you use a wheelchair, walker, quad cane, hospital bed or been prescribed a handicap sticker?	Y ☐ N ☐	Y ☐ N ☐
Are you cognitively impaired, or do you need help with your ADL's?	Y ☐ N ☐	Y ☐ N ☐

Activities of Daily Living



		Client	Spouse
Have you had any LTCI policy denied or rated up?		Y ☐ N ☐	Y ☐ N ☐
Are you Receiving disability benefits?		Y ☐ N ☐	Y ☐ N ☐
Have you used tobacco products in the last 5 years?		Y ☐ N ☐	Y ☐ N ☐
Have you been hospitalized in the last 5 years?		Y ☐ N ☐	Y ☐ N ☐
Do you use narcotic pain medication or medical marijuana?		Y ☐ N ☐	Y ☐ N ☐
Have you been treated for Diabetes?		Y ☐ N ☐	Y ☐ N ☐
	Insulin	_____	_____
	Alc	_____	_____
Has either of your parents been diagnosed with dementia?		Y ☐ N ☐	Y ☐ N ☐
At what age?		_____	_____
Have you been treated for cancer in the last 5 years?		Y ☐ N ☐	Y ☐ N ☐
Have you been treated for Heart Disease in the last 5 years?		Y ☐ N ☐	Y ☐ N ☐
Have you been treated for Sleep Apnea in the last 5 years?		Y ☐ N ☐	Y ☐ N ☐
Have you been treated for Rheumatoid Arthritis or other auto immune disorder in the last 5 years?		Y ☐ N ☐	Y ☐ N ☐
Have you experienced vertigo?		Y ☐ N ☐	Y ☐ N ☐
Have you had any musculoskeletal disorders?		Y ☑ N ☐	Y ☐ N ☐

Please provide details to any questions listed above as "YES". Please include diagnosis, date, and treatment plan.

Client Additional Details

_____

_____

_____

Spouse Additional Details

_____

_____

_____

CLIENT MEDICATIONS			
Prescription Name	Dosage	Frequency	Reason Prescribed

Have any medications changed within the last 6 months? _____

When was your last complete physical with CBC testing? _____

SPOUSE MEDICATIONS			
Prescription Name	Dosage	Frequency	Reason Prescribed

Have any medications changed within the last 6 months? _____

When was your last complete physical with CBC testing? _____

C. Financial Information

	Husband's Monthly Income	Wife's Monthly Income
Employment Income	$ _____	$ _____
Social Security	$ _____	$ _____
Pension(s) Income (Gross)	$ _____	$ _____
Other Income*	$ _____	$ _____

*If other, please explain:

The funding for long-term care insurance (LTCI) doesn't always have to come solely from current income. In many cases, repositioning part of your current assets can provide all or part of your LTC needs. The following assets are commonly repositioned.

ASSET INFORMATION		
Asset	**Value**	**Owner**
Retirement Accounts	$	
Roth Retirement Accounts	$	
Stocks & Bonds	$	
Checking & Savings	$	
CD or Money Market	$	
Life Insurance Cash Value	$	
HSA Account	$	
Do you own your home	$	

NON-QUALIFIED ANNUITY INFORMATION			
Annuity	**Value**	**How much is gain?**	**Is the annuity owned by you or your spouse/partner?**
Annuity 1	$	$	
Annuity 2	$	$	
Annuity 3	$	$	
Annuity 4	$	$	

If repositioning one of these types of assets doesn't match your objective, what annual or monthly amount of income could be budgeted towards meeting your LTC goal?

Annual Premium:	$	Monthly Premium	$