Long Term Care Insurance

Clear Form

Why are you asking about my health history? Your responses are strictly confidential and are shared with our internal insurance professionals and insurance carriers before you ever complete an application. Long term care insurance is medically underwritten. Understanding your current health before completing an application allows our team to find long term care insurance options for you at the most accurate price that can be placed with a high degree of confidence. Rest assured, you do not need to be in perfect health to qualify for coverage. Please also note that completing this questionnaire is not an offer or guarantee for coverage.

Proposed Insured's (PI) name: _____

Date of Birth _____ Height _____ Weight _____

Have you experienced a weight gain or loss of more than 10 pounds in the past year? YES ◯ NO ◯
If yes, how much gain or loss? _____

Have you previously been rated, postponed, or declined for life/disability/LTC insurance? YES ◯ NO ◯
If yes, when and why? _____

1. In which country were you born? If U.S., what state? _____
2. Are you a citizen of the United States of America? YES ◯ NO ◯
3. Have you ever used tobacco or nicotine products? YES ◯ NO ◯
   How long ago? _____ If within the past 3 years, type and quantity _____
4. Do you vape or use any e-cigarettes? YES ◯ NO ◯
5. Do you or have you ever used marijuana or a recreational drug? If so, please provide details including type of drug, quantity, frequency and purpose (medicinal vs. recreational)? YES ◯ NO ◯
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6. Do you have any medical conditions? If yes, please provide details including how many years you have had that/those condition(s), any complications, and any relevant results scores such as A1C score for diabetes. If you were ever diagnosed with a form of cancer, then please provide stage at diagnosis. YES ◯ NO ◯
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   _____
7. Have you previously been diagnosed with any medical conditions that you no longer have? If yes, please provide details including how many years ago were you were diagnosed and how many years ago you recovered. YES ◯ NO ◯
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8. Please list all current medications, both prescription and over the counter, that you are currently taking, including dosage and frequency.

Medication	Dosage	Frequency	Duration of Use	Reason

9. Have you been pregnant or delivered a child within the last 12 months? If yes, were there any complications during pregnancy or after childbirth? Please provide details: YES ◯ NO ◯

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10. Outside of childbirth, have you had any hospitalizations in the past 10 years? If yes, when and for what? YES ◯ NO ◯

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11. Has any biological parent or sibling died prior to age 70? If yes, from what condition and what age? YES ◯ NO ◯

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12. Do you have family history (parent or sibling) of cardiac disease, cerebral vascular disease, diabetes or cancer? If yes, please provide details & age of diagnosis YES ◯ NO ◯

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13. Have you ever been convicted of a felony or misdemeanor? If yes, provide details and current probation/parole status (if applicable) _____ YES ◯ NO ◯

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14. Within the last 5 years, have you had any moving violations or DUIs? If yes, please provide details and status. YES ◯ NO ◯

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15. Are you an active member of the U.S. Military or Armed Forces Reserves? If yes, please provide details. YES ◯ NO ◯

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16. Do you plan to travel outside the borders of the United States in the next 2 years? If yes, please provide destination and purpose of the trip. YES ◯ NO ◯

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17. Do you participate in dangerous sports or activities, such as, but not limited to, piloting an aircraft, hang gliding, rock climbing, bungee jumping, sky diving or scuba diving? If yes, please provide details, frequency and any certifications attained. YES ◯ NO ◯

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18. Are you currently hospitalized, confined to a bed, or residing in an Assisted Living Facility? (If yes, please provide details including date(s) of any scheduled procedures). YES ◯ NO ◯

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19. In the last 2 years have you applied for any long term care policy or long term care rider that was declined or postponed? YES ◯ NO ◯

20. Are you currently using or been medically advised by a Healthcare Professional within the last 5 years to use any of the following?

Care in a nursing facility	YES ○	NO ○	Motorized scooter	YES ○	NO ○
Home health care services	YES ○	NO ○	Hospital bed	YES ○	NO ○
Adult day care services	YES ○	NO ○	Stair Lift	YES ○	NO ○
Walker	YES ○	NO ○	Oxygen	YES ○	NO ○
Wheelchair	YES ○	NO ○	Dialysis machine	YES ○	NO ○
Multi-prong cane	YES ○	NO ○	Hospice care	YES ○	NO ○

21. Do you require assistance or supervision in performing any of the following activities?

Taking medication	YES ○	NO ○	Eating	YES ○	NO ○
Bathing	YES ○	NO ○	Toileting	YES ○	NO ○
Managing your bowel or bladder	YES ○	NO ○	Dressing	YES ○	NO ○
Getting in or out of a chair or bed	YES ○	NO ○	Walking	YES ○	NO ○

22. In the last 5 years, have you been diagnosed or treated by a Health Care Professional, been prescribed or taken medication for any of the following?

Alzheimer's disease or dementia	YES ○	NO ○	Muscular dystrophy	YES ○	NO ○
Lou Gehrig's disease (ALS)	YES ○	NO ○	Multiple sclerosis	YES ○	NO ○
Mild cognitive impairment (MCI)	YES ○	NO ○	Huntington's disease	YES ○	NO ○
Organic brain syndrome	YES ○	NO ○	Hepatitis	YES ○	NO ○
Mental incapacity or retardation	YES ○	NO ○	Cirrhosis	YES ○	NO ○
Recurrent memory loss	YES ○	NO ○	Parkinson's disease	YES ○	NO ○
Paralysis	YES ○	NO ○			
Smoking in conjunction with Emphysema, COPD				YES ○	NO ○
Stroke or Multiple Transient Ischemic Attack (TIA)				YES ○	NO ○
Have you undergone an organ transplant other than cornea or kidney				YES ○	NO ○
Spinal Stenosis or Chronic Back pain with use of narcotic medication				YES ○	NO ○
Autoimmune disorder/disease such as Systemic Lupus, Systemic Scleroderma, CREST syndrome, Connective Tissue disease				YES ○	NO ○

23. In the last 5 years have you been diagnosed or treated by a Healthcare Professional, or been prescribed or taken medication for any of the following?

Had a seizure or convulsion	YES ○	NO ○	Aneurysm	YES ○	NO ○
Heart bypass surgery	YES ○	NO ○	Had multiple falls	YES ○	NO ○
Heart valve replacement	YES ○	NO ○	Tremors	YES ○	NO ○
Congestive heart failure	YES ○	NO ○	Vascular surgery	YES ○	NO ○
Been hospitalized overnight 2 or more times				YES ○	NO ○
Cardiomyopathy				YES ○	NO ○
Had any fall resulting in a fracture				YES ○	NO ○

24. In the last 5 years, have you been diagnosed or treated by a Healthcare Professional, or been prescribed or taken medication for any of the following?		
Hodgkin's disease or other lymphoma	YES ○	NO ○
Leukemia	YES ○	NO ○
Any cancer other than non-melanoma skin cancer?	YES ○	NO ○
Alcohol or drug abuse or dependency	YES ○	NO ○
Depression, schizophrenia, bi-polar disorder or any other psychiatric disorder	YES ○	NO ○
Blood clotting deficiency, Factor V, VII, VIII, IX, X,	YES ○	NO ○
Idiopathic thrombocytopenic purpura (ITP) or essential thrombocythemia	YES ○	NO ○
Von Willebrand disease	YES ○	NO ○
Smoking with peripheral vascular disease, diabetes, or renal disease	YES ○	NO ○
25. In the last 7 years, have you been diagnosed or treated by a Healthcare Professional, or been prescribed or taken medication for any of the following?		
Hodgkin's disease or other lymphoma	YES ○	NO ○
TIA with a history of heart disease	YES ○	NO ○
Rheumatoid arthritis requiring use of narcotic medication	YES ○	NO ○
Rheumatoid arthritis with joint deformity or joint replacement	YES ○	NO ○
Bipolar disorder, schizophrenia or other psychosis	YES ○	NO ○
Kidney or cornea transplant	YES ○	NO ○
Chronic kidney failure	YES ○	NO ○
Myasthenia gravis	YES ○	NO ○
Diabetes currently treated with insulin	YES ○	NO ○
Diabetes with a history of TIA, Stroke, Neuropathy, kidney disease, peripheral vascular disease or congestive heart failure	YES ○	NO ○
26. Have you been advised by a Healthcare Professional to have any surgery, non-routine diagnostic test or medical evaluation that has not yet been completed? (If yes, please provide details including date(s) of any scheduled procedures).	YES ○	NO ○

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