LTCi & Life Insurance Pre-Screen Worksheet

Resident State:_____

Thank you for completing this brief questionnaire. Doing so will help us determine which company will be most receptive to your health profile.
Please use an additional sheet of paper if necessary.

Applicant Name:_____ **Gender:** Male Female **Date of Birth:**_____ **Height:**_____ **Weight:**_____
(as recorded on last doctor's visit)

1. **In the past 5 years, have you used any tobacco products?** Yes or No
2. **Marital Status?** Single or Married
3. **Do you currently require assistance with any of the activities of daily living ?** **(eating, dressing, bathing, toileting, transferring, maintaining continence)** Yes or No
4. **Have you ever been confined to a nursing or rehabilitation facility or needed assistance with any of the activities listed in #2?** Yes or No
   If yes, please explain when and for what reason: _____
5. **Have you had, do you currently have, or have you ever been medically diagnosed as having any of the following:** (Circle if yes and provide details below)

Arthritis (Osteo/Rheumatoid)
Joint Replacements
Osteoporosis/Fractures
Cancer
Depression/Anxiety
High Blood Pressure
Heart Disease
Kidney Disease
Diabetes (Type I/Type
Dizziness/Falls
Liver Disease
Sleep Disorders
AIDS/HIC
*Alzheimer's Disease/Dementia **(>1** family member: mother, father, sibling)
Asthma/COPD
Memory Loss
Multiple Sclerosis
Muscular Dystrophy
Parkinson's Disease
Stroke or TIA

If you answered yes, please include for each condition, date of diagnosis, treatment received, and if you are still under treatment.

_____

_____

_____

_____

5. **Please complete the following chart to reflect any prescription medications you have taken in the past 12 months:**

Medication Name	Prescribed For	Current Dosage/ Taken How Often	Indicate changes made to dosage in past 12 months. *If no longer taking, please indicate month last used.*	Have you stopped taking it, even though it is prescribed? If so, why?

6. **Have you been hospitalized, consulted with or been treated by a medical professional for any reasons not listed above?** Yes or No
   If yes, please explain. Please include date diagnosed, treatment received, and if you are still under treatment_____
7. **Are you currently under any post-operative care, like physical therapy?** If yes, please explain: _____
8. **Have any surgeries or tests been recommended that have yet to be completed?** If yes, please explain:_____
9. **Have you ever been declined for long term care insurance, life insurance, or disability insurance?** If yes, please explain_____
10. **Do you qualify for payment or are you receiving workers compensation, disability income or social security disability?** Yes or No
11. **Do you have a handicap parking permit?** Yes or No