LONG TERM CARE QUESTIONNAIRE

Agent's Name _____ Agent's Phone _____ Fax/E-mail _____

Client Name		D.O.B.		Citizenship
Height ____ ft. ___ in.	Weight _____ lbs.	Sex ☐ Male ☐ Female	Marital Status	Resident State
Desired Monthly Benefit $ _____	Desired Benefit Duration	Additional Information		

- Lost weight in last year? ☐ Yes ☐ No How much: _____ lbs.
- Tobacco use in any form? ☐ Yes ☐ No If yes, give form and frequency:_____
- Recently stopped using tobacco? ☐ Yes ☐ No If yes, when:_____
- Any family history of Dementia, or Alzheimer's? ☐ Yes ☐ No If yes, list family relation:_____
- List any prescribed medications taken (include dosage, frequency, and purpose): _____

_____

- High blood pressure or elevated cholesterol? ☐ Yes ☐ No If yes, current reading: BP _____ / Chol _____

  Highest reading: BP _____ / Chol _____ HDL reading or ratio: _____
- Ever been hospitalized? ☐ Yes ☐ No If yes, please detail: _____

_____

- Any history of the following? (check all that apply)

☐ Cancer: Date diagnosed?_____ Treatment: _____ Cancer type and stage? _____

☐ Diabetes: Date diagnosed?_____ Type(1 or 2) and last A1C reading? _____

☐ Cardiac Disease: Date diagnosed?_____ Type(attack, bypass, stent,etc.)? _____

☐ Sleep Apnea: Date diagnosed?_____ What is current treatment (CPAP, surgery,etc.) and current AHI? _____

☐ Alcohol/Drug Abuse: Date diagnosed_____ Last date of in-treatment_____

- Does the client have foreign travel plans? ☐ Yes ☐ No If yes, when, where and for what duration?: _____

_____

- Had any physical therapy in the last 6 months? ☐ Yes ☐ No If yes, provide details: _____

_____

- Had a routine medical check-up within the past year? ☐ Yes ☐ No If yes, results: ☐ Normal ☐ Other _____
- Any surgery or testing recommended in the past year? ☐ Yes ☐ No If yes, provide details:_____
- List other illnesses or impairments:_____

_____

The above information is for preliminary underwriting purposes only and will not be made part of any contract.

PROVIDENCE PARTNERS
A Risk Management Firm