LTCSHOP.COM

MAKING LONG TERM CARE INSURANCE EASIER

Health Questionnaire to Request Long-Term Care Insurance Quotes and Information

Your Contact Information

First Name_____

Last Name_____

Phone_____

E-mail_____

Address_____

City_____

State_____Zip Code_____

For whom are you requesting quotes and information on long-term care insurance?

- ☐ Myself and My Spouse/Partner (Complete a separate form for each person.)
- ☐ Myself only
- ☐ My Spouse/Partner only
- ☐ My Relative or Friend (please specify relationship): _____
- ☐ My Client

Answer each of the following questions:

1. Do you currently use any of these mechanical devices: wheelchair, walker, dialysis machine, oxygen equipment, respirator, stair life, 3-pronged cane or quad cane?
   - ☐ Yes
   - ☐ No
2. Do you currently need or receive help in doing any of the following: earing; dressing; toileting; transferring into and out of a bed, chair or wheelchair; and/or maintaining continence?
   - ☐ Yes
   - ☐ No
3. Do you currently have, or have you ever had, a diagnosis or symptoms of: Alzheimer's disease, dementia, muscular dystrophy, ALS (Lou Gehrig's disease), cerebral palsy, down's syndrome, paralysis of any type, or organic brain syndrome?
   - ☐ Yes
   - ☐ No
4. Have you ever been diagnosed as having or been told by a medical doctor that you have AIDS, HIV, or ARC disorders, or tested positive for antibodies for the AIDS virus?
   - ☐ Yes
   - ☐ No
5. Have you ever been diagnosed as having or been told by a medical doctor that you have multiple sclerosis or Parkinson's disease?
   - ☐ Yes
   - ☐ No
6. Are you currently receiving Social Security Disability Insurance payments, or any other type of disability insurance payments?
   - ☐ Yes
   - ☐ No

Have you ever been diagnosed with any of the following conditions?

☐ Alcoholism (Active or history within 10 years)	☐ Heart Valve Replacement
☐ Aneurysm	☐ Hepatitis
☐ Balance Disorder/Gait Impairment	☐ Hydrocephalus
☐ Bipolar Disorder	☐ Kidney Failure
☐ Cancer, internal, occurrence within last 5 years	☐ Leukemia
☐ Chronic pain	☐ Lymphoma
☐ Cirrhosis (i.e. systemic lupus, scleroderma)	☐ Multiple Myeloma
☐ Congestive heart failure (CHF)	☐ Myasthenia Gravis
☐ Coronary Heart Disease (heart attack, angioplasty, coronary bypass surgery)	☐ Narcotic Pain Killer – current using
☐ Defibrillator	☐ Organ transplants
☐ Depression – hospitalized within last 5 years	☐ Resides in an Assisted Living Facility, including continued care, retirement communities or received home care assistance
☐ Diabetes – insulin dependent	☐ Stroke – multiple, with residuals, coexisting CAD, diabetes
☐ Drug addiction/illicit drug usage – within last 10 years	☐ Surgery pending – will review after surgery and released from doctor's care
☐ Emphysema (current smoker)	☐ TIA – multiple episodes, residuals

Have you had an unplanned weight change in the past 12 months?

☐ Yes
☐ No

In the last 5 years, have you been declined long term care insurance, life insurance, disability income insurance or offered such insurance with an increased premium or restricted benefits?

- ☐ Yes
- ☐ No

If yes, give Company name, when, and why:

Applicant 1: Company_____ When_____
Why_____
Applicant 2: Company_____ When_____
Why_____

Are you actively at work?

- ☐ Yes
- ☐ No

If Yes, complete the following:
Full Time_____ Part Time_____ Hours Per Week_____
Profession:_____

If Retired, month and year of retirement:_____
Former Profession_____

Have you ever been diagnosed with, treated for, tested positive for, or received medical advice from a member of the medical profession for any of the following conditions?

- ☐ Amputation due to disease
- ☐ Chronic Hepatitis
- ☐ Cystic Fibrosis
- ☐ Frequent or Persistent Forgetfulness
- ☐ Huntington's Chorea
- ☐ Neurological condition affecting spinal cord or brain
- ☐ Osteoporosis with Fracture
- ☐ Polymyositis
- ☐ Schizophrenia
- ☐ Spinal Cord Injury

In the last 5 YEARS, have you been diagnosed with, treated for, tested positive for, or received medical advice from a member of the medical profession for any of the following conditions?

- ☐ Blood Disorders
- ☐ Cancers
- ☐ Circulatory Disorders
- ☐ Endocrine and Pituitary Disorders
- ☐ Eye and Ear Disorders
- ☐ Gastrointestinal Disorders
- ☐ Genitourinary Disorders
- ☐ Musculoskeletal Disorders
- ☐ Neurological Disorders
- ☐ Respiratory Disorders
- ☐ Immune System Disorders

Have you received physical, occupational or speech therapy in the past 6 months?

- ☐ Yes
- ☐ No

Have you ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for sleep apnea? If yes, do you use CPAP, BiPAP or a dental device?

- ☐ Yes
- ☐ No

Have you ever used tobacco or nicotine products?

- ☐ Yes If yes, date last used? _____
- ☐ No

Do you regularly consume 4 or more alcoholic beverages per day, or do you drink 5 or more drinks per day, 1 or more days per week?

☐ Yes
☐ No

Please list all over-the-counter or prescription medications you have taken in the past 12 months in the table below. (NOT Supplements)

Medication Name	Dosage	How Often Taken?	How Long Taken?	Prescribed by Primary Doctor	Why Taken? (Diagnosis or Condition)

Family History Profile

Have any of your family members (mother, father or siblings) been diagnosed or treated by a member of the medical profession for any of the following conditions?

☐ Alzheimer's Disease

☐ ALS (Lou Gehrig's Disease)

☐ Dementia

☐ Diabetes

☐ Heart Disease

☐ Huntington's Chorea

☐ Parkinson's Disease

☐ Stroke

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Once you've completed this form, please fax it to our HIPAA compliant number:

888-582-7177

Or, you can mail it to us at the following address:

LTCShop.com
Carolyn Olson, CLTC
1473 Crestview Drive
Camano Island, WA 98282