LTC Medical Pre-qualifications

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Agent Information

Agent Name:
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Client Information

Client's Name: ____

State: ____

◯ Male ◯ Female

DOB: ___/___/____ Height: __________ Weight: __________

Tobacco User: ◯ Yes ◯ No

If so, please indicate the type and frequency. If quit, indicate last use.

____

Does the client have a spouse or significant other with whom they reside?

◯ Yes ◯ No

Medical Questions

Have you ever been diagnosed with or treated for one of these conditions? *(check all that apply)*

☐ Arthritis (☐ Osteo / ☐ Rheumatoid)
☐ Osteoporosis
☐ Fractures
☐ Diabetes
(☐ Type 1: Insulin Units: ____ / ☐ Type II)
☐ Alzheimer's / ☐ Dementia
☐ Memory Loss

☐ Joint Replacements
☐ Depression / ☐ Anxiety
☐ Heart Disease
☐ Cancer
☐ Type: _________ / Stage: __________
☐ Kidney Disease
☐ Dizziness / ☐ Falls

☐ Liver Disease
☐ Sleep Disorders
☐ Stroke / ☐ TIA
☐ High Blood Pressure
☐ Ashthma
☐ COPD
☐ Back Pain Issues

☐ Bipolar/Schizophrenia
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Parkinson's Disease
☐ AIDS / ☐ HIV
☐ COVID

Medications

☐ Check here if you DO NOT TAKE ANY MEDICATIONS

Record all medications you currently take including **prescription medications** and any **over the counter drugs**.

Name of Drug	Dosage	Frequency	When Prescribed	Reason for Taking

In the past 5 years:

◯ Surgery Completed ◯ Disability
◯ Handicap Tag ◯ Surgery Planned/ Recommended

If yes: ____

____

When was the last time you saw your primary physician and why?

Date Last Seen: ______________________________ Future Scheduled Visits: ______________________________

Reason: ____

____

Have you been previously declined or rated for LTC?

◯ Yes ◯ No

Provide details: ____

____

List any specialists you have seen in the last 5 years.

Type of Specialist:	Month/Year last seen:	Reason for Visit:
1.		
2.		
3.		

Cancer History

Type: ______

Date Diagnosed: ______

Treatment: ______

______

Stage: ______

Grade: ______

Lymph Node Involvement: ◯ Yes ◯ No

Date of Last Treatment: ______

Any Recurrence? ◯ Yes ◯ No

If prostate cancer, please include pre-PSA: ______

current PSA: ______

Gleason Score: ______

To the best of your knowledge, has your biological mother, father or sibling been diagnosed with coronary heart disease or any form of dementia *(e.g. Alzheimer's Disease)*?

Family Member:	Condition:	Age of Diagnosis:
1.		
2.		
3.		
4.		

Diabetes History

◯ Type I ◯ Type II

Date Diagnosed: ______

Medications: ______

A1C: ______

Any Complications (retinopathy, neuropathy, nephropathy): ______

______

Mental Illness/Depression History

Name of condition: ______

Date Diagnosed: ______

Severity: ______

Treatment: ______

______

Seeing a psychiatrist/psychologist? ______

Attempted suicide? If yes, date(s): ______

Hospitalization due to depression? ◯ Yes ◯ No

Bone, Joint, or Muscular Problems:

1. Surgery/joint replacements or recommended surgery in the past 5 years? ◯ Yes ◯ No
2. Any history of joint injections in the last 5 years? ◯ Yes ◯ No
3. Do you have any joint deformities? ◯ Yes ◯ No
4. Are you currently in physical therapy or using any medical equipment (i.e. cane, walker, crutches)? ◯ Yes ◯ No

Additional Information

Please include any Health History that was not covered in above areas. Also, include any additional information that you may have regarding the above areas. If this is a rush, please indicate when needed by. Please allow extra time so we can find you the best carrier given the information provided.

______

______

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Proposed Policy

Monthly Benefit:	Lifetime Pay ◯ 10-Pay ◯ Single Premium ◯ 1035 Amount: ______	Benefit Duration:	Riders Requested: