# Traditional Long-Term Care Questionnaire

Agent Name: ______________________ Date Needed: ______________

Phone: ______________________ Email: ______________________

Primary Insured: ______________________

☐ *(**Check** if client is married, but spouse not applying/uninsurable)*

Date of Birth: ______________ Sex ______

Last Complete Physical: ______________

Last Nicotine Use: ______________

Height: __________ Weight: __________

State of Residence: ______________

State Where App Will Be signed: ______________

**List details of any medical conditions in the past 10 years ***
especially High Blood Pressure, Heart Attack, Angina, Angioplasty, Atrial Fibrillation, Stroke/TIA, Arthritis (all types), Diabetes, Osteoporosis, PSA, Cancer, Fibromyalgia, Anxiety/Depression, Surgeries or Hospital Stays, Previous LTCI Declines (continue list on back if needed):

| Medical Condition: | Prescription Medications: | Dose & Frequency: |
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Spouse/Partner: ______________________

Date of Birth: ______________ Sex ______

Last Complete Physical: ______________

Last Nicotine Use: ______________

Height: __________ Weight: __________

State of Residence: ______________

State Where App Will Be signed: ______________

**List details of any medical conditions in the past 10 years ***
especially High Blood Pressure, Heart Attack, Angina, Angioplasty, Atrial Fibrillation, Stroke/TIA, Arthritis (all types), Diabetes, Osteoporosis, PSA, Cancer, Fibromyalgia, Anxiety/Depression, Surgeries or Hospital Stays, Previous LTCI Declines (continue list on back if needed):

| Medical Condition: | Prescription Medications: | Dose & Frequency: |
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* Auto Decline Conditions: AIDS, Alcoholism (4 or more drinks a day), ALS (Lou Gehrig's Disease), Alzheimer's Disease, Cystic Fibrosis, Equipment Use (4 pronged cane, walker or wheelchair), HIV, Huntington's Chorea, Multiple Sclerosis, Muscular Dystrophy, Multiple Myeloma, Oxygen Use, Paralysis/Paraplegia/Quadriplegia, Parkinson's Disease, Transplants.

| **Monthly Benefit Desired:** | **Elimination Period:** | **Benefit Period:** | **Inflation Protection:** | **Additional Riders:** |
|---|---|---|---|---|
| $ ______<br>Daily Benefit x 30 Days Per Month = ______ Monthly Benefit | ______<br>90, 180, 365 Days<br>☐ 0 Day HHC/Waiver of Home Care EP | ☐ 2 Year<br>☐ 3 Year<br>☐ 4 Year<br>☐ 5 Year<br>☐ 6 Year | ☐ Compound ___%<br>☐ None | ☐ Shared Care/Shared Benefit<br>☐ Joint Waiver of Premium |

***Fax completed form to SBG: 763-522-6251***

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