

Health Questionnaire

Name	Height	Weight	Phone (home, work, or cell)
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Does Long Term Care Insurance make sense for you? Please rank the top 3 statements in order of importance (i.e. 1 most important, 2 next important). "I would like to . . ."

Protect my family from the burden of caregiving		Maintain my dignity	
Know someone will be there to care for me		Plan for the unexpected	
Stay in my own home		Stay in control, independent, have choices	
Protect my life savings/preserve inheritance		Receive quality care	

If you know someone who has received long-term care, briefly describe your experience.

List all medications you are currently taking.

Medication	Dosage&Frequency	How long?	Reason Prescribed/By Whom

Primary care doctor name _____

Doctor address	Doctor telephone	
City, State, Zip	Date last seen: mo/yr	

Please check "yes" or "no" for each question.

	Y	N
1 In the past 12 months , have you had an application rejected for long term care, nursing home care, or other health insurance?	<input type="checkbox"/>	<input type="checkbox"/>
2 Within the past 5 years (10 for cancer) , have you received any medical advice, examination, or treatment from a health care professional; taken any medication; or been medically diagnosed for:	<input type="checkbox"/>	<input type="checkbox"/>
a Cardiovascular or circulatory disorder including congestive heart failure (CHF), peripheral vascular disease, heart attack, chest pain, angina, high blood pressure or irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>
b Cancer or non-cancerous tumors	<input type="checkbox"/>	<input type="checkbox"/>
c Hodgkin's Disease, Lymphoma, Leukemia, other blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
d Skin ulcers	<input type="checkbox"/>	<input type="checkbox"/>
e Non-insulin dependent diabetes	<input type="checkbox"/>	<input type="checkbox"/>
f Insulin dependent diabetes # of units per day _____	<input type="checkbox"/>	<input type="checkbox"/>
g Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
h Asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
i Brain disorder, convulsions, epilepsy or seizures, dizziness or balance problems, fainting spells or black outs	<input type="checkbox"/>	<input type="checkbox"/>
j Depression, anxiety, mental, emotional or nervous disorder, or confusion, or memory loss	<input type="checkbox"/>	<input type="checkbox"/>
k Tremors	<input type="checkbox"/>	<input type="checkbox"/>

continued on page 2

Health Questionnaire

Please check "yes" or "no" for each question.

	Y	N
l Visual disturbances	<input type="checkbox"/>	<input type="checkbox"/>
m Amputation	<input type="checkbox"/>	<input type="checkbox"/>
n Disabling back or spine injury	<input type="checkbox"/>	<input type="checkbox"/>
o Fracture	<input type="checkbox"/>	<input type="checkbox"/>
p Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
q Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
r Paralysis, weakness or numbness of the extremities	<input type="checkbox"/>	<input type="checkbox"/>
s Replacement of the hip, knee or other joint	<input type="checkbox"/>	<input type="checkbox"/>
t Rheumatoid arthritis, Lupus, Scleroderma or other connective tissue disease	<input type="checkbox"/>	<input type="checkbox"/>
u Other conditions causing crippling or limited motion or requiring use of an adaptive device, chronic pain or fatigue, or Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>

3 Within the **past 3 years**, have you been medically advised to enter or been confined to a hospital or other health care facility? Y N

4 Within the **past 3 years**, have you:

been confined to a nursing home, assisted living facility, or long term care facility?	<input type="checkbox"/>	<input type="checkbox"/>
been medically advised to have surgery which has not been performed?	<input type="checkbox"/>	<input type="checkbox"/>
received home health care?	<input type="checkbox"/>	<input type="checkbox"/>
used adult day care?	<input type="checkbox"/>	<input type="checkbox"/>
NONE	<input type="checkbox"/>	<input type="checkbox"/>

5 Within the **past 5 years**, have you been advised to limit, reduce, discontinue or seek counseling for the use of alcohol or drugs? Y N

6 Within the **past 5 years**, have you received any medical advice, examination or treatment from a health care professional for any reason not previously stated? Y N

State law requires that certain financial information be considered to determine if a policy is right for you.

What is your annual income?

Under \$20,000 \$20,000-\$30,000 \$30,000-\$50,000 Over \$50,000

Not counting your home, what is the estimated value of your assets (savings and investments)?

Under \$20,000 \$20,000-\$30,000 \$30,000-\$50,000 Over \$50,000

To find out if long term care insurance is right for you complete this form and mail it to

Long Term Care Advisors
13866 S. Gallery Street
Olathe, KS 66062

If you prefer, you may complete it, scan it, and email it to info@ltcexpert.net.

Call us with your questions. - (913)-829-7555

This information used for the sole purpose of identifying long-term care insurance options.