Long-Term Care & Life Insurance Form

The following information is necessary for our insurance agents to provide a quote for life or longterm care insurance. Please note this form is both front and back. Please attach another sheet if necessary, and please contact us at any time if further clarification is needed for anything. Thanks again for choosing Stockman Insurance for your insurance coverage needs!

CLIENT NAME: ________________________________ **DOB:** ___ / ___ / ___

1. Current Health Conditions: ____

____

2. Medications: ____

____

3. Have you used Tobacco in the last 5 years? _______YES _______NO _______NEVER

If no, when did you quit? ____

4. Do you have High Blood Pressure? _______YES _______NO

Last BP reading: ______________________

5. Height: ____ft ____in Weight: ____ lb

6. Have you been hospitalized in the last 5 years? _______YES _______NO

If yes, date and reason: ____

____

1. Have you ever been treated/diagnosed with Diabetes? _______YES _______NO

TYPE: _______INSULIN DEPENDENT (TYPE 1)

UNITS OF INSULIN ____________________

_______NON-INSULIN DEPENDENT (TYPE 2)

CURRENT GLUCOSE AND/OR HEMOGLOBIN A1C READING: ______________________________

ORAL MEDICATIONS: ____

Do you have any of the following? (may result in rating or declinations)

_______DIABETIC RETINOPATHY (EYE) _______DIABETIC NEUROPATHY

_______PERIPHERAL VASCULAR DISEASE _______KIDNEY PROBLEMS

_______DIABETES WITHOUT CURRENT FOLLOW-UP OR BLOOD SUGAR

2. Have you ever been treated/diagnosed with cancer? ______**YES** ______**NO**

______INTERNAL ______EXTERNAL DIAGNOSIS DATE: ___ / ___ / ___

TYPE: ____________________________ RECURRENCE:______YES ______NO

DATE AND TYPE OF LAST TREATMENT: ____

3. Have you ever been treated/diagnosed with osteoporosis/osteopenia? ______**YES** ______**NO**

DIAGNOSIS DATE: ___ / ___ / ___ TREATMENT TYPE: ______________________________

Have you ever had compression fractures/falls due to osteoporosis? ______YES ______NO

What are the most recent bone density test scores? ______________________________

Do you have chronic pain? ______YES ______NO

4. Have you ever been treated/diagnosed with Chronic Obstructive Pulmonary Disease (COPD)? ______**YES** ______**NO**

Do you have shortness of breath with or without exertion? ______YES ______NO

Are you currently being treated with oral steroids/prednisone? ______YES ______NO

What is your most recent pulmonary fuction test scores? ______________________________

____

5. Have you ever had a stroke or been diagnosed by physician with TIA or TIA symptoms? ______**YES** ______**NO**

DATE OF SYMPTOMS/DIAGNOSIS: ___ / ___ / ___

RECURRENT SYMPTOMS: ____

RESIDUALS: ____

6. Have you ever been treated/diagnosed with any of the following heart condition(s)? ______**YES** ______**NO**

______**CORONARY ARTERY DISEASE, HEART ATTACK**

______ **CONGESTIVE HEART FAILURE**

______**VALVE REPLACEMENT, VALVE DISEASE**

______ **ATRIAL FIBRILLATION**

______**HYPERTENSIONS/OTHER CARDIOVASCULAR DISEASE**

______ **CARDIOMYOPATHY**

TYPE OF TREATMENT AND DIAGNOSIS DATE: ____________________________________

7. Do you have history of degenerative disc disease with chronic pain? _______YES _______NO

8. Have you ever discussed any memory issues with your physician (forgetfulness, memory loss, severe depression, or mental disorders)? _______YES _______NO

9. Do you have a history of Rheumatoid Arthritis/Fibromyalgia? _______YES _______NO

DATE OF SYMPTOMS/DIAGNOSIS: ____ / ____ / ____

Any assistive devices needed? (walker, wheelchair, cane) ____

Is physical therapy a requirement? _______YES _______NO

FINANCIAL CONSIDERATIONS

1. What are your expectations for the cost of premiums? What level of benefits are you seeking?

____

____

2. How will you pay your life or LTC insurance premiums? _______ INCOME

_______ SAVINGS/INVESTMENTS

3. Will your family contribute anything? _______YES _______NO

4. If retirement is coming up in the next 5 - 15 years, how will it impact your ability to pay your premiums?

_______ NO IMPACT _______ MINOR IMPACT _______ MAJOR IMPACT