LONGEVITY PLANNING

Am I Insurable?

Health History Questionnaire

The first step in long-term care expense planning is determining insurability. Long-term care insurance is medically underwritten. Health history will determine carrier, product, and ultimately the cost of a policy. Please complete the information below, providing as much detail as possible, to begin the process.

I. PERSONAL INFORMATION

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Partner/Living Together

Client

Name: _____ Sex: ❑ Male ❑ Female

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Fax Number: _____ Email: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Spouse/Partner

Name: _____ Sex: ❑ Male ❑ Female

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Fax Number: _____ Email: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

II. CAN YOU QUALIFY? (continues)	*Client*		*Spouse/Partner*	
Do you use devices such as a wheelchair, walker, quad cane, crutches, hospital bed, dialysis machine, oxygen, or stair lift? Please circle all that apply.	❑ Yes	❑ No	❑ Yes	❑ No
Are you cognitively impaired or do you currently need or receive help in doing any of the following activities of daily living (ADLs): bathing, eating, dressing, toileting, transferring or maintaining continence? Please circle all that apply.	❑ Yes	❑ No	❑ Yes	❑ No

II. CAN YOU QUALIFY?	Client		Spouse/Partner	
Have you had another long-term care insurance policy inforce during the last 12 months? If so, with which company: _____	○ Yes	○ No	○ Yes	○ No
Are you currently covered by Medicaid (not Medicare)?	○ Yes	○ No	○ Yes	○ No
Are you currently receiving Disability, Worker's Compensation, or Social Security Disability Benefits? Please circle all that apply.	○ Yes	○ No	○ Yes	○ No
Do you intend to replace any of your medical or health coverage with the coverage applied for? (This is not medical or health insurance coverage.)	○ Yes	○ No	○ Yes	○ No
Have you had a gain or loss of more than 10 pounds in the last 12 months? If yes, please explain: _____ _____	○ Yes	○ No	○ Yes	○ No
Have you used tobacco products (smoked, chewed or used nicotine delivery system) including pipes and cigars in the last 12 months? Please circle all that apply.	○ Yes	○ No	○ Yes	○ No
Have you been advised to limit, reduce, discontinue, or seek counseling for the use of alcohol or drugs?	○ Yes	○ No	○ Yes	○ No
Have you been hospitalized in the past five years? If yes, please explain: _____ _____	○ Yes	○ No	○ Yes	○ No
Has surgery been recommended but not performed? If yes, please explain:_____	○ Yes	○ No	○ Yes	○ No
Have you experienced episodes of falling, fainting, dizziness or imbalance?	○ Yes	○ No	○ Yes	○ No
In the last 10 years, have you been diagnosed or treated for any of the following?:				
- AIDS/HIV	○ Yes	○ No	○ Yes	○ No
- ALS (Lou Gehrig's Disease)	○ Yes	○ No	○ Yes	○ No
- Alzheimer's Disease, Dementia or Senility or Memory Loss	○ Yes	○ No	○ Yes	○ No
- Congestive Heart Failure	○ Yes	○ No	○ Yes	○ No

II. CAN YOU QUALIFY?	Client		Spouse/Partner	
- Asthma Or Chronic Bronchitis	○ Yes	○ No	○ Yes	○ No
- Cirrhosis of the Liver	○ Yes	○ No	○ Yes	○ No
- Cystic Fibrosis	○ Yes	○ No	○ Yes	○ No
- Diabetes with Insulin or history of TIA or Vascular Disease	○ Yes	○ No	○ Yes	○ No
- Huntington's Chorea	○ Yes	○ No	○ Yes	○ No
- Hypertension or High Blood Pressure	○ Yes	○ No	○ Yes	○ No
- Metastatic Cancer	○ Yes	○ No	○ Yes	○ No
- Multiple Sclerosis	○ Yes	○ No	○ Yes	○ No
- Muscular Dystrophy	○ Yes	○ No	○ Yes	○ No
- Organic Brain Syndrome	○ Yes	○ No	○ Yes	○ No
- Parkinson's Disease	○ Yes	○ No	○ Yes	○ No
- Stroke or Multiple Transient Ischemic Attack	○ Yes	○ No	○ Yes	○ No
- Alcohol or Drug Addiction	○ Yes	○ No	○ Yes	○ No
- Amputation	○ Yes	○ No	○ Yes	○ No
- Angioplasty or Heart Surgery	○ Yes	○ No	○ Yes	○ No
- Cancer (please see page 6)	○ Yes	○ No	○ Yes	○ No
- Carotid or other Artetial Surgery	○ Yes	○ No	○ Yes	○ No
- CREST Syndrome or Scleroderma	○ Yes	○ No	○ Yes	○ No
- Depression, Anxiety or Bipolar	○ Yes	○ No	○ Yes	○ No
- Diabetes (please see page 6)	○ Yes	○ No	○ Yes	○ No
- Disabling Back or Spine Condition	○ Yes	○ No	○ Yes	○ No
- Emphysema/COPD	○ Yes	○ No	○ Yes	○ No
- Epilepsy, Seizures or Convulsions	○ Yes	○ No	○ Yes	○ No

II. CAN YOU QUALIFY?	Client		Spouse/Partner	
- Fainting Spells or Blacking Out	○ Yes	○ No	○ Yes	○ No
- Fibromyalgia	○ Yes	○ No	○ Yes	○ No
- Heart Attack, Angina or Atrial Fibrillation	○ Yes	○ No	○ Yes	○ No
- Hodgkin's Disease	○ Yes	○ No	○ Yes	○ No
- Immune System Disorders	○ Yes	○ No	○ Yes	○ No
- Irritable Bowel Syndrome or Crohn's Disease	○ Yes	○ No	○ Yes	○ No
- Joint Replacement Surgery	○ Yes	○ No	○ Yes	○ No
- Kidney Failure	○ Yes	○ No	○ Yes	○ No
- Leukemia	○ Yes	○ No	○ Yes	○ No
- Lupus	○ Yes	○ No	○ Yes	○ No
- Mental Illness	○ Yes	○ No	○ Yes	○ No
- Multiple Myeloma	○ Yes	○ No	○ Yes	○ No
- Myasthenia Gravis	○ Yes	○ No	○ Yes	○ No
- Osteoporosis	○ Yes	○ No	○ Yes	○ No
- Post-Polio Syndrome	○ Yes	○ No	○ Yes	○ No
- Rheumatoid Arthritis or Osteoarthritis	○ Yes	○ No	○ Yes	○ No
- Sleep Apnea	○ Yes	○ No	○ Yes	○ No

If you checked "Yes" to any of the conditions listed on Page 3 or have been treated for a condition not listed above, please provide details below.

Client

Condition	*Date First Diagnosed*	*Current Status*	*Date of Last Treatment*

Spouse/Partner

Condition #	*Date First Diagnosed*	*Current Status*	*Date of Last Treatment*

What medications are you taking?

Client

Condition #	*Date First Diagnosed*	*Current Status*	*Date of Last Treatment*

Spouse/Partner

Condition #	*Date First Diagnosed*	*Current Status*	*Date of Last Treatment*

When was your last physical exam?

Client

Date: _____ Outcome: _____

Physician: _____ Phone Number: _____

Address: _____

Spouse/Partner

Date: _____ Outcome: _____

Physician: _____ Phone Number: _____

Address: _____

CANCER ADDITIONAL HEALTH INFORMATION

When was the cancer diagnosed (Month, Year)?:_____

What type of cancer did you have and where was it located?:_____

_____

At the time of diagnosis, what was the stage (1,2,3,4) and grade (A,B,C, or D)?:_____

_____

Were any lymph nodes positive? If so, how many?:_____

What was the treatment protocol? Surgery? Chemo? Radiation? Combination?:_____

_____

When were you released from treatment (Month, Year)?:_____

If Prostate Cancer, when was the last PSA and Gleason Score done?: _____

What were the readings?:_____

DIABETES ADDITIONAL HEALTH INFORMATION

What type of Diabetes do you have? Juvenile onset Type I? Adult onset Type II?: _____

When was it diagnosed (Month, Year)?:_____

What is the treatment? Diet Only? Oral Medicine? Insulin injections? Insulin Pump? Number of CCs or units of insulin?:_____

_____

When was the last blood sugar test done? What was the reading?:_____

When was the last A1C done? What was the reading?:_____

Have there been any complications? Foot ulcers? Vision Problems? Kidney Damage? Neuropathy?:

_____

_____

FAMILY HISTORY

Any family history of Alzheimer's/dementia? ❑ Yes ❑ No

Grandparent/Parent/Sibling? _____ Age of onset:_____