

Thank you for completing this brief questionnaire. Doing so will help us determine which company will be most receptive to your health profile.
This form is fillable and can be completed and saved directly to your computer. Once saved, it can be emailed as an attachment.

Applicant Name: _____ **Gender:** Male Female **Date of Birth:** _____ **Height:** _____ **Weight:** _____
(as recorded on last doctor's visit)

- In the past 5 years, have you used any tobacco products?** Yes No If yes, what type/how often: _____
- Have you ever been declined for Long Term Care Insurance?** Yes No If yes, why and with which carrier? _____
- Have you ever been confined to a nursing or rehabilitation facility or needed assistance with any of activities of daily living?** Yes No
If yes, please explain when and for what reason: _____

4. **Have you had, do you currently have, or have you ever been medically diagnosed as having any of the following:** (Check if yes)

- | | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> Arthritis (<input type="checkbox"/> Osteo/ <input type="checkbox"/> Rheumatoid) | <input type="checkbox"/> Joint Replacements | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke/ <input type="checkbox"/> TIA | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Osteoporosis/ <input type="checkbox"/> Fractures | <input type="checkbox"/> Depression/ <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dizziness/ <input type="checkbox"/> Falls | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Diabetes (<input type="checkbox"/> Type I/ <input type="checkbox"/> Type II) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Asthma/ <input type="checkbox"/> COPD | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Alzheimer's / <input type="checkbox"/> Dementia/ <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sleep Disorders | <input type="checkbox"/> Back pain issues | <input type="checkbox"/> AIDS/ <input type="checkbox"/> HIV |

If you answered yes, please include for each condition: date of diagnosis, treatment received, and if you are still under treatment.

5. **Please complete the following chart to reflect any prescription medications you have taken in the past 12 months:**

Medication Name	Diagnosis/ Date of Diagnosis	Current Dosage/ Taken How Often	Indicate changes made to dosage in past 12 months. <i>If no longer taking, please indicate month last used.</i>	Have you stopped taking it, even though it is prescribed? If so, why?

- Have you been hospitalized, or been treated by a medical professional for any reasons not listed above?** Yes No
If yes, please explain. Please include date diagnosed, treatment received, and if you are still under treatment.

- Are you currently under any post-operative care, like physical therapy?** If yes, please explain: _____
- Have any surgeries been recommended that have yet to be completed?** If yes, please explain: _____
- Do you have any significant family history?** (i.e. Dementia, Coronary Artery Disease, etc.) If yes, please explain: _____
