Advisor_____ URL INSURANCE GROUP **Long Term Care Insurance Pre-Screen** Client Resident State_____

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)

1. **In the past 5 years, have you used <u>any</u> tobacco products?** ☐ Yes ☐ No If yes, what type/how often: _____
2. **Have you ever been declined for Long Term Care Insurance?** ☐ Yes ☐ No If yes, why and with which carrier? _____
3. **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)

☐ Arthritis (☐ Osteo/ ☐ Rheumatoid)	☐ Joint Replacements	☐ Kidney Disease	☐ Stroke/ ☐ TIA	☐ Multiple Sclerosis
☐ Osteoporosis/ ☐ Fractures	☐ Depression/ ☐ Anxiety	☐ Dizziness/ ☐ Falls	☐ High Blood Pressure	☐ Muscular Dystrophy
☐ Diabetes (☐ Type I/ ☐ Type II)	☐ Heart Disease	☐ Liver Disease	☐ Asthma/ ☐ COPD	☐ Parkinson's Disease
☐ Alzheimer's / ☐ Dementia/ ☐ Memory Loss	☐ Kidney Disease	☐ Sleep Disorders	☐ Back pain issues	☐ AIDS/ ☐ 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. *If no longer taking, please indicate month last used.*	Have you stopped taking it, even though it is prescribed? If so, why?

6. **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.

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

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