

Producer Information

Name: _____ Email: _____ Fax: _____

Date: _____ Date needed by: _____ State: _____ Send Via: E-mail Fax Mail

Insured information

Insured information:

Name: _____ DOB: _____ Male: Female

Married living with partner Single Living alone

Name of spouse/ partner: _____ DOB: _____ State: _____ Male Female

License number: _____ License expiration: _____

Current coverage in force: Life Disability Long term care Annuity

Existing long term care coverage

None Group LTC Individual LTC Elimination period _____ monthly/ daily benefit _____

Benefit period _____ Company _____ Replacing coverage: Yes No

Insured Medical information

Height: _____ Weight: _____ Blood Pressure: _____ Cholesterol: _____

Medications- list name and dosage of medication and Condition being treated:

Medical conditions or hospitalization in last 10 years

Family History of Alzheimer's, Parkinson's, or dementia: Yes No

If yes Explain

Insured medical information continued:

1. Heart conditions: Coronary artery, valve, heart muscle, high blood pressure, rhythm disorders? Yes No
2. Nicotine Use: Currently using- Type _____ Formally used- Type _____ - Date quite _____ Never used
3. Peripheral vascular disease: Carotid artery stenosis, blockage of leg arteries? Aneurysms, other? Yes No
4. Cancer or Tumors: Organ involved: _____ Tumor type: _____ Stage/Grade: _____ Not applicable
5. Mental health disorders: anxiety, depression, ADHD, bipolar, panic disorders, PTSD, other? Yes No
6. Lung disorders: asthma, sleep apnea, chronic bronchitis, emphysema, sarcoidosis, pulmonary fibrosis, other? Yes No
7. Brain disorders: stroke, TIA, multiple sclerosis, seizures, dementia, neuropathy, global amnesia, other? Yes No
8. Diabetes: Type-I Type-II Treatment _____ Diagnosis date: _____ Largest HgA1c _____ Not applicable
9. Muscles disorders: myasthenia Gravis, muscular dystrophy, polymyositis, dermatomycosis's, other?
10. Blood disorders: Anemia-type _____ clotting disorders-type _____ other? _____ Not applicable
11. Rheumatoid arthritis, Grave's disease, thyroiditis? Yes No
12. Systematic lupus, Ankylosing spondylitis, chronic fatigue syndrome? Yes No
13. Kidney inflammation, protein or microalbumin in urine? Pituitary disorders, Adrenal disorders? Other? Yes No
14. Liver disorders- hepatitis, fatty liver, abnormal liver function tests, other? Pancreatitis? Other? Yes No
15. Diverticulosis, weight-loss surgery, esophageal disorders, GERD, ulcerative colitis, Crohn's disease, other? Yes No
16. Arteritis, vasculitis, chronic pain syndrome, bone or joint disorders, ear, nose and throat disorders? Yes No
17. Substance use: Type: _____ date of any rehabilitation: _____ Relapse date: _____ Not applicable
18. Any condition not listed?

Please explain any information to which you answered yes or to which more information should be provided:

Policy request information:

Daily/ Monthly benefit amount: _____

Benefit period: 2 yr. 3yr. 4yr. 5yr.

Elimination Period: 30 Day 60 Day 90 Day 180 Day 365 Day

Riders: Compound inflation Simple inflation shared care Waiver of HHC Elimination period

Restoration of benefits Additional cash benefit other