Confidential

LTC Insurance Pre-Qualification Questionnaire

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Client Name _____ **DOB**_____ **Height** _____ **Weight** _____

Spouse Name _____ **DOB**_____ **Height** _____ **Weight** _____

Address _____ **City** _____ **State/Zip** _____

Phone _____ **Fax**_____ **Cell**_____ **Email** _____

Client	Spouse	Circle Y-YES or N-NO for each question below
Y/N	Y/N	1. Are you taking any prescription medications? If yes, please list all medications below, along with the condition each was prescribed for, length of time taken and dosage amounts.
Y/N	Y/N	2. Are you using oxygen, wheelchair, crutches, cane, or receiving physical therapy? If yes, please provide details below.
Y/N	Y/N	3. Have you been declined for LTCI? If yes, please provide details below.
Y/N	Y/N	4. Have you used tobacco in the last 36 months? If yes, please provide details below.
Y/N	Y/N	5. Is any surgery scheduled in the next 6 months or has surgery been recommended? If yes, please provide details below.
Y/N	Y/N	6. Have you been hospitalized in the past 10 years? If yes, please list dates, treatments and details below.
Y/N	Y/N	7. Have you received treatment for any medical condition? Including but not limited to: Anxiety, High Blood Pressure, Diabetes or Arthritis. If yes, please list details below.
Y/N	Y/N	8. Have you applied for or are you eligible for Medicaid? If yes, please provide details below.

Details to "Yes" answers above and ALL medications taken.

Client: _____

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_____

Spouse: _____

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