Long Term Care Insurance Medical History Form

Please print legibly. If husband and wife are both applying, please complete a form for each client.
Should you need to provide more detail on any medical condition, please attach additional sheets.

Agent Information

Name:_____

Email:_____

Phone:_____ Fax:_____

Client Information

Name:_____ Date of Birth:_____ Age:_____

Resident State:_____ Martial Status:_____

Height:_____ Weight:_____ ❑ Male ❑ Female

Smoker: ❑ Yes ❑ No If client has quit, how long has it been:_____

Medical Conditions Treated in Past 10 Years

Medical Condition:_____ Date of Onset:_____/_____/_____

Medical Condition:_____ Date of Onset:_____/_____/_____

Medical Condition:_____ Date of Onset:_____/_____/_____

Medical Condition:_____ Date of Onset:_____/_____/_____

Medical Condition:_____ Date of Onset:_____/_____/_____

Medications Currently Taken

Medication:_____ Taken for:_____ Dosage:_____ Times/Day:_____

Medication:_____ Taken for:_____ Dosage:_____ Times/Day:_____

Medication:_____ Taken for:_____ Dosage:_____ Times/Day:_____

Medication:_____ Taken for:_____ Dosage:_____ Times/Day:_____

Medication:_____ Taken for:_____ Dosage:_____ Times/Day:_____

Medication:_____ Taken for:_____ Dosage:_____ Times/Day:_____

Hospitalizations in the Past 10 Years

Date of Hospitalization:_____/_____/_____ to _____/_____/_____ Reason for Hospitalization:_____

Result:_____

Date of Hospitalization:_____/_____/_____ to _____/_____/_____ Reason for Hospitalization:_____

Result:_____

Date of Hospitalization:_____/_____/_____ to _____/_____/_____ Reason for Hospitalization:_____

Result:_____

Special Notes:_____

_____

Fax completed form to: 877.821.7191 Questions?
Contact us at 800.283.8376. Thank you for your business!