# Long-Term Care Health Questionnaire

Email to Marshall Clement | marshall@gpagency.com

| **AGENT NAME:** Agent name must be provided. | **Return via secure method of Fax or Secure Email** Sending this form unsecurely can be a violation of HIPAA |
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**BASIC CLIENT INFORMATION-** This form is designed for one individual. Please complete a form for each individual in need of a quote.

| First Name | Last Name (initial) | Gender | Date of Birth | Resident State |
|---|---|---|---|---|
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| MARRIED or have a PARTNER? | Exact Height: Exact Weight: | Have you had a weight change in the past 12 months? | Tobacco Use: Check all that apply |
|---|---|---|---|
| ☐ Yes ☐ No | | ☐ Yes ☐ No | ☐ Cigarettes ☐ Cigar ☐ E-Cig ☐ Vaping ☐ Chew ☐ Marijuana |

**MEDICATIONS–** List ALL Medications taken or prescribed within the last 12 months – Explain why /when if your dosage was increased or decreased

| Medication/Steroid | Reason for taking med | Frequency | Dosage | Date Started |
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**HEALTH HISTORY-** Indicate any health condition you have been diagnosed with and details

| ☐ ***Diabetes-*** *provide details below* | ☐ ***Arthritis*** **(Osteo, Rheumatoid, etc)-** *provide details below* |
|---|---|
| *A1C:*<br>*Type:*<br>*Diagnosis Date:*<br>*Insulin Units:* | *Type:*<br>*Any Steroid Injections:*<br>*Joints Affected:*<br>*Diagnosis Date:* |
| ☐ ***Cancer-*** *provide details below* | ☐ ***Heart Disease-*** *provide details below* |
| *Type:*<br>*Stage:*<br>*Treatment Type:*<br>*Last date of Treatment:*<br>*Lymph nodes affected:* | *Type:*<br>*Bi-Pass or Stents:*<br>*Diagnosis Date:*<br>*History of diabetes, stroke, TIA or COPD:*<br>*Nebulizer or Oxygen Use:* |

**ADDITIONAL HISTORY – List Additional Conditions & Details: (Depression, COPD, Blood Clot, Dizziness, etc) Diagnosed Date:**

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**ADDITIONAL HEALTH HISTORY –** If checked, please provide all additional information regarding the condition.

| ☐ **Has a medical professional referred you to a specialist for additional consultation, testing or surgery in the last 3 years? If CHECKED, provide details:** | ☐ **Have you received physical, occupational or speech therapy in the past 6 months? If CHECKED, provide details:** |
|---|---|
| Details: | Details: |
| ☐ **Have you had surgery performed in the last 12 months? If CHECKED, provide details:** | ☐ **Currently on disability income? If CHECKED, provide details:** |
| Details: | Details: (Type & percent) |
| ☐ **Have had 2 or more immediate family members (biological parents or siblings) diagnosed with dementia? If CHECKED, provide details:** | ☐ **Have you been previously declined for LTC or Life Insurance? If CHECKED, provide details below:** |
| Details: | Details: |

Your client's health history is an important factor in determining eligibility for coverage. All information provided is confidential. It will be used solely for the purpose of determining if submission of an application to an insurance company is appropriate. Nothing herein constitutes coverage, nor is to be considered an offer of insurance.

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