

# Long term care insurance medical history form



Please print legibly. If spouses are both applying, please complete a form for each client.

Should you need to provide more details on any medical conditions, please attach additional sheets.

Date: \_\_\_\_\_

## Agent Information

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

## Client Information

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age \_\_\_\_\_

Resident State: \_\_\_\_\_ Marital status: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender:  Male  Female

Smoker:  Yes  No If client has quit smoking, how long has it been since last use?: \_\_\_\_\_

Medical condition: \_\_\_\_\_ Date of onset: \_\_\_\_\_

Medical condition: \_\_\_\_\_ Date of onset: \_\_\_\_\_

Medical condition: \_\_\_\_\_ Date of onset: \_\_\_\_\_

Medical condition: \_\_\_\_\_ Date of onset: \_\_\_\_\_

## Current Medications and Hospitalization History

Medication: \_\_\_\_\_ Taken for: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Taken for: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Taken for: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Taken for: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Taken for: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Taken for: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Taken for: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Date of hospitalization: \_\_\_\_\_ to \_\_\_\_\_ Reason: \_\_\_\_\_

Result: \_\_\_\_\_

Date of hospitalization: \_\_\_\_\_ to \_\_\_\_\_ Reason: \_\_\_\_\_

Result: \_\_\_\_\_

Date of hospitalization: \_\_\_\_\_ to \_\_\_\_\_ Reason: \_\_\_\_\_

Result: \_\_\_\_\_

Date of hospitalization: \_\_\_\_\_ to \_\_\_\_\_ Reason: \_\_\_\_\_

Result: \_\_\_\_\_

Special notes: \_\_\_\_\_



If you have additional questions, please contact GPAgency at 800.283.8376.



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