Long-Term Care Insurance Planning Form

By providing this information, I will be able to review illustrations with you when we meet. You don't need to provide me with your full address, but I do need to know the state where you reside. Providing this information does not obligate you in any way.

Personal and Contact Information

Name: _____

Home Address: _____

Preferred phone number to contact you: _____

Preferred email to contact you: _____

Health & Medical Questions

Date of Birth: _____

Height (inches): _____ Weight (lbs): _____

Do you have a partner/spouse with whom you live? ☐ Yes ☐ No

Were any of your recent labs outside the normal range? ☐ Yes ☐ No

Do you have any medical appointments or tests pending? ☐ Yes ☐ No

Please list all medications you are currently taking, including dosage, reason for taking, and for approximately how long:

Have you been prescribed medications that you chose not to take? ☐ Yes ☐ No

Do you use tobacco? If yes, what type, how frequently and for how long?

Do you use THC marijuana in any form? If yes, what type, how frequently, for how long?

Are these prescribed or recreational?

Do you currently have HIV/AIDS? ☐ Yes ☐ No

If yes, please provide date of diagnosis: _____

Do you have ALS, Cirrhosis, Cystic Fibrosis, etc.? ☐ Yes ☐ No

If yes, please provide date of diagnosis: _____

Do you currently use assistive devices? ☐ Yes ☐ No

Do you currently receive any disability-related benefits? ☐ Yes ☐ No

Family Medical History

Have any immediate family members had Alzheimer's or Dementia? ☐ Yes ☐ No

If yes, provide more information:

Medical History and Lifestyle

Have you had an MRI in the last 5 years? ☐ Yes ☐ No

If yes, what was it for and status of that condition: _____

Had/Have cancer? ☐ Yes ☐ No

Please provide detailed information:

Had a stroke or a TIA? ☐ Yes ☐ No

Had any major injuries or falls in the last 2 years? ☐ Yes ☐ No

Have Osteoporosis? ☐ Yes ☐ No

If yes, identify T-Scores or severity: _____

Have any other chronic illnesses? ☐ Yes ☐ No

If yes, explain with diagnosis date and treatment:

Have Sleep Apnea? ☐ Yes ☐ No

If yes, do you use a CPAP or other device regularly? ☐ Yes ☐ No

Had Cortisone or steroid injections in the last 2 years? ☐ Yes ☐ No

Had Physical or Occupational Therapy in the last 2 years? ☐ Yes ☐ No

If yes, provide reason and dates:

Had any substance abuse history? ☐ Yes ☐ No

If yes, explain when and sobriety:

Had Depression and/or Anxiety in the last 5 years? ☐ Yes ☐ No

If yes, provide condition, date, and treatment:

Do you have any residual symptoms from COVID or Lyme Disease? ☐ Yes ☐ No

Had any other health issues or surgeries in the last 3 years? ☐ Yes ☐ No

Explain details including diagnosis, treatment, and date of surgery:

Financial Questions

Do you own or rent? _____

If own, approximate present value: _____

Do you have a second property(ies)? _____

Retirement location (state/country): _____

Other insurances owned: _____

Total assets (excluding properties): _____

Is it important to leave assets? _____

Are you self-employed or own a business? _____

Annual income: _____

Do you have an HSA account? _____

Attitudes Toward Long-Term Care Insurance

Level of concern (1–10): _____

Estimated time you might need care: _____

Years you want to fund care: _____

Affordable annual premium: _____

Have you looked at LTC insurance before? ☐ Yes ☐ No

Are you currently looking at LTCI with another source? ☐ Yes ☐ No

Have you been declined for LTCI in the past? ☐ Yes ☐ No

If yes, please explain:

Who referred you to us? _____