LONG TERM CARE INSURANCE
FIELD UNDERWRITING QUESTIONNAIRE-ILLUSTRATION REQUEST

CLIENT INFORMATION:

CLIENT **A**:_____ DOB_____ CLIENT **B**:_____DOB_____

MALE/FEMALE_____ TOBACCO USER _____ MALE/FEMALE_____ TOBACCO USER _____

HEIGHT_____ WEIGHT_____ HEIGHT_____WEIGHT_____

BASIC BENEFITS:

DAILY BENEFIT AMOUNT: $_____ ELIMINATION PERIOD: 0 / 30 / 60 / 90 / 180 / 360 DAYS: _____

BENEFIT PERIOD: 2 / 3 / 4 / 5 / 6 / 10 YEARS: _____ CONSIDERING REPLACEMENT: Y/N _____

COST OF LIVING INCREASE RIDER: NONE _____ EQUAL INCREASES _____ COMPOUND INCREASES _____

RIDERS:

Shared Benefit _____ Survivorship Waiver of Premium _____ Waiver of Home Health Care Elimination Period _____

Monthly Benefit Rider _____ Other _____

MEDICAL HISTORY SCREENING:
Check all that apply:

	CLIENT A	CLIENT B
1. Do you use a cane or a walker?	O	O
2. Do you use oxygen or a respirator?	O	O
3. Do you require assistance in performing the following: Moving in and out of bed or a chair, bathing, dressing, eating, toileting, bladder/bowel control?	O	O
4. History of Cancer, Heart Disease, Diabetes?	O	O
5. History of Asthma, COPD, Emphysema?	O	O
6. History of Memory Loss, Stroke, TIA, Dementia, Parkinson's Disease?	O	O
7. History of Liver or Kidney disorder?	O	O
8. Other _____		

List Medications Currently Taking: _____

Details to "Yes" Answers Above: _____

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_____

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