LONG-TERM CARE FIELD UNDERWRITING QUESTIONS

EMAIL COMPLETED FORM TO: quotes@nationalconsortiums.com

Name of Client #1: _____ DOB: _____

HEIGHT: _____ WEIGHT: _____ **Any weight change in last year: +/- 10 lbs? _____**

Tobacco use: Type & last time used: _____ Last Physical Exam with Blood Work Completed: _____

Please list all Medical Conditions, date diagnosed, any current symptoms or any complications? Please see questions on pages 3-4

_____

_____

_____

_____

What was treatment and when did it end/anticipated to end?_____

Medication:	**Reason Taking?**	**Dosage?**	**How Long Taking?**

Been advised to have surgery or had surgery? Yes ◯ No ◯

Details: _____

Currently receiving or has received physical therapy within the past 12 months? Yes ◯ No ◯

What type of physical therapy & when will it be completed _____

Have you been diagnosed with a CVA, Stroke, or TIA? Yes ◯ No ◯

Name of Diagnosis & Date: _____

Any Hospitalizations in past 5 years? Yes ◯ No ◯

Date(s) of hospitalization? _____ Reason for hospitalization(s):_____

Family History: Have your parents been diagnosed with coronary artery disease or dementia? Yes ◯ No ◯

What was official diagnosis and age that diagnosis was made?

_____

Have you in the past or are you currently receiving payments for disability? Yes ◯ No ◯

Please list reason for disability & source of payment:

_____

Have you ever been declined for LTC? Yes ◯ No ◯

When & Reason why:_____ _____

Do you currently have a handicap parking sticker, placard, or license plate? Yes ◯ No ◯

Reason:_____

LONG-TERM CARE FIELD UNDERWRITING QUESTIONS

EMAIL COMPLETED FORM TO: ltc@mgaprt.com

Name of Client #2: _____ DOB: _____

HEIGHT: _____ WEIGHT: _____ Any weight change in last year: +/- 10 lbs? _____

Tobacco use: Type & last time used: _____ Last Physical Exam with Blood Work Completed: _____

Please list all Medical Conditions, date diagnosed, any current symptoms or any complications? Please see questions on pages 3-4

_____

_____

_____

_____

What was treatment and when did it end/anticipated to end?_____

Medication:	**Reason Taking?**	**Dosage?**	**How Long Taking?**

Been advised to have surgery or had surgery? Yes ◯ No ◯

Details: _____

Currently receiving or has received physical therapy within the past 12 months? Yes ◯ No ◯

What type of physical therapy & when will it be completed _____

Have you been diagnosed with a CVA, Stroke, or TIA? Yes ◯ No ◯

Name of Diagnosis & Date: _____

Any Hospitalizations in past 5 years? Yes ◯ No ◯

Date(s) of hospitalization? _____ Reason for hospitalization(s):_____

Family History: Have your parents been diagnosed with coronary artery disease or dementia? Yes ◯ No ◯

What was official diagnosis and age that diagnosis was made? _____

Have you in the past or are you currently receiving payments for disability? Yes ◯ No ◯

Please list reason for disability & source of payment:

_____

Have you ever been declined for LTC? Yes ◯ No ◯

When & Reason why:_____ _____

Do you currently have a handicap parking sticker, placard, or license plate? Yes ◯ No ◯

Reason:_____

LONG-TERM CARE FIELD UNDERWRITING QUESTIONS:
SPECIFIC CONDITIONS AND CORRESPONDING QUESTIONS

Email Completed Forms to: nationalconsortiums.com

Please provide the following information if any of these conditions apply:

AREAS OF CONCERN & SPECIFIC QUESTIONS FOR CONDITIONS:

- Height and Weight Ratio particularly in combination with Arthritis, Diabetes, Heart Disease or Hypertension.
- Tobacco use in combination with Heart Attack/Heart Surgery, Circulatory Disease, or Chronic Respiratory Disease will result in a decline.
- Tremors and/or tremulous handwriting.
- Combinations of conditions (e.g., the combination of a heart condition with other circulatory problems, diabetes and/or respiratory conditions) may present an increased risk versus having one of these conditions independently, and therefore, may lead to a substandard rating or a decline.
- Client's difficultly getting out of the chair or walking across the room.

DIABETES:

1) What type of diabetes (Juvenile, Type I or Type II)?
2) Date of Diagnosis?
3) What is your most recent blood sugar level or Hemoglobin A1C?
4) Does your doctor feel your blood sugar level is in good control? How long has it been stable?
5) What is your height and weight?
6) Are you taking Insulin? Units/Day?
7) Are you taking any medication for diabetes? Name(s) and dosage?
8) Do you have any diabetes-related complications? (e.g., eye problems directly related to diabetes, kidney problems, circulatory problems, numbness and tingling of the extremities, or non-healing wounds or skin ulcers?) Any amputations? Please provide details…

DEPRESSION, BIPOLAR OR ANXIETY:

1) Date of diagnosis?
2) Are you taking any medications? Name(s) and dosage?
3) Has this been diagnosed as situational?
4) Have you ever been hospitalized for depression, anxiety or other mental illness? Date/details?
5) Have you ever received electroconvulsive shock therapy?
6) Have you had any history of anxiety or other mental illness disorders? Details/date of diagnosis?

COGNITIVE IMPAIRMENT: Listen for cues of cognitive impairment throughout your interview. Did the client remember your name and the appointment? Does the client or spouse self-report memory loss? If so, the following questions are appropriate:

1) Have you discussed memory loss with your doctor or family?
2) Have you had any memory testing? Do you have the results of that testing?
3) Do you manage your own finances?
4) Do you drive?
5) Do you do your own shopping?

OTHER:

1) During the last 10 years, have you ever used unlawful drugs, or used prescription medications other than as prescribed by your doctor?
2) Have you ever received medical treatment, counseling or been hospitalized for drug use?
3) Do you regularly consume 4 or more alcoholic beverages per day, or do you drink 5 or more drinks per day1 or more days per week?

LONG-TERM CARE FIELD UNDERWRITING QUESTIONS:

SPECIFIC CONDITIONS AND CORRESPONDING QUESTIONS, cont.

Email Completed Forms to: nationalconsortiums.com

HYPERTENSION/HEART DISEASE:

1) What was your last & average blood pressure reading?
2) Does your doctor feel your condition is controlled?
3) Are you taking any medications? Name(s) and dosage? Have you had any recent changes in medications?
4) Do you have any other heart or circulatory problems?
5) Have you been hospitalized for any other heart or circulatory problems? Details…
6) Do you have any kidney problems? Details…

ARTHRITIS:

1) With what type of arthritis have you been diagnosed (Osteo, Rheumatoid or Degenerative Arthritis)?
2) What joints are affected?
3) Have you had any joint replacements?
4) What is your height and weight?
5) Are you taking any medication for arthritis? Name(s) and dosage? Have you had any recent changes in medications?
6) Have you ever used steroids to treat your arthritis? How much and for how long?
7) Do you have any limits in activity as a result of your arthritis? How far can you walk without resting? Do you have any difficulty with stairs?

OSTEOPOROSIS:

1) Date of diagnosis?
2) Are you taking any medications? Name(s) and dosage?
3) Have you had any recent fractures such as bone or spinal? Dates/details…
4) Have you had any loss in your height?
5) Has your doctor done any bone density studies?
6) What were the T-Scores of the last bone density study & date?
7) What is your degree of osteoporosis?
8) Do you have Degenerative Disc Disease or Scoliosis? Details…
9) What type of exercise do you engage in? Frequency?

CANCER: For any type of cancer other than basal cell skin cancer, squamous cell of the skin or early state breast or prostate cancer, the client must have gone at least two years without surgery or treatment.

1) What type of cancer did you have? Date of diagnosis?
2) Where was the cancer located?
3) Do you know the stage/grade of cancer?
4) Do you have any positive lymph nodes or did it spread to other areas? # of nodes involved?
5) Was the cancer diagnosed as metastatic?
6) Do you have a history of cancer or is the cancer recurrent? Dates/details…
7) What type of treatment did you receive (surgery, x-ray therapy, chemotherapy)? Dates of last treatment…
8) Any complications or residual problems?
9) If prostate cancer, do you know your current PSA?