LTC Quote Request Form

Not an application for insurance. This form is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classifications.

ASH BROKERAGE

Agent Name: _____

CLIENT INFORMATION

Name: _____

Address: _____

Phone Number: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

Are you married? ❑ Yes ❑ No Are you a U.S. Citizen? ❑ Yes ❑ No Height: _____ Weight: _____

Have you had any weight loss in the last 12 months? ❑ Yes ❑ No If yes, how much and why? _____

Do you or have you ever used tobacco products? ❑ Yes ❑ No

Are you a current user? ❑ Yes ❑ No If not, when did you last use? _____

Do you currently have another long-term care insurance, nursing home and home care, nursing home only, home health care, accident and health policy or certificate in-force (including a health care service, health maintenance organization, Medicare Supplement contract or life insurance with long term care coverage)? ❑ Yes ❑ No

Have you had another long-term care insurance, nursing home and home care, nursing home only, home health care policy or certificate in-force during the last 12 months? ❑ Yes ❑ No

Do you intend to replace any of your long-term care coverage, nursing home and home care, nursing home only, home health care, medical or health insurance coverage with the policy for which you are applying? ❑ Yes ❑ No

Have you ever been declined, rated or denied reinstatement for long-term care insurance? ❑ Yes ❑ No

If yes, by what company, when, and why? _____

Do you currently use any of the following?

❑ Wheelchair ❑ Walker ❑ Nebulizer ❑ Electric Scooter ❑ Quad Cane ❑ Oxygen
❑ Hospital Bed ❑ Respirator ❑ Kidney Dialysis ❑ Crutches ❑ Stair lift

Have you been confined to, or been advised to have, or used any of the following:

❑ Residential Care ❑ Assisted Living or Adult Day Care Facility Services ❑ Nursing Home or Home Health Care Services
❑ Long-Term Care Facility ❑ Physical Therapy ❑ Occupational Therapy ❑ Speech Therapy

Have you been medically advised to enter or been confined to a hospital or other health care facility? ❑ Yes ❑ No

Do you require assistance or supervision of another person or a device of any kind for any of the following? Bathing, toileting, dressing, eating, walking, medication management, getting in and out of a chair or bed, or control of your bowel or bladder ❑ Yes ❑ No

Do you require assistance with shopping, using transportation or housekeeping/cooking? ❑ Yes ❑ No

Do you have diabetes? ❑ Yes ❑ No

Date of diagnosis? _____ What was your last A1C reading? _____

If you are currently using insulin, how many units per day? _____

Do you have diabetes **in combination with any** of the following (please check all that apply): ❑ Yes ❑ No

❑ Peripheral Neuropathy ❑ Numbness ❑ Tingling or decreased sensation in your feet
❑ Retinopathy or history of stroke, mini stroke or TIA ❑ Heart Disease or Circulatory/Vascular Disease

Have you ever been diagnosed with cancer? ❑ Yes ❑ No

Type (note if metastatic cancer) and stage: _____

Treatment and date of last treatment: _____ If prostate cancer, provide PSA levels: _____

Have you ever been diagnosed with Chronic Obstructive Pulmonary Disease (COPD), Emphysema or Chronic Bronchitis or Asthma? ❑ Yes ❑ No

Do you have congestive heart failure **in combination with any** of the following (please check all that apply): ❑ Yes ❑ No

❑ Heart Attack ❑ Angina ❑ Emphysema/COPD ❑ Angioplasty
❑ Heart Surgery ❑ Asthma ❑ Chronic Bronchitis

Have you ever been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), any other sickness or condition derived from such infection, or tested positive for HIV or exposure to the HIV infection? ❑ Yes ❑ No

Are you currently eligible for benefits under, or covered by or received Medicaid, Disability Income, Worker's Compensation, Social Security Disability or any Federal or State Disability Plan? ❑ Yes ❑ No

Are you taking or have you taken any prescription medication(s) within the past three years, or are you currently taking any over-the-counter medications on a weekly basis or more frequently?

If yes, please provide medication name, dosage and frequency, the disease/disorder/condition or reason you are taking the medication: _____ ❑ Yes ❑ No

Are you taking any kind of narcotic pain medication? ❑ Yes ❑ No

If yes, what, how much, how often, and reason for taking? _____

Have you received inpatient or outpatient treatment at a hospital, surgical center or rehabilitation facility in the past five years? ❑ Yes ❑ No

If yes, provide details: _____

Are you scheduled for, or have you been advised by a physician or health care provider, to have additional testing, surgery or consultation(s) to evaluate health? ❑ Yes ❑ No

If yes, provide details: _____

Are there any pending test results which you have not yet received? ❑ Yes ❑ No

If yes, provide details: _____

Have you had any recent lab work or testing that has come back abnormal, or shown elevated PSA levels? ❑ Yes ❑ No

If yes, provide details: _____

Have you been seen by a physician, health care provider or any specialist more than three times in the past 12 months? ❑ Yes ❑ No

If yes, provide details: _____

Within the past three years, have you consulted with or been treated by a licensed health care provider, other than your primary care doctor, for any reason, excluding eye doctors, podiatrists and dentists? ❑ Yes ❑ No

If yes, provide details: _____

When was your last physical and full lab work completed? _____

Do you have, for your use, a handicap parking sticker or handicap license plate? ❑ Yes ❑ No

Do you currently work? ❑ Yes ❑ No

If yes, how many hours per week? _____

Do you perform volunteer work? ❑ Yes ❑ No

If so, approximately how many hours per week? _____

Do you have any hobbies or interests, or participate in any outside activities on a regular basis? ❑ Yes ❑ No

If yes, how many hours per week? _____

Do you drive an automobile? ❑ Yes ❑ No

If yes, approximately how many miles per year? _____

Do you live in some form of a residential retirement community? ❑ Yes ❑ No

If yes, list the services that are received: _____

Is your mother living? ❑ Yes ❑ No

What is her current age or her age at death? _____

Check if your mother has/had any of the following and age of onset for each:

❑ Diabetes:_____ ❑ Coronary Artery Disease/Vascular Disease:_____ ❑ Alzheimer's/Dementia:_____

Is your father living? ❑ Yes ❑ No

What is his current age or his age at death? _____

Check if your father has/had any of the following and age of onset for each:

❑ Diabetes:_____ ❑ Coronary Artery Disease/Vascular Disease:_____ ❑ Alzheimer's/Dementia:_____

In the past 24 months, have you had to or been advised by a member of the medical profession to limit, reduce, discontinue or restrict any activities or hobbies? ❑ Yes ❑ No

Has there been a diagnosis or treatment by a health care professional for Alzheimer's Disease, Dementia or Huntingtons Disease in the your birth mother, birth father or birth siblings? ❑ Yes ❑ No

To the best of your knowledge and belief, do you have, or have you ever received any advice, treatment, consultations or diagnosis from a physician or health care provider for any of the following conditions? Please check any that apply and provide details.

Y	N		Y	N		Y	N	
❑	❑	Alcohol or Drug Abuse/Addiction	❑	❑	Difficulty Walking	❑	❑	Musculoskeletal Disorders
❑	❑	Alzheimer's Disease	❑	❑	Depression or Mental Disorder/Illness	❑	❑	Myasthenia Gravis
❑	❑	Amputation	❑	❑	Dizziness/Fainting Spells/Blacking out	❑	❑	Neurological Disease/Disorder
❑	❑	Amyotrophic Lateral Sclerosis (ALS)	❑	❑	Ear or Eye Disorders	❑	❑	Organ Transplant
❑	❑	Anemia or Blood Disease/Disorder	❑	❑	Endocrine or Pituitary Disorders	❑	❑	Organic Brain Syndrome
❑	❑	Aneurysm	❑	❑	Epilepsy or Tremors	❑	❑	Osteoporosis
❑	❑	Angina or Atrial Fibrillation	❑	❑	Fibromyalgia	❑	❑	Paralysis
❑	❑	Angioplasty or Heart Surgery	❑	❑	Falls or Injuries due to Falls or Imbalance	❑	❑	Parkinson's Disease
❑	❑	Arthritis	❑	❑	Gastrointestinal Disorders	❑	❑	Peripheral Vasculary Disease
❑	❑	Back, Bone, Joint Disorder, Broken Bones	❑	❑	Genitourinary Disorders	❑	❑	Post-Polio Syndrome
❑	❑	Balance Disorder	❑	❑	Heart Attack	❑	❑	Polymyositis
❑	❑	Blood Disease/Disorder	❑	❑	Hodgkin's Disease	❑	❑	Psychosis
❑	❑	Brain Disorder	❑	❑	Huntington's Chorea	❑	❑	Respiratory Disease/Disorders
❑	❑	Bowel or Bladder Disease/Disorder	❑	❑	Heart Disease/Disorder or High Blood Pressure	❑	❑	Rheumatoid Arthritis
❑	❑	Bypass Surgery	❑	❑	Immune System Disease/Disorder	❑	❑	Sarcoidosis
❑	❑	Cancer	❑	❑	Joint Replacement Surgery	❑	❑	Schizophrenia
❑	❑	Cardiomyopathy	❑	❑	Kidney Failure or received Dialysis	❑	❑	Scleroderma
❑	❑	Carotid or other Arterial Surgery	❑	❑	Kidney or Liver Disease/Disorder	❑	❑	Seizures
❑	❑	Cerebrovascular Accident	❑	❑	Leukemia	❑	❑	Senility
❑	❑	Chronic Hepatitis	❑	❑	Lupus/Systemic Lupus	❑	❑	Skin Ulcers
❑	❑	Circulatory Disease/Disorder	❑	❑	Lymph Node Disease/Disorder	❑	❑	Spinal Cord Injury
❑	❑	Cirrhosis	❑	❑	Macular Degeneration	❑	❑	Thyroid Disease
❑	❑	Congestive Heart Failure	❑	❑	Mental or Cognitive Disorder	❑	❑	Tuberculosis
❑	❑	Convulsions	❑	❑	Mental Retardation	❑	❑	Unexplained/Unplanned weight loss/gain
❑	❑	CREST Syndrome	❑	❑	Multiple Myeloma	❑	❑	Ulcerative Colitis
❑	❑	Cystic Fibrosis	❑	❑	Memory Loss or Frequent/Persistent forgetfulness	❑	❑	Vision Disorder
❑	❑	Dementia	❑	❑	Multiple Sclerosis (MS)	❑	❑	Weakness or Fatigue
❑	❑	Diabetes	❑	❑	Muscular Dystrophy	❑	❑	Any other conditions causing Crippling/Limited Motion/Requiring Adaptive Devices
❑	❑	Disabling Back or Spine Condition	❑	❑	Mini stroke or Transient Ischemic Attack (TIA)			

Details for YES answers. Provide name and dosage of medication and the condition being treated.

Condition	Nature of Condition/ Date of Diagnosis	Date Last Treated/ Medicaiton Taken	Name of Physician Seen/Physician's Address

Comments: _____