Lifeco Associates, Inc.

Life and Health Insurance Agency

JASON HOCHSTADT, CFP®, AIF®
CHIEF EXECUTIVE OFFICER
jason@lifecoassociates.com

ONE BRIDGE PLAZA NORTH
SUITE 275
FORT LEE, NEW JERSEY 07024
201-482-0288 PHONE
201-482-8107 FAX
www.lifecoassociates.com

Long-Term Care Insurance: Pre-Qualifying Client Data Summary Sheet

Please complete all fields and provide as accurate information as possible. Thank you.

Disclaimer: Completing this Pre-Qualification Form is not a guarantee that you will be approved for long-term care insurance. It is not an application for insurance. The purpose of completion is to receive feedback from one or more underwriters to determine whether they will entertain your application and process it through underwriting without automatically declining it. For every question where the answer is 'Yes,' please provide a detailed explanation. If a question is Not Applicable, please insert 'N/A.' Feel free to use additional/separate sheets of paper if necessary. Thank you.

Client Name: _____ Gender: _____

Date of Birth: _____

Resident State (if more than one residence is owned in multiple states, please insert both and specify your living situation):

_____

_____

Height: _____ Weight: _____

(please note if changed considerably in the past 12 mos.)

Marital Status: * _____

_____

*If not married, please specify if you are in a committed relationship.
*If married or in a committed relationship, will the other individual (or any other family member(s) be applying for long-term care insurance?

Do you currently maintain individual or group long-term care insurance? If yes, please specify.

_____

_____

When was the last time you visited your primary care physician and any applicable specialists? What was the purpose of such visit(s)?

Current Medical Conditions:

Current medications, dosages and the reasons for your prescriptions (as well as any changes in the past year):

Aside from medication(s), are your medical conditions being treated in any other manner? If yes, has the treatment changed over the past year (and, if so, how)?

Other than as mentioned previously, are there any conditions which you have been treated for in the past 10 years? If so, please explain.

Have you been hospitalized or had surgery any time over the past 10 years? If yes, please describe.

Have you ever been confined to a skilled nursing or rehabilitative facility and required assistance with activities of daily living? If yes, please describe.

Do you currently have any functional limitations? If yes, please describe – and have you received, or are you presently receiving, any treatment such as physical therapy?

Are you currently disabled (if so, are you receiving disability insurance from any source)?

Have you previously been disabled (if so, when, and provide specifics regarding how you improved and over what period of time)?

Do you drive? If so, do you have a handicap parking permit?

Have you had any driving violations in the past 10 years? If so, please specify how many and whether any involved a DUI.

Has any surgery or medical test(s) been recommended for you yet not completed? If so, please explain.

Have you ever had an application for long-term care insurance, life insurance or disability income (or other disability-based) insurance declined, modified or rated? If yes, please explain.

_____

_____

_____

_____

_____

Do you smoke, or have you ever smoked? If so, please specify type (e.g. cigarettes) and quantity. If not currently, but in the past, when was the last time you smoked, for how long and what type?

_____

_____

_____

_____

Please provide applicable information regarding (a) alcohol use and (b) drug use (e.g. marijuana), if any.

_____

_____

_____

_____

Have you ever had (including now) any of the following conditions?

- Alcohol or drug dependency
- Arthritis
- Asthma
- Bone, joint or muscular problems (including osteoporosis and any fractures)
- Cancer
- Depression/anxiety
- Diabetes (specify Type I or Type II)
- Heart disease or heart related problems
- High blood pressure
- Joint replacements
- Kidney disease
- Liver disease
- Neuropathy
- Memory loss
- Multiple sclerosis
- Muscular dystrophy
- Parkinson's Disease
- Sleep disorders, including sleep apnea
- Stroke or TIA

If you answered 'Yes' to any of the above conditions (or you have had a significant medical condition not listed therein), for each condition please note (a) the date of diagnosis; (b) treatment received; (c) if you are still receiving treatment and (d) how this condition is currently?

Please provide us with any other information you believe would be relevant (e.g. if you exercise, including how often; if you currently work; any activities/hobbies you engage in; etc.).