LTC QUESTIONNAIRE

Client Information

Written Plan of Care for _____ Date _____

	Client 1	Spouse (If Joint)
Name		
State of Residence		
Sex	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth		
Marital Status	☐ Married ☐ Single	

Attorney/CPA/Trustee/Other _____

Banker/Financial Advisor(s) _____

What experience do you have with any family or friends needing care? _____

_____

Do you believe you could live a longer life and need help from other for you care? ☐ Yes ☐ No

If no, please explain _____

You may never need care, but if you did:
How would it affect your family? (Physically, emotionally, financially)

_____

_____

Any other concerns? _____

_____

Benefit Information

	Client 1	Spouse (If Joint)
Monthly Benefit Amount		
Benefit Duration		
Inflation Protection	☐ Yes ☐ No	☐ Yes ☐ No

If you ever need care, would you like to:

- ☐ Preserve your ability to choose
- ☐ Decide now where you will receive care
- ☐ Defer this decision until later
- ☐ Defer this decision to someone else

  Who ?

Who do you want to physically provide care?

- ☐ Your spouse
- ☐ Your child
- ☐ A professional caregiver
- ☐ Other _____

Where would you want to receive care?

- ☐ Your home
- ☐ Your child's home
- ☐ Assisted living facility
- ☐ Nursing home facility
- ☐ Other _____

Who do you want to be responsible for coordinating your care

- ☐ Your spouse
- ☐ Your children
- ☐ A professional care coordination service
- ☐ Other

How will you generate the income every month to pay for your care needs?

Which asset first ? _____
Which asset next? _____
Which asset next? _____
Which asset next? _____
Which asset next? _____

What other planning have you done?

- ☐ Living will
- ☐ Health care directive
- ☐ Power of attorney
- ☐ Trust
- ☐ Other _____

Pre-Underwriting Information

	Client 1	Spouse (If Joint)
Health Conditions with Prescription Medication		
Hospitalizations/ Surgeries (Date of last related treatment)		
Cancer (Stage, spreading, type/date of treatment)		
Diabetes (A1C, complications, insulin units per day)		
Height/Weight		
Tobacco Use	☐ Yes ☐ No	☐ Yes ☐ No

Please select all that apply:

- ☐ Stroke/ TIA
- ☐ Emphysema
- ☐ Heart Attack
- ☐ Arthritis

Product Preference:

- ☐ Standalone LTC
- ☐ Life/LTC Hybrid

FOR ASSET BASED/ LINKED BENEFIT QUOTE ONLY

Source of Funds:_____

Single Premium Amount: _____ Flex Pay Amount:_____ for _____ years

Desired Death Benefit:_____

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