

LTC QUESTIONNAIRE

Client Information

Written Plan of Care for _____ Date _____

	Client 1	Spouse (If Joint)
Name		
State of Residence		
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth		
Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

SUBMIT