

# Long-Term Care Insurance Eligibility Questionnaire & Request for Quote

## Eligibility Questionnaire

**Do you currently have or have you ever had a diagnosis for:**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Alzheimer's</li> <li>• Cerebral Atrophy</li> <li>• Cystic Fibrosis</li> <li>• Dementia</li> <li>• Kidney Failure</li> <li>• Mental Retardation</li> <li>• Mixed Connective Tissue Disease</li> <li>• Muscular Dystrophy</li> <li>• Multiple Myeloma</li> <li>• Organic Brain Syndrome</li> <li>• Post Polio Paralytic Syndrome</li> <li>• Scleroderma</li> <li>• Myasthenia Gravis</li> </ul> | <ul style="list-style-type: none"> <li>• Amyotrophic Lateral Sclerosis</li> <li>• Cirrhosis</li> <li>• Crest</li> <li>• TIA (transient ischemic attack) 2 or more</li> <li>• Memory Loss</li> <li>• Metastasis Cancer</li> <li>• Multiple Sclerosis</li> <li>• Neurological conditions affecting brain or spinal cord</li> <li>• Parkinson's</li> <li>• Schizophrenia</li> <li>• Spinal Cord Injury</li> <li>• Stroke/CVA</li> </ul> |
|--|--|

Member:  Yes  No

Spouse/Partner:  Yes  No

**Do you require human assistance or supervision in any of the following activities**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Eating</li> <li>• Walking</li> <li>• Dressing</li> <li>• Bathing</li> </ul> | <ul style="list-style-type: none"> <li>• Maintaining continence</li> <li>• Toileting</li> <li>• Transferring from bed to chair</li> </ul> |
|--|---|

**Do you currently reside in, have you been advised to enter, are you planning to enter a nursing home, assisted care living facility or other custodial facility, or are you currently receiving home health care services or attending adult day care?**

Member:  Yes  No

Spouse/Partner:  Yes  No

**Do you currently use one of the following medical devices?**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Wheelchair</li> <li>• Hospital bed</li> <li>• Oxygen</li> <li>• Dialysis</li> </ul> | <ul style="list-style-type: none"> <li>• Walker</li> <li>• Quad cane</li> <li>• Stair lift</li> </ul> |
|--|---|

Member:  Yes  No

Spouse/Partner:  Yes  No

**Have you been diagnosed or treated by a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex?**

Member:  Yes  No

Spouse/Partner:  Yes  No

**Are you currently receiving Social Security disability benefits?**

Member:  Yes  No

Spouse/Partner:  Yes  No

**If you have answered "no" to all of the questions above you may proceed with your request for quote.**

**Do NOT request a quote for any individual who answers "yes" to any of the questions listed in the above eligibility questionnaire.**

**ALL INFORMATION PROVIDED IN YOUR REQUEST IS KEPT CONFIDENTIAL**

## Long-term Care Request for Quote

Member: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex  M  F

Spouse/  
Partner: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex  M  F

**Have you used tobacco during the last twelve (12) months?**

Member:  Yes  No

Spouse/Partner:  Yes  No

**Do you work, volunteer or socialize outside the home at least 3 times week?**

Member:  Yes  No

Spouse/Partner:  Yes  No

**Have you completed a routine health examination (physical and blood work) administered by a doctor within the last two years?**

Member:  Yes  No

Spouse/Partner:  Yes  No

**Please list all medications for health problems. (Medications do not include female hormone replacement, thyroid replacement, allergy medication, vitamins or one "preventative" medication.)**

Member:

Spouse/Partner:

Medication \_\_\_\_\_ Medication \_\_\_\_\_  
Purpose \_\_\_\_\_ Purpose \_\_\_\_\_  
Dosage \_\_\_\_\_ Dosage \_\_\_\_\_  
Frequency \_\_\_\_\_ Frequency \_\_\_\_\_

Medication \_\_\_\_\_ Medication \_\_\_\_\_  
Purpose \_\_\_\_\_ Purpose \_\_\_\_\_  
Dosage \_\_\_\_\_ Dosage \_\_\_\_\_  
Frequency \_\_\_\_\_ Frequency \_\_\_\_\_

Medication \_\_\_\_\_ Medication \_\_\_\_\_  
Purpose \_\_\_\_\_ Purpose \_\_\_\_\_  
Dosage \_\_\_\_\_ Dosage \_\_\_\_\_  
Frequency \_\_\_\_\_ Frequency \_\_\_\_\_

Medication \_\_\_\_\_ Medication \_\_\_\_\_  
Purpose \_\_\_\_\_ Purpose \_\_\_\_\_  
Dosage \_\_\_\_\_ Dosage \_\_\_\_\_  
Frequency \_\_\_\_\_ Frequency \_\_\_\_\_

Medication \_\_\_\_\_ Medication \_\_\_\_\_  
Purpose \_\_\_\_\_ Purpose \_\_\_\_\_  
Dosage \_\_\_\_\_ Dosage \_\_\_\_\_  
Frequency \_\_\_\_\_ Frequency \_\_\_\_\_

Medication \_\_\_\_\_ Medication \_\_\_\_\_  
Purpose \_\_\_\_\_ Purpose \_\_\_\_\_  
Dosage \_\_\_\_\_ Dosage \_\_\_\_\_  
Frequency \_\_\_\_\_ Frequency \_\_\_\_\_

**Please provide your height and weight:**

Member: Height \_\_\_\_\_ Weight \_\_\_\_\_

Spouse/Partner: Height \_\_\_\_\_ Weight \_\_\_\_\_

**Are you covered by Medicaid? (If you are eligible for or covered by Medicaid, you may not need this policy.)**

Member:  Yes  No

Spouse/Partner:  Yes  No

**Are you receiving any disability benefits? If yes, please explain below:**

Member:  Yes  No

Spouse/Partner:  Yes  No

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Do you need assistance or supervision with your daily activities, such as bathing, dressing, toileting, bowel or bladder control, transferring, managing medications, using the telephone, or walking?**

Member:  Yes  No

Spouse/Partner:  Yes  No

**Have you had a diagnosis for Diabetes and require 50 units or more of insulin per day? If you answer yes, do not request a price quotation.**

Member:  Yes  No

Spouse/Partner:  Yes  No

**Within the last 5 years, have you received medical advice, diagnosis or treatment or consulted with a member of the medical profession for any of the following conditions? If yes, explain below.**

<ul style="list-style-type: none"> <li>• Circulatory disorders</li> <li>• Cancers</li> <li>• Gastrointestinal disorders</li> <li>• Hematology disorders</li> <li>• Respiratory disorders</li> <li>• Substance abuse</li> </ul>	<ul style="list-style-type: none"> <li>• Endocrine &amp; Pituitary disorders</li> <li>• Genitourinary disorders</li> <li>• Neurological disorders</li> <li>• Musculoskeletal disorders</li> <li>• Eye &amp; Ear disorders</li> </ul>
Member: <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse/Partner: <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____
_____	_____

### Choose Your Coverage

**SELECTION OF PLAN: Member & spouse/Partner must have the same coverage.**

<b>Custom Care II</b>	<b>Family Care II</b>
<b>Daily and/or Monthly Benefit (Daily from \$50 to \$500 / Monthly from \$1500 to \$15000)</b>	
Daily: \$ _____	Monthly: \$ _____

**Included in your quotation:**

<ul style="list-style-type: none"> <li>• Nursing Facility: 100%</li> <li>• Alternate Facility: 100%</li> <li>• Home Care: 100%</li> </ul>	<ul style="list-style-type: none"> <li>- is 100% of the benefit for all plans of coverage</li> <li>- is 100% of the benefit for all plans of coverage</li> <li>- is 100% of the benefit for all plans of coverage</li> </ul>
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**Benefit period:**

2 year   
  3 year   
  4 year   
  5 year   
  6 year   
  10 year

**Elimination period:**

30 day   
  60 day   
  90 day   
  180 day   
  365 day

**Automatic benefit increase:**

5% compounded   
  5% simple   
  GPO-guaranteed purchase option   
  CPI-consumer price index/compounded

**Riders: Please refer to your material for explanation of the following riders. Some riders may not be available under some plans or benefit periods.**

<input type="checkbox"/> Survivorship & Waiver of Premium Benefit <input type="checkbox"/> Shared Care <input type="checkbox"/> Non-forfeiture <input type="checkbox"/> Enhanced Return of Premium	<input type="checkbox"/> Restoration of Benefits* <input type="checkbox"/> Additional Cash Benefit <input type="checkbox"/> Waiver of Elimination Period (Home Care) <i>*Not available ages 80-84</i>
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**Please provide the following contact information:**

SCHOOL DISTRICT: \_\_\_\_\_ RETIRED:  YES  NO  
 NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
 PHONE: (\_\_\_\_) \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_