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McQueenKalligan
Insurance Services, Inc.

LONG TERM CARE
Fact Finder

Producer: _____ **Date:** _____

Name of Client: _____ **DOB:** _____/_____/_____
___Female ___Smoker ___Married/Partner
___Male ___Non-Smoker
Rating: ___Preferred Discount ___Standard Height: _____Weight: _____
Medications:
1) _____Dosage_____ 3)_____Dosage_____
2) _____Dosage_____ 4)_____Dosage_____

Spouse/Partner Name: _____ **DOB:** _____/_____/_____
___Female ___Smoker
___Male ___Non-Smoker
Rating: ___Preferred Discount ___Standard Height: _____ Weight: _____
Medications:
1) _____Dosage_____ 3) _____Dosage_____
2) _____Dosage_____ 4) _____Dosage_____

Health History/Pre-Qualification:
Does or has the applicant:
___Used assistive devices-cane/walker/wheelchair ___Received DI benefits in the last 5 years
___Had surgery recommended or scheduled ___Have a requirement for/use of handicap permit
___A history of any of the following:
(Circle any that apply and include client name with details where condition applies)

Osteoarthritis/Osteoporosis
Cancer (Type) _____
Heart Disease/Stroke
Cardiovascular/Circulatory
Other_____
Nerve Disorder/Huntington's
Back injury
Fibromyalgia/Chronic Pain
Depression/Anxiety
Diabetes
Respiratory or Pulmonary Condition
Parkinson's/Multiple Scleroses
Dizziness/Seizures/Memory Loss

Details/Additional Information:
_____
_____

Product Requested:
___**Traditional** ___**Asset-Based Linked Hybrid** ___**Life w/LTC Rider Hybrid** ___**Annuity**

How will you fund the policy:
___From Income ___1035 Exchange ___Cash ___IRA/Qual Plan ___Other_____

___Continuous Pay ___5-pay ___10-pay ___Single Pay-Amount? _____

Notes: _____
_____