



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 _____

State of Residence: _____

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:

(Check any that apply and include client name with details where condition applies)

Osteoarthritis/Osteoporosis

Nerve Disorder/Huntington's

Diabetes

Cancer (Type) _____

Back injury

Respiratory or Pulmonary Condition

Heart Disease/Stroke

Fibromyalgia/Chronic Pain

Parkinson's/Multiple Scleroses

Cardiovascular/Circulatory

Depression/Anxiety

Dizziness/Seizures/Memory Loss

Family History of Dementia

Other _____

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:
