American Brokerage Co.
Making Life Easier

Long Term Care Insurance Pre-qualification Questionnaire
Applicant #1

Note: If you currently need assistance with any of the following, **do not** complete this form.

Bathing Dressing Continence Eating Walking/Getting out of bed/chair Toileting

Applicant Name: _____ **DOB:** _____ **Married?** _____ **Ht/Wt?** _____

Plan Details: - Household Income: $ _____ **Net Worth: $** _____ **Retirement Age:** _____

Do you want Premiums that are Guarnateed never to Increase?	☐ Yes	☐ No
Do you want Cost Recovery, meaning total premiums paid will be used for care OR refunded at death	☐ Yes	☐ No
Do you want 1 policy with benefits shared between 2 spouses?	☐ Yes	☐ No
Do you want to limit the number of years premiums are required?	☐ Yes	☐ No
If Yes, Number of Years 1-20: _____		
Do you want to have the entire LTC benefit paid out as a death benefit if not used for LTC	☐ Yes	☐ No
Do you have an IRA, CD, or other asset that you will use to pay a lump-sum premium?	☐ Yes	☐ No
If Yes, Amount: $_____		
Do you want a policy with Simplified Underwriting even if it costs more than full underwriting?	☐ Yes	☐ No

Have you used any tobacco products in the previous two years?	☐ Yes ☐ No	If yes, advise the last date used:	_____
Have you ever been confined to a nursing or rehabilitation facility?	☐ Yes ☐ No	If yes, advise the date and reason:	_____
Do you ever use an assistive device, such as a cane or walker?	☐ Yes ☐ No	If yes, advise the date and reason:	_____
In the past 10 years, have you been hospitalized?	☐ Yes ☐ No	If yes, advise the date and reason:	_____
Are you seeing a psychologist, psychiatrist or counselor for any reason?	☐ Yes ☐ No	If yes, advise the date and reason:	_____
Are you being treated for ANY other medical conditions not named above?	☐ Yes ☐ No	If yes, advise the date and reason:	_____

Please provide the date and reason for your last doctor visit: _____

Please list all Prescription Medications currently used

Name	Dosage	How often is it taken?	Date started	Reason

In the past 10 years, have you been diagnosed, treated or tested for any of the following?

Illness	Date(s)	Details, treatments and current status
Stroke/TIA		
Alzheimer's/Dementia		
Parkinson's		
Cancer (type & stage)		
Heart Disease		
Diabetes (type)		
Arthritis (type)		
Osteoporosis/Osteopenia		

All information is confidential and will be used for the sole purpose in the determination if an application to an insurance company would be appropriate. The information provided is not an application for coverage, a guarantee of, or an offer of insurance.

One Vantage Way, Ste E-100 · Nashville, TN 37228 · Tel. (615) 227-8292 · Toll Free (800) 869-8292 · Fax (615) 227-6908 ·

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Long Term Care Insurance Pre-qualification Questionnaire
Applicant #2

Note: If you currently need assistance with any of the following, **do not** complete this form.

Bathing Dressing Continence Eating Walking/Getting out of bed/chair Toileting

Applicant Name: _____ **DOB:** _____ **Married?** _____ **Ht/Wt?** _____

Plan Details: -	**If known: Specific Benefits Desired?** _____		
If not known: -	**Do you want Premiums that are Guaranteed never to Increase?**	☐ Yes	☐ No
	Do you want Cost Recovery, meaning total premiums paid will be used for care OR refunded at death	☐ Yes	☐ No
	Do you want 1 policy with benefits shared between 2 spouses?	☐ Yes	☐ No
	Do you want to limit the number of years premiums are required?	☐ Yes	☐ No
	If Yes, Number of Years 1-20: _____		
	Do you want to have the entire LTC benefit paid out as a death benefit if not used for LTC	☐ Yes	☐ No
	Do you have an IRA, CD, or other asset that you will use to pay a lump-sum premium?	☐ Yes	☐ No
	If Yes, Amount: $_____		
	Do you want a policy with Simplified Underwriting even if it costs more than full underwriting?	☐ Yes	☐ No

Have you used any tobacco products in the previous two years?	☐ Yes ☐ No	If yes, advise the last date used: _____
Have you ever been confined to a nursing or rehabilitation facility?	☐ Yes ☐ No	If yes, advise the date and reason: _____
Do you ever use an assistive device, such as a cane or walker?	☐ Yes ☐ No	If yes, advise the date and reason: _____
In the past 10 years, have you been hospitalized?	☐ Yes ☐ No	If yes, advise the date and reason: _____
Are you seeing a psychologist, psychiatrist or counselor for any reason?	☐ Yes ☐ No	If yes, advise the date and reason: _____
Are you being treated for ANY other medical conditions not named above?	☐ Yes ☐ No	If yes, advise the date and reason: _____

Please provide the date and reason for your last doctor visit: _____

Please list all Prescription Medications currently used

Name	Dosage	How often is it taken?	Date started	Reason

In the past 10 years, have you been diagnosed, treated or tested for any of the following?

Illness	Date(s)	Details, treatments and current status
Stroke/TIA		
Alzheimer's/Dementia		
Parkinson's		
Cancer (type & stage)		
Heart Disease		
Diabetes (type)		
Arthritis (type)		
Osteoporosis/Osteopenia		

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