Long-Term Care Insurance Pre-Screen

Thank you for completing this brief questionnaire. Doing so will help us determine which company will be most receptive to your health profile.

Please use an additional sheet of paper if necessary.

Applicant Name: ___________________________          Gender: Male      Female          Date of Birth: ___________________          Height: ___________          Weight: ___________

1. In the past 5 years, have you used any tobacco products? Yes      No
   If yes, what type/how often: __________________________________________________________

2. Do you currently require assistance with any of the following activities? Bathing      Continence      Dressing      Eating      Toileting      Walking

3. Have you ever been confined to a nursing or rehabilitation facility or needed assistance with any of the activities listed in #2? Yes      No
   If yes, please explain when and for what reason: __________________________________________

4. Have you had, do you currently have, or have you ever been medically diagnosed as having any of the following: (Circle if yes)

   Arthritis (Osteo/Rheumatoid)          Depression/Anxiety          Diabetes (Type I/Type II)          AIDS/HIC          Multiple Sclerosis
   Joint Replacements          High Blood Pressure          Dizziness/Falls          Alzheimer’s Disease/Dementia          Muscular Dystrophy
   Osteoporosis/Fractures          Heart Disease          Liver Disease          Asthma/COPD          Parkinson’s Disease
   Cancer          Kidney Disease          Sleep Disorders          Memory Loss          Stroke or TIA

   If you answered yes, please include for each condition, date of diagnosis, treatment received, and if you are still under treatment.

   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________

5. Please complete the following chart to reflect any prescription medications you have taken in the past 12 months:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Prescribed For</th>
<th>Current Dosage/Taken How Often</th>
<th>Indicate changes made to dosage in past 12 months. If no longer taking, please indicate month last used.</th>
<th>Have you stopped taking it, even though it is prescribed? If so, why?</th>
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6. Have you been hospitalized, consulted with or been treated by a medical professional for any reasons not listed above? Yes      No
   If yes, please explain. Please include date diagnosed, treatment received, and if you are still under treatment.

   __________________________________________________________________________________
   __________________________________________________________________________________

7. Are you currently under any post-operative care, like physical therapy? If yes, please explain:__________________________________________

8. Have any surgeries or tests been recommended that have yet to be completed? If yes, please explain:________________________________________