

Long Term Care Questionnaire

Name _____ Spouse (if applicable) _____

DOB _____ Smoker Non-Smoker

Level of Care Needed:

Does your client or their spouse currently have a need for assistance in the activities of daily living? (Eating, dressing, toileting, transferring, bathing and continence) and/or a current cognitive impairment? Please explain: _____

Level of Benefits:

Waiting Period for Benefits (circle one): 60 days 90 days 100 days 120 days 180 days
Benefit Period (circle one): 2 yrs 3 yrs 4 yrs 5 yrs 6 yrs Lifetime
Shared Care? _____

Current Assets:

Not counting your client's home, about how much are all your client's assets worth?
 Under \$200,000 \$200,000-\$500,000
 \$500,000- \$1M Greater than \$1M

Premium:

Is there a current premium with which you believe your client might be comfortable - either on a monthly or an annual basis? _____

Please fax this request to (763) 522-6251