Long-Term Care
Pre-Underwriting Inquiry

Please complete the Client Information along with any pertinent medical history. Submit a separate form for each client. Provide as much information as possible.

Client Information *(REQUIRED)*

Gender	Age	Height	Weight
☐ Male ☐ Female			

Products Used *(select all that apply, current or within the last 12 months)*	Frequency	Amount of Use
☐ Tobacco ☐ Nicotine Products ☐ Marijuana		

Do you have any surgery, testing, or treatment pending/recommended?
☐ Yes ☐ No If YES, Provide Details

Previously Declined by Another Company	Currently/Previously Receive Social Security Disability Benefits
☐ Yes ☐ No If YES, please attach a copy of the decline letter.	☐ Yes ☐ No

Cardiac/Heart – Complete for All
(Atrial Fibrillation, Coronary Artery Disease, or Valvular Heart Disease Require Additional Details)

Diagnosis	Date Diagnosed *(mm/yyyy)*

Dates and Results of Most Recent Cardiac Testing EKG, Catheterization, Echocardiogram, Stress Test

Provide Details of Any Current Blockages or Recent Symptoms *(shortness of breath, chest pain, fatigue, lightheadedness, other)*

Select All That Apply
☐ Stroke ☐ TIA ☐ Diabetes ☐ Peripheral Vascular Disease
☐ Cardiomyopathy ☐ Congestive Heart Failure ☐ Any Other Condition of the Heart

Provide Dates and Details

Atrial Fibrillation

Treatment *(select all that apply)*
☐ Medication ☐ Ablation ☐ Cardioversion ☐ Pacemaker ☐ Defibrillator

Provide Details *(include dates and medications)*

Coronary Artery Disease

Treatment *(select all that apply)*
☐ Medication ☐ Angioplasty ☐ Stenting ☐ Bypass Surgery ☐ Any Other Heart Surgery ☐ Any Left Main Involvement

History of Heart Attack
☐ Yes ☐ No

If YES, Provide Details *(include dates, medications, vessels involved and number of stents and/or vessels bypassed)*

Valvular Heart Disease

Which Valve(s) *(Aortic, Mitral, other)*

Treatment *(select all that apply)*
☐ Medication ☐ Surgery *(repair or valve replacement)*

Provide Dates and Details

Cancer – Complete for All *(Breast, Prostate, Leukemia, and Lymphoma Require Additional Details)*

Diagnosis and Location | Date Diagnosed *(mm/yyyy)*

Stage, Grade, and Type | Size of Tumor

Lymph Node Involvement or Spread to Any Other Organs

Treatment *(select all that apply)*
☐ Surgery ☐ Chemo ☐ Radiation ☐ Other
| Date Last Treated *(mm/yyyy)*

Any Recurrence or Additional/Other Cancer
☐ Yes ☐ No

If YES, Provide Details as Outlined Above

Breast Cancer

Select Type
☐ Ductal ☐ Lobular ☐ Tubular ☐ Mucoid ☐ Papillary ☐ Medullary

Estrogen Receptor
☐ Positive ☐ Negative ☐ Unknown

Prostate Cancer

Gleason Score | PSA at Time of Diagnosis | Current PSA

Treatment *(select all that apply)*
☐ Surgery ☐ Chemo ☐ Radiation ☐ Active Surveillance ☐ Watchful Waiting ☐ Other
| Date Last Treated *(mm/yyyy)*

Leukemia

Select Type
☐ Acute Lymphoid *(lymphoblastic)* Leukemia (ALL) ☐ Acute Myeloid *(myelogenous leukemia)* (AML)
☐ Chronic Lymphocytic Leukemia (CLL) ☐ Hairy Cell Leukemia ☐ Chronic Myeloid Leukemia (CML)

| Age at Diagnosis

Lymphoma

Select Type
☐ Hodgkin's
☐ Non-Hodgkin's *(select subtype)*
☐ MALT Lymphomas ☐ Maltomas ☐ Extra Nodal Marginal Zone B-Cell
☐ Follicular ☐ Transformed Follicular ☐ Nodal Marginal Zone B-Cell
☐ Diffuse Large B-Cell ☐ Burkitt ☐ Mantle Cell ☐ Peripheral T-Cell ☐ Other High-Grade Lymphoma
☐ Cutaneous Lymphoma ☐ Mycosis Fungoides ☐ Sèzary Syndrome
☐ Adult T-Cell Lymphoma/Leukemia

Diabetes

Date Diagnosed *(mm/yyyy)* | Type of Diabetes ☐ Type I ☐ Type II | Date Last Tested A1C *(mm/yyyy)* | A1C Result

Names and Dosage of Medications

Select All That Apply
☐ Retinopathy
☐ Background ☐ Proliferative
☐ Heart Disease ☐ Neuropathy ☐ Kidney Disease ☐ Urine Protein/Microalbumin
☐ Cerebrovascular ☐ Peripheral Vascular Disease ☐ Skin Ulcers ☐ Amputations

Provide Dates and Details

Mental/Nervous

Select All That Apply
☐ Anxiety ☐ Depression ☐ Bipolar ☐ ADD/ADHD ☐ PTSD

Date Diagnosed *(mm/yyyy)*

Medication Dosage and Any Other Treatment

Any Hospitalizations or ER Visits
☐ Yes ☐ No

Provide Details *(including dates and length of stay)*

Alcohol and/or Drug Use Disorder

Substance(s)

Date Last Used *(mm/yyyy)*

Treatment *(select all that apply)*
☐ Medication ☐ Hospitalization ☐ Treatment Programs ☐ Support Group

Provide Date Last Treated and Details

Any Relapse
☐ Yes ☐ No

Complications
☐ Yes ☐ No

If YES, Provide Dates and Details

Musculoskeletal

Diagnosis

Date Diagnosed *(mm/yyyy)*

Treatment *(select all that apply)*
☐ Medications
☐ Injection

Injection Type *(if applicable)*

Injection Frequency*(if applicable)*

Date of Last Injection *(mm/yyyy) (if applicable)*

Physical Therapy
☐ Yes ☐ No

Use of Any Assistive Devices
☐ Yes ☐ No

Any Functional Limitations
☐ Yes ☐ No

Surgery Recommended or Planned
☐ Yes ☐ No

If YES to Any of the Above, Provide Complete Details

Osteoporosis

Date of Last Bone Density *(mm/yyyy)*

Provide Actual T-Scores

Any Falls/Broken Bones/Fractures
☐ Yes ☐ No If YES, Provide Date and Location

Treatment

Respiratory/Asthma/COPD/Sleep Apnea

Diagnosis

Date Diagnosed *(mm/yyyy)*

Treatment

Any Prior Tobacco Use
☐ Yes ☐ No If YES, Date Last Used *(mm/yyyy)*

Hospitalizations, ER Visits or Any Limitations Due to Shortness of Breath
☐ Yes ☐ No

Any Use of Supplemental Oxygen
☐ Yes ☐ No

If YES, Provide Details

Stroke/TIA

Select All That Apply	Date(s) Diagnosed *(mm/yyyy)*
☐ Stroke ☐ Single ☐ Multiple ☐ TIA ☐ Single ☐ Multiple	

Treatment

List Any Residuals

Other Medical Impairments Not Listed Above and All Current Medications

Impairment	**Treatment, Medication *(include dosage)*, Surgery**	**Date(s) *(mm/yyyy)***

Additional Comments