

## Health Questionnaire

Name	Height	Weight	Phone (home, work, or cell)
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Does Long Term Care Insurance make sense for you? Please rank the top 3 statements in order of importance (i.e. 1 most important, 2 next important). "I would like to . . ."

Protect my family from the burden of caregiving		Receive quality care	
Know someone will be there to care for me		Plan for the unexpected	
Stay in my own home		Stay in control, independent, have choices	
Protect my life savings/preserve inheritance		Maintain my dignity	

If you know someone who has received long-term care, briefly describe your experience.

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Please check "Yes" or "No" beside each question.

Yes    No

1. Do you require supervision or assistance with activities of daily living such as walking, eating, bathing, dressing, toileting, moving into or out of a bed or chair or with taking medication?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you use a walker, wheelchair, quad cane, motorized personal transport, chair lift or oxygen?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had an organ transplant (other than corneal) or a defibrillator implanted?	<input type="checkbox"/>	<input type="checkbox"/>
4. In the past 12 months, have you been confined in a hospital or had heart surgery including bypass, angioplasty, stent placement or heart valve surgery?	<input type="checkbox"/>	<input type="checkbox"/>
5. In the past two years:		
a. Has a medical professional scheduled or advised you to have surgery requiring general anesthesia, or undergo testing and you have not done so?	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you resided or been advised to reside in a Nursing Home or Assisted Living Facility?	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you received or been medically advised to receive Home Health Care or Adult Day Care services?	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you had a balance disorder or difficulty walking?	<input type="checkbox"/>	<input type="checkbox"/>
6. In the past two years, have you had, been diagnosed, received treatment or taken medication for any of the following conditions?		
a. Alzheimer's disease, dementia or memory loss	<input type="checkbox"/>	<input type="checkbox"/>
b. Acquired Immune Deficiency Syndrome (AIDS) or HIV positive	<input type="checkbox"/>	<input type="checkbox"/>
c. Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis, Muscular Dystrophy, Parkinson's disease or myasthenia gravis	<input type="checkbox"/>	<input type="checkbox"/>
d. Psychosis or Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
e. Diabetes with complications such as retinopathy (eye disease), neuropathy (numbness/tingling in hands or feet), or kidney failure	<input type="checkbox"/>	<input type="checkbox"/>
f. Internal cancer, leukemia, lymphoma or melanoma	<input type="checkbox"/>	<input type="checkbox"/>
g. Osteoporosis with related fracture(s)	<input type="checkbox"/>	<input type="checkbox"/>
h. Systemic lupus, kidney failure, cirrhosis or the liver or hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>
i. Stroke or cerebrovascular accident (CVA), TIA, congestive heart failure or atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>
j. Amputation due to disease	<input type="checkbox"/>	<input type="checkbox"/>

State law requires that certain financial information be considered to determine if a policy is right for you.

What is your annual income?

- Under \$20,000     
  \$20,000-\$30,000     
  \$30,000-\$50,000     
  Over \$50,000

Not counting your home, what is the estimated value of your assets (savings and investments)?

- Under \$20,000     
  \$20,000-\$30,000     
  \$30,000-\$50,000     
  Over \$50,000