

RETAIL LONG-TERM CARE INSURANCE PREQUALIFYING INQUIRY

Fax this form to 505-246-0620. A preliminary opinion will be provided within 24 hours. Please feel free to contact our prequalification line at 505-688-6703, to obtain a verbal opinion. This is not an application for long-term care insurance benefits. No offer of insurance will be made from this inquiry. Your client's signature and medical records are not required. A copy of this form with our "preliminary opinion" should be submitted with your client's application. This form is for internal use only.

Name: _____

Address: _____

Applicant's Date of Birth: _____

1. Height: _____ Weight: _____

2. Have you used tobacco products in the last 12 months? Yes No

3. Within the last five years, have you received medical advice, diagnosis, or treatment, or consulted with a member of the medical profession for any of the following conditions:

- A. Circulatory disorders Yes No
- B. Endocrine and pituitary disorders Yes No
- C. Cancers Yes No
- D. Genital urinary disorders Yes No
- E. Gastrointestinal disorders Yes No
- F. Neurological disorders Yes No
- G. Blood disorders Yes No
- H. Musculoskeletal disorders Yes No
- I. Respiratory disorders Yes No
- J. Eye and ear disorders Yes No
- K. Substance abuse Yes No

4. Do you currently use any assistive or mechanical devices? Yes No

5. Have you ever received home health care or been confined to a nursing home or rehabilitation facility? Yes No

6. Do you require human assistance or supervision in performing any of your activities of daily living? Yes No

7. Have you had a complete physical exam within the past 18 months? Yes No

Physician Name: _____ Phone: _____ Address: _____

Details to questions 3-6:

Q #	Diagnosis	Diagnosis date	Treatment dates

List all prescription medications prescribed over the past 12 months: _____

Insurance Representative's Name: Mary Lou Dobbs Fax #: 505-246-0620

Comments: _____

Signature: _____ Date: _____