Name: ____________________________________

Date of Birth: __________ State of Residence: ___

Phone Number: _____________________________

Email: _____________________________________

Referral Source: _____________________________

Agent: Brian I. Gordon (Brian@magaltc.com)

Long Term Care Insurance Eligibility Worksheet

1) Please provide your height: ______________ and weight: _____________ and gender: _____________

2) Have you used Tobacco in the last 3 Years (circle): Yes or No
   If yes, please provide quit date:_________

3) Have you used Marijuana in the last 3 Years (circle): Yes or No
   If yes, please provide frequency: ________ per week or _______ per month

4) List of all Medications, including name, dosage, frequency taken and reason taken:

Name	Dosage	Frequency	Reason

5) Have you ever been diagnosed with Cancer, Stroke, Heart Disease or other Chronic Illness (circle): Yes or No
   If yes, please provide name of condition, approximate date of diagnosis and treatment received.

6) Have you been hospitalized in the last 10 years (circle): Yes or No
   If yes, please provide approximate date, reason/diagnosis and treatment.

7) Have you had any injuries, falls or broken bones in the last 5 years (circle): Yes or No
   If yes, please provide approximate date, reason/diagnosis and treatment.

8) Has a family member been diagnosed with a Cognitive Impairment (circle): Yes or No
   If yes, please select:
   _____ Mother ______ Father _____ Sibling and provide the age they were diagnosed
   _____ Age ______ Age _____ Age

9) Do you have Diabetes (circle): Yes or No
   If yes, which Type? Please also provide date of diagnosis, meds and most current A1C.

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Name: ___________________________________

Long Term Care Insurance Eligibility Worksheet Continued

10) Have you been diagnosed with Sleep Apnea (circle): Yes or No
    If yes, provide date of diagnosis: ____________ and device used to control apnea: _____________________

11) Do you have any pending or recommended surgeries (circle): Yes or No
    If yes, please provide details.

12) Any Physical Therapy in the last 5 years (circle): Yes or No
    If yes, please provide approximate date, reason for treatment and approximate date you completed PT.

13) Are you on Social Security Disability or any type of Disability (circle): Yes or No

14) Need assistance with Dressing, Bathing, Transferring, Continence, Eating or Toileting (circle): Yes or No

15) Have you ever been diagnosed or received medical advice or medical care for any of the following
    (check all that apply):

___ AIDS/HIV	___ Cirrhosis	___ Kidney Failure/Dialysis	___ Oxygen Use
___ Alcoholism	___ Connective Tissue Disease	___ Macular Degeneration (wet)	___ Paralysis
___ ALS/Lou Gehrig's	___ Down Syndrome	___ Memory Loss	___ Parkinson's Disease
___ Alzheimer's/Dementia	___ Drug Addiction	___ Multiple Myeloma	___ Pregnancy (current)
___ Balance Disorder	___ Huntington's Disease	___ Multiple Sclerosis	___ Psychosis
___ Cerebral Palsy	___ Huntington's Disease	___ Organ Transplant	___Scleroderma
___ Chronic Hepatitis	___ Hydrocephalus	___ Osteoporosis with Fractures	___ Systemic Lupus

16) Have you ever been declined Long Term Care Insurance (circle): Yes or No
    If yes, please provide the carrier that declined you, the approximate date and reason for decline.

17) Do you have a handicap placard or use a wheelchair, walker or cane (circle): Yes or No

18) Do you consume Alcoholic Beverages (circle): Yes or No
    If yes, please provide approximate frequency: _____ drinks per week or _____ drinks per month

19) Did you have a positive test result for COVID-19 (circle): Yes or No
    If yes, please provide date of diagnosis _________ and details on treatment and recovery.

Please provide details on any health history items not listed above (use a supplemental page if needed). Sharing details up front helps determine if you are eligible for LTCI, therefore allowing us to provide accurate quotes.

Let us know what you would like to accomplish (number in order of importance).

What are your biggest concerns/goals?

__ Asset Preservation
__ Don't want to burden my family
__ I want to be able to choose the type of care I receive
__ I want to make sure I'm taken care of in my later years
__ Protect retirement funds
__ I'm worried the cost of care is more than I've put aside
__ Other (please specify): ________________________________

Please return completed form via fax to 847-940-8870 or stephanie@magaltc.com

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