



# LTCi Pre-Screening Questionnaire

**PLEASE FAX TO : 650-692-5204**

Agent Name:	E-mail or fax:
Client Name:	Birthdate:
Spouse Name:	Birthdate:

Mark "C" for Client , "S" for spouse or "B" for both if diagnosed/treated in the last 10 years with any of the following conditions.

Items marked with a "\*" are uninsurable conditions.

Abnormal blood pressure	Atrial fibrillation	Coronary Artery disease	Leukemia	Organic brain Syndrome*
AIDS/ARC*	Bipolar Manic	Crohn's disease	Lupus	Osteoporosis
Alcohol Abuse	Cancer	Dementia *	Memory loss*	Paralysis*
ALS*	Cardiomyopathy	Diabetes insulin dependent?	Multiple Sclerosis*	Parkinson's disease*
Alzheimer's disease*	Carotid Artery Disease	Drug Abuse	Muscular dystrophy*	Peripheral vascular disease
Anemia	Cerebral Vascular disease	Emphysema	Myasthenia gravis*	Renal failure*
Aneurysm	Cirrhosis	Eye disease	Neurogenic bladder	Scleroderma
Arthritis	Congestive heart failure	Heart Attack	Neuropathy*	Seizures
Asthma	COPD	Hepatitis	Organ transplant	Stroke/TIA

Other conditions not mentioned? \_\_\_\_\_

1. Are you currently using oxygen, a wheelchair, crutches or cane?  Yes  No Spouse:  Yes  No

2. Are you currently in a nursing home or receiving home health care?  Yes  No Spouse:  Yes  No

3. Are you eligible for Medicaid (Welfare)?  Yes  No Spouse:  Yes  No

4. Are you currently receiving disability benefits or on physical therapy?  Yes  No Spouse:  Yes  No

5. Have you ever been declined for LTCi?  Yes  No Spouse:  Yes  No

6. Have you used tobacco in the last 24 months?  Yes  No Spouse:  Yes  No

7. Do you have any surgery scheduled for the next 6 months?  Yes  No Spouse:  Yes  No

8. What prescriptions do you take? \_\_\_\_\_

9. Spouses prescriptions: \_\_\_\_\_

10. Do you have any physical limitations?  Yes  No Spouse  Yes  No

11. Height/Weight \_\_\_\_\_ / \_\_\_\_\_

Spouse: \_\_\_\_\_ / \_\_\_\_\_