LONG TERM CARE EVALUATION

Confidential

Information Gathering Kit

FIRST ELEMENT
INSURANCE PLANNERS

Please Return Completed Form To:
RMTeam@firstelementinsurance.com
Questions? Call (866) 351-3745

COMPLETION OF THIS DOCUMENT IN ITS ENTIRETY IS REQUIRED TO INITIATE THIS ANALYSIS

Client Profile

Advisor Name _____

Client 1 Information

Full Legal Name_____ Sex_____ Birthdate_____

Height _____ Weight_____ ☐ Single ☐ Married ☐ Other _____

City & State *(Primary Residence)*_____ Net Worth / Income_____

Client 2 Information

Full Legal Name_____ Sex_____ Birthdate_____

Height _____ Weight_____ ☐ Single ☐ Married ☐ Other _____

City & State *(Primary Residence)*_____ Net Worth / Income_____

Do either of you currently have Long Term Care Insurance? ☐ **Yes*** ☐ **No**

**If yes, please provide a summary of benefits (this is typically found in the policy).*

Do either of you currently have Life Insurance? ☐ **Yes** ☐ **No**

Longevity Concerns

I am concerned about the risk of…	None	Low	Medium	High
Rising cost of Long Term Care	☐	☐	☐	☐
Sacrificing standard of living in retirement years	☐	☐	☐	☐
Paying premium for Long Term Care insurance and not using the benefit	☐	☐	☐	☐
Outliving Retirement Assets	☐	☐	☐	☐
Government Dependency (Medicaid)	☐	☐	☐	☐
My income decreasing and affecting my ability to pay for Long Term Care	☐	☐	☐	☐
Long Term Care expenses diminishing the legacy I leave for my heirs.	☐	☐	☐	☐

If you had a long-term health care event today, which asset in your portfolio would you liquidate in order to fund this need?

☐ Savings / Investments ☐ IRA / Pension ☐ Real Estate ☐ Other, Please give details

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I am accustomed to a style of living that is _____ that of others in my state of residence:

☐ Slightly below ☐ Consistent with ☐ Slightly above ☐ Significantly above

Family History

Client 1	**Do you …**	**Client 2**
☐ Yes ☐ No	Have a parent that died before age 60?	☐ Yes ☐ No
☐ Yes ☐ No	Have a parent who required nursing care?	☐ Yes ☐ No
☐ Yes ☐ No	Have a family history of Alzheimer's or dementia?	☐ Yes ☐ No
☐ Yes ☐ No	Have a family history of diabetes or any form of stroke	☐ Yes ☐ No

or coronary artery disease?

Health & Activity Information

Please list all medications (including over the counter) taken in the last 24 months and why:

Client 1:

Client 2:

Client 1		Client 2
☐ Yes ☐ No	Have you used a walker, wheelchair, quad cane or motorized scooter or have you received care in a nursing home, rehabilitation facility or other type of long-term care?	☐ Yes ☐ No
☐ Yes ☐ No	Have you been diagnosed with Alzheimer's disease, any other form of dementia, or taken medication for memory loss?	☐ Yes ☐ No
☐ Yes ☐ No	Have you ever been charged with a DUI or DWI?	☐ Yes ☐ No
☐ Yes ☐ No	Have you ever declared bankruptcy?	☐ Yes ☐ No
☐ Yes ☐ No	Do you plan to travel outside the United States?	☐ Yes ☐ No
☐ Yes ☐ No	Have you ever used tobacco or nicotine products (gum, patch, etc.)? If "Yes", please indicate type, frequency and last use below.	☐ Yes ☐ No
☐ Yes ☐ No	Do you engage in motor vehicle racing, SCUBA or sky diving, cliff or base jumping, mountain / ice / rock climbing, pilot an airplane, other similar activity or plan to do so in the future?	☐ Yes ☐ No
☐ Yes ☐ No	Have you ever been treated by a chiropractor or had physical therapy? If yes, have you been released from all care/physical therapy with no limitations?	☐ Yes ☐ No
☐ Yes ☐ No	Have you ever been treated for any type of mood disorder?	☐ Yes ☐ No
☐ Yes ☐ No	Have you ever missed work for longer than 1 week due to a medical ailment?	☐ Yes ☐ No

If you answer yes to any of the questions or check any of the following conditions listed above, please provide details of the condition or activity in the space provided. Details include: medications, date of onset, treatment along with treatment dates, stage, level, grade, etc…

Client 1:

Client 2:

Health & Activity Information (cont.)

Have you ever received treatment or diagnosed for any of the following conditions?

- ☐ Alcohol and/or Drug Use
- ☐ Anxiety / Depression
- ☐ Arthritis / Osteoporosis
- ☐ Asthma
- ☐ Blood Pressure
- ☐ Cancer
- ☐ Cirrhosis of the Liver
- ☐ Cholesterol
- ☐ Crohn's Disease
- ☐ Diabetes / High Blood Sugar
- ☐ Gastric / Intestinal Bypass
- ☐ Heart or Coronary Artery Disease
- ☐ Hepatitis A, B, C
- ☐ Irregular Heart Beat
- ☐ Joint Replacement
- ☐ Kidney Disease or Dialysis
- ☐ Lung / Pulmonary Condition
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Psoriatic Arthritis
- ☐ Pulmonary Disease
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Stroke / TIA
- ☐ Ulcerative Colitis

If you checked any of the conditions listed above, please provide details of the condition or activity below including medications, date of onset, treatment along with treatment dates, stage, level, grade, etc…

Client 1:

Client 2:

When was your most recent visit to a doctor? *Please provide the reason for your most recent visit:*

Client 1:

Client 2:

Do you schedule regular visits with any doctor other than your primary physician? *Please provide date(s) of last visit and results.*

Client 1:

Client 2:

Please list the date and reason for any previous or scheduled hospitalizations and surgeries.

Client 1:

Client 2:

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed at the bottom of this page and their re-insurers as well as the Representative and its staff, employees and affiliated companies.