FINANCIAL INDEPENDENCE GROUP®

CARE PLANNING PREQUALIFYING QUESTIONNAIRE

Agent Name: _____

Primary Insured (PI)
Name: _____
DOB: _____
Height/Weight: _____

Insured Spouse (IS)
Name: _____
DOB: _____
Height/Weight: _____

In order to properly prequalify you and your spouse to find the best coverage for you, please complete the following questions:

		Primary Insured	Insured Spouse
1.	Have you had a complete physical in the last 18 months?	☐ Yes/No ☐	☐ Yes/No ☐
2.	Have you received in the past, or are you currently on disability? _____ Type/when/how long? _____	☐ Yes/No ☐	☐ Yes/No ☐
3.	In the past 12 months have you been in a hospital, nursing facility, received home care services, or physical therapy? Circle which?	☐ Yes/No ☐	☐ Yes/No ☐
4.	Do you have any surgeries scheduled/recommended? Type: _____	☐ Yes/No ☐	☐ Yes/No ☐
5.	Have you used any tobacco products in the past 12 months?	☐ Yes/No ☐	☐ Yes/No ☐
6.	Do you use a cane, crutches, braces, hospital bed, lift chair, walker wheelchair, oxygen or kidney dialysis?	☐ Yes/No ☐	☐ Yes/No ☐
7.	Actively working? f no, why? _____	☐ Yes/No ☐	☐ Yes/No ☐
8.	Have you been recently declined for long term care insurance? Reason/When? _____	☐ Yes/No ☐	☐ Yes/No ☐

Have you received any medical advice, diagnosis or treatment for any of the following? Please check all that apply. f yes, please review next page.

☐ PI/IS ☐	Amputation	☐ PI/IS ☐	Anemia
☐ PI/IS ☐	Autoimmune Disorder (type _____	☐ PI/IS ☐	Angioplasty/Bypass Surgery
☐ PI/IS ☐	Dizziness	☐ PI/IS ☐	Back Disorder/Surgery
☐ PI/IS ☐	Arthritis	☐ PI/IS ☐	Epilepsy/Seizures (last occurrence) _____
☐ PI/IS ☐	Blindness	☐ PI/IS ☐	Drug/Alcohol Abuse
☐ PI/IS ☐	Falls	☐ PI/IS ☐	Blood Disorder (type) _____
☐ PI/IS ☐	High Blood Pressure	☐ PI/IS ☐	Heart Problems
☐ PI/IS ☐	Bronchitis/Asthma	☐ PI/IS ☐	Joint Replacement/Fractures
☐ PI/IS ☐	Fibromyalgia/Chronic Fatigue	☐ PI/IS ☐	Cancer (type) _____
☐ PI/IS ☐	Mental/Nervous Disorder	☐ PI/IS ☐	Neurological Disorder (type) _____
☐ PI/IS ☐	COPD/Emphysema	☐ PI/IS ☐	Peripheral Vascular Disease
☐ PI/IS ☐	Stress incontinence	☐ PI/IS ☐	Ulcerative Colitis/Crohn s Disease
☐ PI/IS ☐	Depression hospitalizations?	☐ PI/IS ☐	Respiratory Disorders
☐ PI/IS ☐	Stroke/T A	☐ PI/IS ☐	Hepatitis (when/type) _____
☐ PI/IS ☐	Diabetes	☐ PI/IS ☐	Lupus
☐ PI/IS ☐	Elevated PSA or Prostate Disorders	☐ PI/IS ☐	Sleep Apnea
☐ PI/IS ☐	Osteoporosis with fractures	☐ PI/IS ☐	Aneurysm (type, size, operated?) _____

List all prescription medications taken over the past 12 months:
Please Check One:

☐ PI/IS ☐ Medication: _____ Dose: _____ Currently Taking: _____
How long taking: _____ Reason Prescribed: _____

☐ PI/IS ☐ Medication: _____ Dose: _____ Currently Taking: _____
How long taking: _____ Reason Prescribed: _____

☐ PI/IS ☐ Medication: _____ Dose: _____ Currently Taking: _____
How long taking: _____ Reason Prescribed: _____

☐ PI/IS ☐ Medication: _____ Dose: _____ Currently Taking: _____
How long taking: _____ Reason Prescribed: _____

PLEASE SEE NEXT PAGE

FINANCIAL INDEPENDENCE GROUP®

LTC PREQUALIFYING QUESTIONNAIRE

Agent Name:_____

Arthritis: ☐ **PI/IS** ☐
1. Type (osteo-, degenerative or rheumatoid?)_____
2. When diagnosed?_____
3. Medications?_____
4. Injections?_____
5. Any steroid use including dosage?_____
6. Daily narcotic use?_____
7. Any deformities or joint replacement?_____
8. Any physical therapy? When?_____
9. Recent flare-ups?_____

Asthma: ☐ **PI/IS** ☐
1. Frequency of attacks?_____
2. Oral steroids/inhalers?_____
3. Stable pulmonary function tests?_____
4. COPD or emphysema?_____
5. When diagnosed?_____

Cancer: ☐ **PI/IS** ☐
1. Stage of Cancer?_____
2. Treatment, last date of, fully recovered?_____
3. When diagnosed?_____
4. PSA (prostate cancer)?_____

COPD/Emphysema: ☐ **PI/IS** ☐
1. Medications?_____
2. Shortness of breath/limitations?_____
3. Oxygen use, daily steroid use?_____
4. When diagnosed?_____

Sleep Apnea: ☐ **PI/IS** ☐
1. When diagnosed?_____
2. Severity of condition?_____
3. Use of CPAP machine?_____
4. Any other treatment?_____

Heart Disease: ☐ **PI/IS** ☐
1. Surgeries, when, type, bypass, pacemaker, angioplasty, heart valve replacement?_____
2. Recovered?_____
3. Medications?_____
4. Any congestive heart failure/atria fibrillation/heart attack/ chest pains?_____
5. Regular checkups?_____

Osteoporosis or osteopenia: ☐ **PI/IS** ☐
1. Treatment?_____
2. T-Score on last bone density test and date?
3. When diagnosed?_____
4. Any multiple fractures or loss of height?_____

Stroke/CVA/TIA: ☐ **PI/IS** ☐
1. How many strokes?_____
2. When was the episode(s)?_____
3. Any residuals (numbness, pain, slurring)?_____
4. Any cognitive abnormalities?_____

Diabetes: ☐ **PI/IS** ☐
1. Type or?_____
2. Date of onset?_____
3. A1C Reading?_____
4. Complications (eye, nerve, kidney, damage)?_____
5. Insulin? Units?_____
6. Oral Medication?_____

Physical Therapy: ☐ **PI/IS** ☐
1. Current? Est. end date?_____
2. When?_____
3. Why?_____

Have you ever been diagnosed by a physician as having any of the following conditions?
PLEASE NOTE, these are most likely reason for declines.

☐ PI/IS ☐ AIDS/HIV
☐ PI/IS ☐ Positive ALS
☐ PI/IS ☐ Alzheimer s Disease
☐ PI/IS ☐ Mental Retardation
☐ PI/IS ☐ Multiple Myeloma
☐ PI/IS ☐ Multiple Strokes or TIAs
☐ PI/IS ☐ Multiple Sclerosis
☐ PI/IS ☐ Scleroderma
☐ PI/IS ☐ Post Polio Paralytic Syndrome
☐ PI/IS ☐ Spinal Cord injury
☐ PI/IS ☐ Kidney Failure
☐ PI/IS ☐ Schizophrenia
☐ PI/IS ☐ Urinary incontinence
☐ PI/IS ☐ Lou Gehrig s Disease
☐ PI/IS ☐ Crest
☐ PI/IS ☐ Metastatic Cancer
☐ PI/IS ☐ Muscular Dystrophy
☐ PI/IS ☐ Cystic Fibrosis
☐ PI/IS ☐ Neutrogena Bladder
☐ PI/IS ☐ Parkinson s Disease
☐ PI/IS ☐ Dementia/Confusion/Memory Loss
☐ PI/IS ☐ Cerebral Atrophy/Whiter Matter Changes
☐ PI/IS ☐ Liver Cirrhosis
☐ PI/IS ☐ Pulmonary Hypertension
☐ PI/IS ☐ Crest
☐ PI/IS ☐ Handicap Sticker? Why_____

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