LONG TERM CARE INSURANCE QUESTIONNAIRE

Elite Insurance Associates – FAX: 904-527-1318

Agent Name: _____

GENERAL INFORMATION

First Name: _____ MI: _____ Last Name: _____

Age: _____ DOB: _____ Gender: _____ Height: _____ Weight: _____

Home Address: _____ City: _____ County: _____ State: _____ Zip: _____

Phone Numbers: Best: _____ Secondary: _____

E-mail Address: _____

Do you smoke Tobacco? _____ Do you chew Tobacco? _____ Do you Vape? _____ Do you any form of Marijuana? _____

If so, what type, how often & is it prescribed? _____

Do you have any infractions on your Motor Vehicle Report – if so, what are they: _____

_____

Medications Name: _____ Condition: _____

Medications Name: _____ Condition: _____

Have you been Hospitalized within the past 10 years? If so, for what: _____

_____

Do you have any felonies, mistermeaner, or Incarcerations? : _____

COVERAGE INQUIRIES

How much in assests are you trying to protect? _____

Do you have existing long term care coverage? If so, how much coverage, what plan type, with what company & do you plan on replacing any coverage? _____

_____

Have you ever been declined on long term care or life insurance? _____

Signature: _____ Date: _____

Elite Insurance Associates
1710 Shadowood Lane, Unit 240 Jacksonville, Florida 32207 904-527-1304 www.eiafl.com

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Agent Name: _____

If you answer "Yes" to any of the questions in this Section, we are unable to accept this application or offer you Long-Term Care Insurance. Do not continue.

	YES	NO
1. Do you currently use any of the following: • wheelchair • walker • nebulizer • electric scooter • quad cane • oxygen	☐	☐
2. Within the past 6 months have you been confined to, or been advised by a licensed health care practitioner/medical professional to have, any of the following: • residential care, assisted living or adult day care facility services • nursing home or home health care services • physical, occupational or speech therapy	☐	☐
3. Do you require the assistance or supervision of another person or a device of any kind for any of the following: • bathing • toileting • dressing • eating • medication management • getting in and out of a chair or bed • your inability to control your bowel or bladder	☐	☐
4. Have you ever consulted with a licensed health care practitioner/medical professional for treatment or diagnosis of any of the following: • Alzheimer's Disease • Amyotrophic Lateral Sclerosis (ALS) • Chronic Hepatitis • Dementia • Huntington's Chorea • Cirrhosis • Memory Loss • Kidney Failure or received Dialysis • Myasthenia Gravis • Mental Retardation • Parkinson's Disease • Paralysis • Schizophrenia • Multiple Sclerosis • Scleroderma • Psychosis • Muscular Dystrophy • Systemic Lupus • Organ Transplant • Ministroke or Transient ischemic Attack (TIA) in the past year, single episode stroke in the past 2 years, two or more strokes or TIAs, or you have not fully recovered or continue to have weakness, decreased sensation or loss of function from a stroke or TIA • Diabetes and currently taking more than 50 units of insulin daily, or with peripheral neuropathy, numbness, tingling or decreased sensation in your feet, retinopathy, or history of a stroke, ministroke or a TIA • Cancer (except basal or squamous cell skin cancers, or stage I/A bladder, thyroid, breast, or prostate cancers) in the past 2 years • Chronic Obstructive Pulmonary Disease (COPD), Emphysema or Chronic Bronchitis and have used tobacco in the past year	☐	☐
5. Have you ever tested positive for exposure to the HIV infection, or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness, or condition derived from such infection?	☐	☐
6. Are you currently eligible for benefits under, or covered by, Medicaid (not Medicare), disability income, workers' compensation, Social Security disability or any federal or state disability plan?	☐	☐

Signature: _____ Date: _____

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