Long Term Care (LTC) Applicant Personal and Family Health History

Please take the time to answer all the questions. The results of this document will determine the available carriers we market to.

Name: Date:
Home Address:
Phone: Fax: Email:
Date of Birth: Age: Height: Weight:
Spouse: (only for obtaining LTC Illustration)
Name: Date of Birth: Age: Height: Weight:

Medical Insurance Provider:
Primary Care Doctor with the most of your medical records:
Name: Phone#:
Address:
Date last seen: Reason:

Have you had, do you currently have, or have ever been diagnosed with:(check those that apply to you)

- ☐ Diabetes treated w/ insulin
- ☐ Alzheimer's Disease
- ☐ TIA Transient Ischemic Attack w/in the past 5 yrs.
- ☐ TIA combined w/ Diabetes or Heart Surgery
- ☐ TIA two or more times
- ☐ Stroke
- ☐ Memory Loss/ senility/Dementia
- ☐ Frequent Forgetfulness
- ☐ AIDS Acquired Immune Deficiency Syndrome
- ☐ AIDS related complex (ARC)
- ☐ Congestive Heart Failure (CHF) combined with Heart attack or Angina
- ☐ Congestive Heart Failure (CHF) combined with Angioplasty or Heart Surgery
- ☐ Congestive Heart Failure (CHF) combined with Emphysema/COPD
- ☐ Congestive Heart Failure (CHF) combined with Asthma or chronic Bronchitis
- ☐ Congestive Heart Failure (CHF) combined with Diabetes
- ☐ Congestive Heart Failure (CHF) combined with Tuberculosis
- ☐ Organic Brain Syndrome
- ☐ Parkinson's Disease
- ☐ Metastatic Cancer (spread from original site)
- ☐ Cirrhosis of the Liver
- ☐ Muscular Dystrophy
- ☐ Multiple Sclerosis
- ☐ ALS (Gehrig's Disease)
- ☐ Emphysema/COPD combined with current smoking
- ☐ Emphysema/COPD combined with Congestive Heart Failure (CHF)
- ☐ Emphysema/COPD combined with Asthma
  Emphysema/COPD combined with Chronic Bronchitis
- ☐ In the past four (4) years, have you had Cancer; Bone, Brain, Esophagus, Liver, Lung, Ovary, Testes, Pancreas, Stomach?
- ☐ Do you take Kidney Dialysis?
- ☐ In the past (6) months, have you had; Open Heart Surgery, Back or Spine Surgery?

☐ Do you need the assistance or supervision by another person in performing any of the following activities: Moving, Bathing, in/out of bed or chair, Dressing, Eating, Toileting, Bowel/ Bladder Control, Walking?

In the past 5 years ((10) ten years for Cancer) have you: received medical advise or treatment; been medically diagnosed; or consulted w/ a health professional for any of the following conditions? Check the ones that apply)

- ☐ Alcoholism
- ☐ Congestive Heart Failure
- ☐ Asthma or Chronic Bronchitis
- ☐ Disabling Back or Spine condition
- ☐ Drug Addiction
- ☐ Rheumatoid Arthritis
- ☐ Fainting spells or Blacking out
- ☐ Tremor
- ☐ Injury due to falls or imbalance
- ☐ Mental Illness
- ☐ Any condition causing crippling or limited motion/adaptive devices
- ☐ Cancer (excluding Basil Cell)
- ☐ Angioplasty or Heart Surgery
- ☐ Diabetes not treated w/ insulin
- ☐ Atrial Fibrillation
- ☐ Paralysis, Epilepsy, Seizures, Convulsions
- ☐ Skin Ulcers
- ☐ Hodgkin's Disease
- ☐ Leukemia
- ☐ Amputation
- ☐ Depression
- ☐ Brain Disorder
- ☐ Osteoporosis
- ☐ Emphysema/ COPD
- ☐ Shortness of Breath
- ☐ Heart Attack or Angina
- ☐ Tuberculosis (TB)
- ☐ Lymphoma
- ☐ Joint Replacement Surgery

Please answer the following questions with Y or a N in the box that is correct;

☐ Have you seen a Doctor in the past 2 years?

In the past 3 years, have you;

- ☐ Smoked or used other tobacco products w/in the past 3 years?
- ☐ Been medically advised to enter or confined to a nursing home, assisted Living Facility?
- ☐ Been medically advised to have surgery, which has not been performed?
- ☐ Been medically advised to enter or been confined to a hospital or other health care facility?
- ☐ Taken medications for High Blood Pressure and/or Osteoarthritis?
- ☐ Consulted with or been treated by a licensed health care practitioner other than your primary care doctor? Including osteopaths/chiropractors/ physical therapists/medical doctors, excluding optometrists/podiatrists/dentists

Are you currently taking any prescription medications? *(Please list RX, dosage, how often, and why you take them)*

☐ **Did you complete this to the best of your knowledge?**

You must PRINT and save to PDF file now.

If you do NOT you will lose all the answers you just completed!

Please forward your completed application to;

BackNine Insurance Services email **Elana@back9ins.com**

Or fax to 805-557-1503