LTC Financial Solutions Case Development Worksheet

Agent: _____ ID: _____ Date: _____

Clients Name: _____ DOB: _____ Gender: Male ☐ Female ☐

Partner: _____ DOB: _____ Gender: Male ☐ Female ☐

Marital Status: Single ☐ Married ☐ Widowed ☐ Relative ☐ Residence State: _____

Tobacco User: Yes ☐ No ☐ If Yes, Smoke ☐ Chew ☐ Cigar ☐ Vapor ☐ When ceased: _____

Second Insured: Yes ☐ No ☐ If Yes, Smoke ☐ Chew ☐ Cigar ☐ Vapor ☐ When ceased: _____

Height/Weight: First insured: _____/_____ Second Insured: _____/_____

☐ Yes, I have been declined for LTC / Life. When? _____ Why? _____

Where is FUNDING (money) coming from?

Current Income? _____ Cash Value Life Insurance? _____

Savings/CD/Money Market Fund? _____ RMD? _____

Non-Qualified Annuity? _____ Death Benefit _____

Tax-Qualified Funds? _____

Does this annuity investment represent over 50% of clients liquid assets? Yes ☐ No ☐ If yes, explain: _____

_____

Objectives: Primary Objective? LTC: _____ Life _____ Annuity _____

Why LTC protection:

Where? _____ Who? _____ Funding/Amount? _____

Personal Experience? _____

Protect Income/other assets? _____ Maintain Independence? _____ Avoid dependence on family? _____

Other: _____

Wants LTC benefits to pass to family if not used for LTC? ☐ Yes ☐ No

Business? _____ Type: _____ other Key employees? _____

Tax Issues: _____

Other: _____

Notes: _____

_____

_____

_____

_____

***Health Conditions and Medications – Please see next page**

For Agent Use Only

Medical Screening Questionnaire

(THIS INFORMATION IS TO BE USED AS A GUIDELINE. DIFFERENT CARRIER REQUIREMENTS WILL VARY.)

Check all that apply and answer the corresponding questions.

Are you currently receiving Social Security Disability Insurance benefits: ☐Yes ☐No
Do you have any surgeries that are pending or have been recommended: ☐Yes ☐No If yes, please explain: _____
Do you currently use and/or need a Handicapped Parking tag or permanent plate: ☐Yes ☐No
MVR: Driving infractions or felony charges in past 10 years: ☐Yes ☐No If yes, please explain: _____
When was your last Doctor visit: _____ Why: _____
Did your last Doctor visit include labs: ☐Yes ☐No

Medical Conditions – Please check all that apply:

☐Coronary Artery Disease ☐Heart Attack ☐Congestive Heart Failure ☐ COPD
☐Atrial Fibrillation ☐Cardiomyopathy ☐Valve Disease ☐Peripheral Vascular Disease
☐Valve Replacement ☐Coronary Artery Disease ☐Heart Disease ☐Physical Therapy When:_____
☐Hypertension/High Blood Pressure Current Blood Pressure Reading:_____/_____
Average Blood Pressure Reading:_____/_____
☐**Stroke/TIA Symptoms** Date of symptom and diagnosis: _____ Recurrence of symptoms:_____
If you have any residuals, please describe: _____
☐**Osteopenia/Osteoporosis**
Date of Diagnosis: _____ Type of Treatment: _____
Have you ever had compression fractures due to Osteopenia/Osteoporosis: ☐Yes ☐No Describe: _____
What are your bone mineral density T and Z scores:_____ Do you have chronic pain: ☐Yes ☐No
☐**Arthritis** ☐Rheumatoid
Date of Diagnosis:_____ Any joint deformities: ☐Yes ☐No Any joint replacements: ☐Yes ☐No How many?_____
When? _____ Have you taken steroids? ☐Yes ☐No When?_____ For how long?_____
☐**Cancer Type**:_____ Stage or grade_____ Date of diagnosis:_____
Date of last treatment_____Type of treatment_____ Any treatments at this time: ☐Yes ☐No
☐**Diabetes** ☐Type1 (Juvenile) ☐Type II
Date of Diagnosis:_____ Current Glucose and/or Hemoglobin A1C reading: _____
Do you use insulin: ☐Yes ☐No Units per day: _____
☐Tingling ☐Numbness ☐Neuropathy ☐Skin Ulcers
☐Kidney or Liver Problems ☐Cellulitis ☐Visual Changes ☐Retinopathy
☐Organ Damage
☐Mental Health/Psychiatric Conditions Date of Diagnosis:_____ What is your specific diagnosis: _____
Within the last five years, have you been hospitalized for this condition or any other mental health issue: ☐Yes ☐No
Provide details: _____
☐**Sleep Apnea** Date of Diagnosis: _____ CPAP Machine Usage: ☐Yes ☐No

Current Medications (Daily usage of prescription narcotics are an automatic decline.)
Have you been prescribed medication that you aren't currently taking: ☐Yes ☐No Please Explain:_____

Please list medications you are currently taking. (Please include over-the-counter medications that are used daily)

Name of Medication	**Dosage Amount**	**Condition**	**Start Date of Medication**

Notes: _____

_____

_____

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