



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: _____



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: _____

