the KRAUSE AGENCY

Long-Term Care Health Questionnaire

Information of individual completing this form:

Name: _____ Company: _____

Address Line 1: _____ Phone: _____

Address Line 2: _____ Facsimile: _____

City/State/Zip: _____ / _____ / _____ Email: _____

Return via secure method of Fax or Secure Email - Sending this form insecurely can be a violation of HIPPA

ONCE COMPLETED, RETURN THIS FORM TO:

The Krause Agency
1234 Enterprise Drive, De Pere, WI 54115
Phone: (800) 255-1932 Facsimile: (805) 683-6313
ltcsales@thekrauseagency.com

A. Client Data - This form is designed for one individual. Please complete a form for each individual in need of a quote

First Name: _____ Last Initial: _____ Date of Birth: _____ Resident State:

Gender: ☐ Male ☐ Female Married or have a partner? ☐ Yes ☐ No

Exact Height: _____ Exact Weight: _____ Have you had a weight change in the last 12 months? ☐ Yes ☐ No

Tobacco Use: Check all that apply ☐ Cigarettes ☐ Cigar ☐ E-Cig ☐ Chew ☐ Vaping ☐ Marijuana

B. Medications - List ALL medications taken or prescribed within the last 12 months— Explain why/when if your dosage was increased or decreased

Medication/Steroid	Reason Prescribed	Frequency	Dosage	Date Started

C. Health History - Indicate any health condition you have been diagnosed with and detail

☐ **Diabetes** – *provide details below*
A1C: _____
Type: _____
Diagnosis Date: _____
Insulin Units: _____

☐ **Arthritis (Osteo, Rheumatoid, etc)** – *provide details below*
Type: _____
Any Steroid Injections: _____
Joints Affected: _____
Diagnosis Date: _____

☐ **Cancer** – *provide details below*
Type: _____
Stage: _____
Treatment Type: _____
Last Date of Treatment: _____
Lymph Nodes Affected: _____

☐ **Heart Disease** – *provide details below*
Type: _____
Bi-Pass or Stents: _____
Diagnosis Date: _____
History of Diabetes, Stroke, TIA, or COPD: _____
Nebulizer or Oxygen Use: _____

Additional History - List additional conditions & details (depression, COPD, blood clot, dizziness, etc.)	**Diagnosis Date**

	Additional Health History - If checked, please provide all additional information regarding the condition	
☐	Has a medical professional referred you to a specialist for additional consultation, testing or surgery in the last 3 years?	Details
☐	Have you received physical, occupational or speech therapy in the past 6 months?	Details
☐	Have you had surgery performed in the last 12 months?	Details
☐	Are you currently on disability income?	Details (Type & Percent)
☐	Have had 2 or more immediate family members (biological parents or siblings) diagnosed with dementia?	Details
☐	Have you been previously declined for LTC or Life Insurance?	Details

Your client's health history is an important factor in determining eligibility for coverage. All information provided is confidential. It will be used solely for the purpose of determining if submission of an application to an insurance company is appropriate. Nothing herein constitutes coverage, nor is to be considered an offer of insurance.

This form is for agent/producer use only. Not for distribution to the public.