the KRAUSE AGENCY

# LONG-TERM CARE INSURANCE INTAKE FORM

## Information of individual completing this form:

Name: _____ Company: _____

Address Line 1: _____ Phone: _____

Address Line 2: _____ Facsimile: _____

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

Are you, or are you completing this form on behalf of, a licensed insurance agent? ☐ Yes ☐ No

ONCE COMPLETED, RETURN THIS FORM TO:

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

## A. Applicant Data

Applicant Name: _____ Is the applicant Married? ☐ Y ☐ N

Applicant's Gender: ☐ Male ☐ Female If yes, is the applicant's spouse seeking coverage? ☐ Y ☐ N

Applicant's Height: _____ Applicant's Weight: _____

Street Address: _____

City: _____ State/Zip: _____ / _____

Applicant's Birth Date: _____ Co-Applicant's Name: _____

Co-Applicant's Gender: ☐ Male ☐ Female Co-Applicant's Birth Date: _____

Co-Applicant's Height: _____ Co-Applicant's Weight: _____

## B. Applicant Questions

| | Applicant | Co-Applicant |
|---|---|---|
| Has the individual had a weight change in the last 12 months? | ☐ Y ☐ N | ☐ Y ☐ N |
| Does the individual own a business? | ☐ Y ☐ N | ☐ Y ☐ N |

Does the individual use tobacco? Check all that apply.

| Applicant | | Co-Applicant | |
|---|---|---|---|
| ☐ Cigarettes | ☐ Chew | ☐ Cigarettes | ☐ Chew |
| ☐ Cigars | ☐ Marijuana | ☐ Cigars | ☐ Marijuana |
| ☐ E-cigarettes | ☐ None | ☐ E-cigarettes | ☐ None |
| ☐ Vaping | | ☐ Vaping | |

## C. Medications

List all medications taken or prescribed within the past 12 months. If the dosage of the medication has changed within the last 12 months, please explain why and when.

**APPLICANT MEDICATIONS**

| Medication | Reason for Taking | Frequency | Dosage | Date Started |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**CO-APPLICANT MEDICATIONS**

| Medication | Reason for Taking | Frequency | Dosage | Date Started |
|---|---|---|---|---|
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| | | | | |
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## D. Health History

**APPLICANT**

Has the applicant been diagnosed with any of the following health conditions? If yes, please provide additional details.

☐ **Diabetes**

A1C: _____

Type: _____

Diagnosis Date: _____

Insulin Units: _____

☐ **Arthritis (Osteo, Rheumatoid, etc.)**

Type: _____

Any Steroid Injections: _____

Joints Affected: _____

Diagnosis Date: _____

☐ **Cancer**

Type: _____

Stage: _____

Last Date of Treatment: _____

Lymph Nodes Affected: _____

☐ **Heart Disease**

Type: _____

Bi-Pass or Stents: _____

Diagnosis Date: _____

History of diabetes, stroke, TIA, or COPD:

_____

Nebulizer or Oxygen Use: _____

Please list any additional conditions, details, and diagnosis dates. _____

**CO-APPLICANT**

Has the co-applicant been diagnosed with any of the following health conditions? If yes, please provide additional details.

☐ **Diabetes**

A1C: _____

Type: _____

Diagnosis Date: _____

Insulin Units: _____

☐ **Arthritis (Osteo, Rheumatoid, etc.)**

Type: _____

Any Steroid Injections: _____

Joints Affected: _____

Diagnosis Date: _____

☐ **Cancer**

Type: _____

Stage: _____

Last Date of Treatment: _____

Lymph Nodes Affected: _____

☐ **Heart Disease**

Type: _____

Bi-Pass or Stents: _____

Diagnosis Date: _____

History of diabetes, stroke, TIA, or COPD:

_____

Nebulizer or Oxygen Use: _____

Please list any additional conditions, details, and diagnosis dates. _____

| ADDITIONAL HEALTH QUESTIONS | | | |
|---|---|---|---|
| | **Applicant** | **Co-Applicant** | **If Yes, Provide Details** |
| Has a medical professional referred the applicant to a specialist for additional consultation, test, or surgery in the last three years? | Y ☐ N ☐ | Y ☐ N ☐ | |
| Has the applicant had surgery performed in the last 12 months? | Y ☐ N ☐ | Y ☐ N ☐ | |
| Has the applicant had two or more immediate family members (biological parents or siblings) diagnosed with dementia? | Y ☐ N ☐ | Y ☐ N ☐ | |
| Has the applicant received physical, occupational, or speech therapy in the past six months? | Y ☐ N ☐ | Y ☐ N ☐ | |
| Is the applicant currently receiving disability income? | Y ☐ N ☐ | Y ☐ N ☐ | |
| Has the applicant been prescribed a handicap sticker? | Y ☐ N ☐ | Y ☐ N ☐ | |
| Has the applicant been previously declined for Long-Term Care Insurance or Life Insurance? | Y ☐ N ☐ | Y ☐ N ☐ | |

## E. Financial Information

**APPLICANT**

Social Security: $_____ Pension: $_____

Other Income: $_____ Total Income: $_____

**CO-APPLICANT**

Social Security: $_____ Pension: $_____

Other Income: $_____ Total Income: $_____

**ASSET INFORMATION**
Please enter the applicant and co-applicant's assets and liabilities

| Asset Type | Owner | Value | Liability |
|---|---|---|---|
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| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | 0 | 0 |
| **Total Assets and Liabilities:** | | 0 | 0 |

## E. Certification

The undersigned hereby represents to The Krause Agency that the information contained in this intake form is accurate and complete. The individual completing this form understands the 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.

Dated: _____

Signature of Applicant or Applicant Representative: _____