



Underwriting Questionnaire

(Please Print Clearly)

Agent's Name: _____ Phone: _____

Agent's Address: _____

Suite No.: _____ City: _____ State: _____ Zip: _____

Fax: _____ Email: _____

Applicant's Name: _____
(FIRST) (MIDDLE INITIAL) (LAST)

State: _____ Birthdate: _____ Age: _____ Height: _____ Weight: _____ Sex: _____
(Month) / (Day) / (Year) (Ft./In.) (Lbs.)

Smoker: Yes No Premium Commitment: \$ _____ Daily Benefit Amount: \$ _____

Waiting Period: 30 60 90 180 Days (circle one) Benefit Period: 1 2 3 4 5 6 Years (circle one)

Benefit Type: Comprehensive Home Care Facility Care

Yes No

Medical Profile

1. Does your client currently have, or have you been medically diagnosed as having any of the following conditions?
- Acquired Immune Deficiency Syndrome (AIDS)
 - HIV Positive
 - Organic Brain Syndrome
 - Down's Syndrome
 - ALS (Lou Gehrig's Disease)
 - Chronic Memory Loss
 - Muscular Dystrophy
 - Cerebral Palsey
 - Alzheimer's Disease
 - Senility/Dementia
 - Huntington's Chorea
 - Psychosis/Schizophrenia

If any of the above are answered "YES," THE CLIENT WILL NOT QUALIFY. Otherwise, please continue.

Yes No

1. Does your client currently need the assistance or supervision of another person in performing any of the following activities:
Moving in/out of bed or chair; Bathing; Dressing; Toileting; Bowel/Bladder Control; Eating?

2. Within the past five (5) years has your client: received medical advice or treatment, taken any medications, diagnosed, been confined to a convalescent care facility, hospital, or nursing facility, or professional for any of the following conditions: (If "YES," please circle any that apply).

A. Paralysis; Stroke; Transient Ischemic Attack (TIA); Hodgkin's Disease; Leukemia; Lymphoma; Cancer, Heart Surgery; Angioplasty; Heart Attack; High Blood Pressure; Congestive Heart Failure (CHF); Disabling Back or Spine Injury?

B. Emphysema; Shortness of Breath; Fainting Spells; Blacking Out; Injury due to Falls or Imbalance?

C. Brain Disorder; Mental Illness; Depression; Alcoholism; Drug Addiction?

D. Epilepsy; Seizures; Convulsions; Tremor; Diabetes; Skin Ulcers?

E. Multiple Sclerosis; Osteoporosis; Arthritis; other conditions causing Crippling or Limited Motion?

3. During the past three (3) years have you:

A. Been medically advised to have surgery which has not been performed?

B. Consulted with or been treated by a health professional for any reason not previously stated (excluding eye doctors, podiatrists, chiropractors, and dentists)?

C. Received home care; used an adult day care facility; been medically advised to enter a nursing home; or been confined to a hospital or other health care facility? (If "YES," please circle any that apply).

DETAILS FOR "YES" ANSWERS TO ANY PART OF QUESTIONS 1, 2 AND 3

Attach additional sheets with extra medical information

DESCRIBE SICKNESS, INJURY and TREATMENT If surgery performed – state type	DATES OF Symptoms and/or Treatment From To		DEGREE OF RECOVERY	MEDICATION(S) TAKEN