

Scott A. Olson, CLTC

www.LTCInsuranceShopper.com

Making Long Term Care Insurance EasierSM

Health Profile

Purpose:

It's impossible to give you accurate premium calculations from several of the leading long term care insurers without answers to the following health questions. These questions are based on actual underwriting guidelines for many of the leading long term care insurance policies.

This is NOT an application for insurance:

This is simply an information gathering tool from which I can generate accurate premium calculations and make sound recommendations regarding which long term care insurance policy you should choose. No insurance will go into effect until after you complete an actual application, are approved by the insurer, and pay your first premium.

Your Privacy is Respected:

All information shared with me is kept confidential and will not be shared with anyone else. The only other party with whom we will share your health information will be the insurance company with whom you choose to apply for long term care insurance. The information you provide me here will not be shared with any insurance company until you complete an actual application for a long term care insurance policy.

Sincerely,



Scott A. Olson, CLTC

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Toll-free: 1-877-727-9582

To receive comparison quotes from 9 of the leading long term care insurance policies, complete the following information for yourself (and spouse/partner, if applicable.) If you need more space to answer any questions, use the blank pages as needed.

Fax the completed form to: 1-888-582-7761

(This fax is on 24 hours a day and there is no need to include a cover sheet.)

Name:		Spouse/Partner's Name:	
Date of Birth:		Spouse/Partner's Date of Birth:	
Mailing Address:			
City:		State:	Zip:
Preferred E-mail:			
Secondary E-mail:			
Preferred Phone:		Best time to call:	
Secondary Phone:		Best time to call:	
Do you currently have a long term care insurance policy? If so, how long have you owned the policy and why are you considering a new policy?			
What is your state of residence? Do you reside in more than one state? If so, which states?			

Please circle the appropriate answer

In the past 5 years, have you or your spouse/partner had any type of:	<u>Yourself:</u>		<u>Your Spouse/Partner:</u>	
surgery or hospital stay	Yes	No	Yes	No
cancer, including skin cancer	Yes	No	Yes	No
stroke, mini-stroke, or bell's palsy	Yes	No	Yes	No
arthritis or any joint replacement	Yes	No	Yes	No
heart surgery, heart/circulatory disorders, peripheral vascular disease, or aneurysm	Yes	No	Yes	No
physical therapy or other rehabilitative care	Yes	No	Yes	No
multiple sclerosis, Lou Gehrig's disease (ALS), parkinson's disease or any other disorder of the nervous system	Yes	No	Yes	No
bone fracture, osteoporosis or osteopenia	Yes	No	Yes	No
back, spine, or neck disorders or surgery	Yes	No	Yes	No
auto-immune disorders like lupus, fibromyalgia, polymyalgia rheumatica, or CREST syndrome	Yes	No	Yes	No
persistent memory loss, amnesia, Alzheimer's disease or any type of dementia	Yes	No	Yes	No
diabetes or diabetic complications	Yes	No	Yes	No
sleep disorders, sleep apnea, CPAP use or restless leg syndrome	Yes	No	Yes	No
asthma, bronchitis, chronic obstructive pulmonary disease, or other lung disorders	Yes	No	Yes	No
high blood pressure	Yes	No	Yes	No
stress incontinence, or bowel or bladder incontinence, use of a catheter or colostomy	Yes	No	Yes	No
epilepsy or any type of seizure disorder	Yes	No	Yes	No
neuralgia, neuropathy, polyneuropathy, chronic fatigue syndrome or any type of chronic pain	Yes	No	Yes	No
Use of a cane, walker, wheelchair or scooter	Yes	No	Yes	No
pancreatitis, kidney or liver disorders, any type of hepatitis, or any type of blood disorders	Yes	No	Yes	No
anxiety, depression, bipolar, or any other type of mental/nervous disorder	Yes	No	Yes	No
Are you currently receiving any type of disability benefits?	Yes	No	Yes	No
Has it been recommended that you have some type of surgery or therapy in the next 24 months (including elective procedures)?	Yes	No	Yes	No

Policy Design Worksheet

Choose your 5, Foundational Features

1. For which settings do you want the policy to pay benefits for qualified care you receive?

- Home-Healthcare-Only
- Facility-Only
- Integrated (Facility Care AND Home Healthcare)

2. How much do you want the policy to pay for each day that you receive qualified care?

Enter your choice of Starting Daily Benefit here: \$_____

3a. How do you want the Daily Benefit to grow in order to try to keep pace with inflation?

- No Inflation Benefit
- Future Purchase Option
- Automatic Inflation Benefit

3b. If you want an Automatic Inflation Benefit, which type do you want?

- 5% Compound
- 5% Simple
- Other, please explain: _____

4a. For how long do you want the policy to be able to pay benefits while you qualify to receive benefits?

- 2 Years
- 3 Years
- 4 Years
- 5 Years
- 6 Years
- 10 Years
- Lifetime/Unlimited
- Other, please explain: _____

4b. If you want to share benefits with your spouse/partner, how many years of benefits do you want in TOTAL? _____

5a. For how long do you want to receive qualified care before the policy will begin to pay benefits for care?

- 0 days
- 30 days
- 60 days
- 90 days
- 180 days
- 365 days
- Other, please explain: _____

5b. Would you like your policy to be able to pay benefits for the first day that you receive qualified care at home? (This is called the "Waiver of Elimination Period" for home healthcare.)

- Yes
- No

Which "Tailored Features" might be important to You?

6a. Do you own a business that could use a tax deduction?

Yes
 No

6b. If "Yes", please specify the type of entity your business uses for filing federal income taxes:

C-corporation
 S-corporation
 Partnership
 Sole Proprietorship
 Other, please explain: _____

7a. Is it very important for you to have a policy that will pay benefits for care that is received outside the United States?

Yes
 No

7b. If "Yes", please specify the country or region in which you would most likely live:

8. Is it very important for you to have a policy that will pay a relative to care for you?

Yes
 No

