AIB LTC Pre-Qualification Health Form

fax to ~~518-688-8139~~ Rose DiVirgilio 1-866-375-5132 FAX

Broker Name: Rose DiVirgilio Phone / E-mail: 607-777-9526 / rose@dbrservice.com

Client Name:________________ Date of Birth:________ State:________

Spouse applying? ☐ No ☐ Yes (If yes, please complete a separate form)

Client Email: ________________ Client Contact No: ____________

1. Height:________ Weight:________ 2. Do you smoke? ☐ No ☐ Yes

3. Do you have symptoms of, or within the last 10 years, have you received medical advice, diagnosis or treatment or consulted with a member of the medical profession for any of the following conditions:

	Yes		Yes		Yes		Yes
a. heart disease	☐	h. paralysis	☐	o. alcoholism	☐	v. fainting spells	☐
b. coronary artery disease	☐	i. stroke	☐	p. drug addiction	☐	w. dizziness	☐
c. circulatory disorders	☐	j. bowel disorders	☐	q. osteoporosis	☐	x. seizures	☐
d. high blood pressure	☐	k. bladder disorders	☐	r. arthritis	☐	y. tremors	☐
e. leukemia	☐	l. prostate disorders	☐	s. reproductive organ disorders	☐	z. diabetes	☐
f. lymphoma	☐	m. kidney disorders	☐	t. respiratory disorders	☐	aa. liver disorders	☐
g. cancer	☐	n. depression	☐	u. shortness of breath	☐		☐

Question #________ Date of Onset________

Details________________

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Details________________

Medications:________________

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4. Have you received physical therapy in the past 12 months?

Date________ Details________________

5. Have you been hospitalized in the last 10 years?

Date________ Details________________

6. Are you presently, or in the past collecting Social Security Disability or other disability benefits?

Date________ Details________________

7. Have you been previously declined for long-term care insurance?

Date________ Carrier and reason(s)________________

8. Is there family history of dementia or alzheimers (parents or siblings)? Details________________

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