



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: _____

RETURN COMPLETED FORM TO:

Krause Financial
 1234 Enterprise Drive, De Pere, WI 54115
 Phone: (866) 605-7437 Facsimile: (866) 605-7438
 info@krausefinancial.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
 Street Address: _____
 City: _____ State/Zip: _____ / _____
 Applicant's Birth Date: _____ Co-Applicant's Name: _____
 Co-Applicant's Gender: Male Female Co-Applicant's Birth Date: _____

B. Applicant Questions

	<u>Applicant</u>	<u>Co-Applicant</u>
Has the individual had a weight change in the last 12 months?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Does the individual own a business?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

Does the individual use tobacco?
Check all that apply.

Applicant

Co-Applicant

- Cigarettes
- Cigars
- E-cigarettes
- Vaping

- Chew
- Marijuana
- None

- Cigarettes
- Cigars
- E-cigarettes
- Vaping
- Chew
- Marijuana
- None

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

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 <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Has the applicant had surgery performed in the last 12 months?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Has the applicant had two or more immediate family members (biological parents or siblings) diagnosed with dementia?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Has the applicant received physical, occupational, or speech therapy in the past six months?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Is the applicant currently receiving disability income?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Has the applicant been prescribed a handicap sticker?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Has the applicant been previously declined for Long-Term Care Insurance or Life Insurance?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	

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
Total Assets and Liabilities:			

E. Certification

The undersigned hereby represents to Krause Financial 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 professional use only. Not for distribution to the public.

Dated: _____

Signature of Applicant or Applicant Representative: _____