Making Long Term Care Insurance Easier

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.

Herman Bruns
770-844-0883

Fax the completed form to: 678-669-9969 or scan and email

to me at hbruns@aol.com

(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?		

Your Height:	**Your Weight:**	**Your Weight 12 months ago (approx.):**

Spouse/Partner's Height:	Spouse/Partner's Weight:	Spouse/Partner's Weight 12 months ago (approx.):
When was the last time you smoked a cigarette?		
When was the last time you used any other type of tobacco product? What kind?		
When was the last time your spouse/partner smoked a cigarette?		
When was the last time your spouse/partner used any other type of tobacco product? What kind?		

Please list any prescription medications that you (and your spouse/partner) are currently taking or have taken in the last 12 months, other than for routine colds/flu/etc:		
Name of Medication:	**Purpose of the Medication:**	**Taken by:**

Please circle the appropriate answer

In the past 5 years, have you or your spouse/partner had any type of:	**Yourself:**	**Your Spouse/Partner:**
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

For any questions circled 'yes' on the previous page, please

provide as many details as possible on this page.
Use additional paper if necessary