Simplicity ABLTC
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SIMPLICITY ASSET-BASED LTC

LTC HEALTH QUESTIONNAIRE

Comparison quotes needed for: Asset-Based Traditional LTC Short-Term LTC

Advisor Name: ______________________

Phone Number: ______________________ **Email:** ______________________

Name: ______________________ Spouse, if married: ______________________

Date of Birth: ______________________ Spouse's DOB: ______________________

State: ______________________

Pre-Screening Health Statement - **Part A**

	Client	Spouse (if applicable)
1. Within the past two years have you been confined to a nursing home, assisted living center, received or been advised to receive hospice care, been advised that you have a terminal illness or need assistance with: bathing, eating, dressing, toileting, transferring into and out of bed, chair, or wheelchair and/or maintain continence?	**Yes** **No**	**Yes** **No**
2. Are you currently hospitalized, bedridden or use medical devices such as: wheelchair, walker, dialysis machine, oxygen equipment, respirator, stair lift, chair lift, motorized scooter or taking medications Aricept, Exelon, Reminyl or Namenda?	**Yes** **No**	**Yes** **No**
3. Have you ever been diagnosed by a member of the medical profession as having AIDS, HIV, or ARC disorders, or tested positive for antibodies for the AIDS virus?	**Yes** **No**	**Yes** **No**
4. If under the age of 65, is there any reason you are not physically and mentally capable of active employment or are you currently receiving or have received within the past five years social security disability income benefits?	**Yes** **No**	**Yes** **No**
5. Have you ever been diagnosed, treated, tested positive for, or been given professional medical advice for: Alzheimer's disease, dementia, memory loss, multiple sclerosis, muscular dystrophy, ALS (Lou Gehrig's disease) Parkinson's disease, down syndrome, organ transplant (other than kidney) or active cancer?	**Yes** **No**	**Yes** **No**

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Pre-Screening Health Statement - **Part B**

SIMPLICITY
ASSET-BASED LTC

Client: ______________________ **Height:** ______________ **Weight:** ______________

In the past 5 years, is there a history of:

Diabetes
Depression
Uncontrolled High Blood Pressure
Cancer
Leukemia
Heart Disease
Congestive Heart Failure
Organ Failure/Disease
Heart Attack
Cardiomyopathy
Amyotrophic Lateral Sclerosis (ALS)
Chronic Obstructive Lung Disease (COLD)
Chronic Obstructive Pulmonary Disease (COPD)
Stroke

IF ABOVE CHECKED PLEASE PROVIDE DETAILS ON NOTES PAGE

Other: ____

CLIENT	DOSE	FREQUENCY	REASON

Spouse: ______________________ **Height:** ______________ **Weight:** ______________

In the past 5 years, is there a history of:

Diabetes
Depression
Uncontrolled High Blood Pressure
Cancer
Leukemia
Heart Disease
Congestive Heart Failure
Organ Failure/Disease
Heart Attack
Cardiomyopathy
Amyotrophic Lateral Sclerosis (ALS)
Chronic Obstructive Lung Disease (COLD)
Chronic Obstructive Pulmonary Disease (COPD)
Stroke

IF ABOVE CHECKED PLEASE PROVIDE DETAILS ON NOTES PAGE

Other: ____

CLIENT	DOSE	FREQUENCY	REASON

Assets:

Asset	Value	
	Client	Spouse
Cash Reserves (CDs, savings)		
Life Insurance (cash value)		
Annuity (cash value)		
IRAs		
401-K		
Stocks and Bonds		
Annual Income		

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