Most of the leading long term care insurers have very different methods for determining if someone is insurable. There are only 13 health conditions which are automatic declines with the top 15 long term care insurers. Those 13, uninsurable conditions are:

AIDS, Alzheimer's/dementia, ALS (Lou Gehrig's disease), Ataxia, Chorea, Cystic Fibrosis, Dialysis, mental retardation, MS/Multiple Sclerosis, Muscular Dystrophy, Parkinson's, Schizophrenia, or currently uses a wheelchair or walker.

If your client does not have any of those 13 conditions, then complete the rest of this form.

Answer the health questions to the best of your ability. If you are not sure how to answer a question, then enter "not sure". If we need additional information in order to pre-approve your client, we'll e-mail you within 24 hours with the additional questions we need answers to.

Fax this completed form to: **1-888-582-7761** (***press start as soon as you hear the voice greeting***)

Your Name:		Your Preferred e-mail address:
Your Preferred Phone:		Best time to call you?
Which insurer(s) has previously declined your client?		What reason(s) was given for your client’s declination?
Since underwriting standards and requirements can vary by state, what is your client’s primary state of residence?		What is your client’s secondary state of residence, if any?

Your Client's Health Information

Because many health conditions are underwritten differently depending upon one's age, what is your client's date of birth?
Height?
Weight? Weight 12 months ago?
Has your client used any type of tobacco in the last five (5) years? ___Yes___No If yes, what kind? ____ If yes, when did they last use tobacco? ____

MEDICATION LIST

Name of Medication: Dosage: Purpose:		Name of Medication: Dosage: Purpose:
Name of Medication: Dosage: Purpose:		Name of Medication: Dosage: Purpose:
Name of Medication: Dosage: Purpose:		Name of Medication: Dosage: Purpose:
Name of Medication: Dosage: Purpose:		Name of Medication: Dosage: Purpose:
Name of Medication: Dosage: Purpose:		Name of Medication: Dosage: Purpose:

Please circle the appropriate answer

In the past 10 years, has your client had any type of the following:	
Surgery or hospital stay or emergency room visit?	Yes No
Cancer, including skin cancer	Yes No
Stroke, mini-stroke, or Bell's Palsy	Yes No
Arthritis or any joint replacement	Yes No
Heart surgery, heart disorders, peripheral vascular disease, or aneurysm, embolism or other circulatory disorders	Yes No
Physical therapy, speech therapy or other rehabilitative care	Yes No
Multiple Sclerosis, Lou Gehrig's disease (ALS), Parkinson's disease or any other disorder of the nervous system	Yes No
Bone fracture, Osteoporosis or Osteopenia	Yes No
Back, spine, or neck disorders or surgery	Yes No
Auto-immune disorders like Lupus, Fibromyalgia, Polymyalgia Rheumatica, or CREST syndrome	Yes No
Persistent memory loss, Alzheimer's disease or any type of dementia	Yes No
Pre-diabetes, Diabetes or any diabetic complications like neuropathy	Yes No
Sleep disorders, sleep apnea, CPAP use, or Restless Leg Syndrome	Yes No
Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease, or other lung disorders	Yes No
High blood pressure	Yes No
Stress incontinence, or bowel or bladder incontinence, use of a catheter or colostomy	Yes No
Epilepsy or any type of seizures	Yes No
Neuralgia, Neuropathy, Polyneuropathy, Chronic Fatigue Syndrome or any type of chronic pain	Yes No
Use of a cane, walker, wheelchair or scooter	Yes No
Pancreatitis, kidney or liver disorders, any type of Hepatitis, or any type of blood disorders	Yes No
Anxiety, depression, bipolar, or any other type of mental/nervous disorder	Yes No
Received any type of disability benefits?	Yes No
Has it been recommended that they have some type of surgery or therapy in the next 24 months (including elective procedures)?	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.