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: ______________________

Are you, or are you completing this form on behalf of, a licensed insurance agent? ☐ Yes ☐ No

ONCE COMPLETED, RETURN THIS FORM TO:

The Krause Agency
1234 Enterprise Drive, De Pere, WI 54115
Phone: (800) 255-1932 Facsimile: (805) 683-6313
info@thekrauseagency.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

Applicant's Height: ______________________ Applicant's Weight: ______________________

Street Address: ______________________

City: ______________________ State/Zip: __________ / __________

Applicant's Birth Date: ______________________ Co-Applicant's Name: ______________________

Co-Applicant's Gender: ☐ Male ☐ Female Co-Applicant's Birth Date: ______________________

Co-Applicant's Height: ______________________ Co-Applicant's Weight: ______________________

B. Applicant Questions

	Applicant	Co-Applicant
Has the individual had a weight change in the last 12 months?	☐ Y ☐ N	☐ Y ☐ N
Does the individual own a business?	☐ Y ☐ N	☐ Y ☐ N

Does the individual use tobacco?
Check all that apply.

Applicant

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

Co-Applicant

- [ ] 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. ____________________

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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. ____________________

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

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 The Krause Agency 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 agent/producer use only. Not for distribution to the public.

Dated: ______________________

Signature of Applicant or Applicant Representative: ____