



LTC Insurance Pre-Qualification Questionnaire

Agent Ken Dicken, Business Director State/Zip KY 40241
Phone 502-327-0151 Fax 502-327-8566 Email ken-dicken@dicken.com

Client Name _____ **DOB** _____ **Height** _____ **Weight** _____

Spouse Name _____ **DOB** _____ **Height** _____ **Weight** _____

Address _____ **City** _____ **State/Zip** _____

Phone _____ **Fax** _____ **Cell** _____ **Email** _____

Client Spouse **Circle Y-YES or N-NO for each question below**

- | | | |
|-----|-----|---|
| Y/N | Y/N | 1. Are you taking any prescription medications? If yes, please list all medications below, along with the condition each was prescribed for, length of time taken and dosage amounts. |
| Y/N | Y/N | 2. Are you using oxygen, wheelchair, crutches, cane, or receiving physical therapy? If yes, please provide details below. |
| Y/N | Y/N | 3. Have you been declined for LTCI? If yes, please provide details below. |
| Y/N | Y/N | 4. Have you used tobacco in the last 36 months? If yes, please provide details below. |
| Y/N | Y/N | 5. Is any surgery scheduled in the next 6 months or has surgery been recommended? If yes, please provide details below. |
| Y/N | Y/N | 6. Have you been hospitalized in the past 10 years? If yes, please list dates, treatments and details below. |
| Y/N | Y/N | 7. Have you received treatment for any medical condition? Including but not limited to: Anxiety, High Blood Pressure, Diabetes or Arthritis. If yes, please list details below. |
| Y/N | Y/N | 8. Have you applied for or are you eligible for Medicaid? If yes, please provide details below. |

Details to "Yes" answers above and ALL medications taken.

Client: _____

Spouse: _____

