



### LTC Financial Solutions Case Development Worksheet

Agent: \_\_\_\_\_ ID: \_\_\_\_\_ Date: \_\_\_\_\_

Clients Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: Male  Female

Partner: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: Male  Female

Marital Status: Single  Married  Widowed  Relative  Residence State: \_\_\_\_\_

Tobacco User: Yes  No  If Yes, Smoke  Chew  Cigar  Vapor  When ceased: \_\_\_\_\_

Second Insured: Yes  No  If Yes, Smoke  Chew  Cigar  Vapor  When ceased: \_\_\_\_\_

Height/Weight: First insured: \_\_\_\_\_ / \_\_\_\_\_ Second Insured: \_\_\_\_\_ / \_\_\_\_\_

Yes, I have been declined for LTC / Life. When? \_\_\_\_\_ Why? \_\_\_\_\_

#### Where is FUNDING (money) coming from?

Current Income? \_\_\_\_\_ Cash Value Life Insurance? \_\_\_\_\_

Savings/CD/Money Market Fund? \_\_\_\_\_ RMD? \_\_\_\_\_

Non-Qualified Annuity? \_\_\_\_\_ Death Benefit \_\_\_\_\_

Tax-Qualified Funds? \_\_\_\_\_

Does this annuity investment represent over 50% of clients liquid assets? Yes  No  If yes, explain: \_\_\_\_\_

Objectives: Primary Objective? LTC: \_\_\_\_\_ Life \_\_\_\_\_ Annuity \_\_\_\_\_

#### Why LTC protection:

Where? \_\_\_\_\_ Who? \_\_\_\_\_ Funding/Amount? \_\_\_\_\_

Personal Experience? \_\_\_\_\_

Protect Income/other assets? \_\_\_\_\_ Maintain Independence? \_\_\_\_\_ Avoid dependence on family? \_\_\_\_\_

Other: \_\_\_\_\_

Wants LTC benefits to pass to family if not used for LTC? Yes No

Business? \_\_\_\_\_ Type: \_\_\_\_\_ other Key employees? \_\_\_\_\_

Tax Issues: \_\_\_\_\_

Other: \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Medical Screening Questionnaire

**(THIS INFORMATION IS TO BE USED AS A GUIDELINE. DIFFERENT CARRIER REQUIREMENTS WILL VARY.)**

**Check all that apply and answer the corresponding questions.**

Are you currently receiving Social Security Disability Insurance benefits:  Yes  No  
 Do you have any surgeries that are pending or have been recommended:  Yes  No If yes, please explain: \_\_\_\_\_  
 Do you currently use and/or need a Handicapped Parking tag or permanent plate:  Yes  No  
 MVR: Driving infractions or felony charges in past 10 years:  Yes  No If yes, please explain: \_\_\_\_\_  
 When was your last Doctor visit: \_\_\_\_\_ Why: \_\_\_\_\_  
 Did your last Doctor visit include labs:  Yes  No

**Medical Conditions** – Please check all that apply:

Coronary Artery Disease     Heart Attack     Congestive Heart Failure     COPD  
 Atrial Fibrillation     Cardiomyopathy     Valve Disease     Peripheral Vascular Disease  
 Valve Replacement     Coronary Artery Disease     Heart Disease     Physical Therapy When: \_\_\_\_\_  
 Hypertension/High Blood Pressure    Current Blood Pressure Reading: \_\_\_\_\_ / \_\_\_\_\_  
 Average Blood Pressure Reading: \_\_\_\_\_ / \_\_\_\_\_

**Stroke/TIA Symptoms** Date of symptom and diagnosis: \_\_\_\_\_ Recurrence of symptoms: \_\_\_\_\_  
 If you have any residuals, please describe: \_\_\_\_\_

**Osteopenia/Osteoporosis**

Date of Diagnosis: \_\_\_\_\_ Type of Treatment: \_\_\_\_\_  
 Have you ever had compression fractures due to Osteopenia/Osteoporosis:  Yes  No Describe: \_\_\_\_\_  
 What are your bone mineral density T and Z scores: \_\_\_\_\_ Do you have chronic pain:  Yes  No

**Arthritis**

Rheumatoid  
 Date of Diagnosis: \_\_\_\_\_ Any joint deformities:  Yes  No Any joint replacements:  Yes  No How many? \_\_\_\_\_  
 When? \_\_\_\_\_ Have you taken steroids?  Yes  No When? \_\_\_\_\_ For how long? \_\_\_\_\_

**Cancer Type:** \_\_\_\_\_

Stage or grade \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_  
 Date of last treatment \_\_\_\_\_ Type of treatment \_\_\_\_\_ Any treatments at this time:  Yes  No

**Diabetes**

Type1 (Juvenile)     Type II  
 Date of Diagnosis: \_\_\_\_\_ Current Glucose and/or Hemoglobin A1C reading: \_\_\_\_\_  
 Do you use insulin:  Yes  No Units per day: \_\_\_\_\_  
 Tingling     Numbness     Neuropathy     Skin Ulcers  
 Kidney or Liver Problems     Cellulitis     Visual Changes     Retinopathy  
 Organ Damage

**Mental Health/Psychiatric Conditions** Date of Diagnosis: \_\_\_\_\_ What is your specific diagnosis: \_\_\_\_\_

Within the last five years, have you been hospitalized for this condition or any other mental health issue:  Yes  No  
 Provide details: \_\_\_\_\_

**Sleep Apnea**

Date of Diagnosis: \_\_\_\_\_ CPAP Machine Usage:  Yes  No

**Current Medications** (Daily usage of prescription narcotics are an automatic decline.)

Have you been prescribed medication that you aren't currently taking:  Yes  No Please Explain: \_\_\_\_\_

**Please list medications you are currently taking.** (Please include over-the-counter medications that are used daily)

Name of Medication	Dosage Amount	Condition	Start Date of Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_