WESTROCK INSURANCE AGENCY

151 N MAIN STREET #204
NEW CITY, NY 10956
PHONE: 845-638-2300
FAX: 845-638-6222

LONGTERM CARE PRE-QUALIFYING FORM

Please answer all of the following questions:

1. Client Name:_____ DOB:_____

SS#_____ Height & Weight:_____

2. Spouse Name:_____ DOB:_____

SS#_____ Height & Weight:_____

3. Home Address: _____

_____

Phone(s): _____

4. State of potential nursing home confinement: _____

5. Approximate Net Estate:_____

Medical Information

1. Do you now, or have you within the past 5 years, used any tobacco products?

Client: Yes____ No_____ **Spouse:** Yes____ No___

1A.Is there any surgery that is anticipated or recommended?

Client: Yes____ No_____ **Spouse:** Yes____ No___

1B. Is physical therapy ongoing or contemplated? If so, when?

Client: Yes____ No_____ **Spouse:** Yes____ No___

WESTROCK INSURANCE AGENCY

151 N MAIN STREET #204
NEW CITY, NY 10956
PHONE: 845-638-2300
FAX: 845-638-6222

PROPOSAL REQUEST FORM

1. List all conditions you have been treated or diagnosed with in the last 10 years:

	Date of Diagnosis: From/To:	Medical Condition/Diagnosis/ Date of Last Treatment	Name/Address/Phone # of Physician
Client:	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
	_____	_____	_____

2. List all prescriptions you have taken within the past 12 months:

	Medication Name/Dosage	Name ofMedical Condition	Treatment Dates From/To	Name/Address/Phone # of Prescribing Physician
Client:	_____	_____	_____	_____
	_____	_____	_____	_____
Spouse:	_____	_____	_____	_____
	_____	_____	_____	_____

(Please attach an extra sheet if needed)

In the past 10 years, have you or your spouse:

	CLIENT		SPOUSE	
	Yes	**No**	**Yes**	**No**
Visited a doctor or been hospitalized for:				
Cirrhosis of the Liver	___	___	___	___
Kidney Failure	___	___	___	___
Alzheimer's Disease	___	___	___	___
Lou Gehrig's Disease	___	___	___	___
Multiple Sclerosis	___	___	___	___
Muscular Distrophy	___	___	___	___
Myasthenia Gravis	___	___	___	___
Parkinson's Disease	___	___	___	___
Cerebral Palsy	___	___	___	___
Cancer	___	___	___	___
Stroke	___	___	___	___
Heart Attack	___	___	___	___
Rheumatoid Arthritis	___	___	___	___
Diabetes	___	___	___	___
Have you or your spouse ever:				
A. **Been** declined for Long Term Care insurance or another form of insurance?	___	___	___	___
B. **Received home** health care or been confined to a **nursing** home or rehabilitation facility?	___	___	___	___