PRE-QUALIFICATION HEALTH FORM

Client Name: DOB:

Married? ☐ Yes ☐ No Is your spouse applying? ☐ Yes ☐ No (if yes, please complete a separate form)

Height: Weight: State of Residence: Tobacco: ☐ Y ☐ N

Are you currently collecting or have you ever collected Disability or Social Security Disability Benefits? ☐ Y ☐ N

Have you ever been declined for LTC or Disability Income Insurance? ☐ Yes ☐ No

Are you taking any prescription medications? ☐ Yes ☐ No

If so, what is the dosage and frequency?

Have you been hospitalized in the last 10 years? ☐ Yes ☐ No (Please provide details below)

Do you have symptoms of, or within the last 10 years, have you received medical advice, diagnosis, or treatment or consulted with a member of the medical profession for any of the following conditions?

a. heart disease	☐ Yes ☐ No	o. blood disorders	☐ Yes ☐ No
b.coronary artery disease	☐ Yes ☐ No	p. alcoholism	☐ Yes ☐ No
c. circular disorders	☐ Yes ☐ No	q. drug addiction	☐ Yes ☐ No
d. high blood pressure	☐ Yes ☐ No	r. depression	☐ Yes ☐ No
e. leukemia	☐ Yes ☐ No	s. arthritis	☐ Yes ☐ No
f. lymphoma	☐ Yes ☐ No	t. osteoarthritis	☐ Yes ☐ No
g. cancer	☐ Yes ☐ No	u. dizziness	☐ Yes ☐ No
h. paralysis	☐ Yes ☐ No	v. seizures	☐ Yes ☐ No
i. stroke	☐ Yes ☐ No	w. tremors	☐ Yes ☐ No
j. reproductive organ disorders	☐ Yes ☐ No	x. fainting spells	☐ Yes ☐ No
k. bowel disorders	☐ Yes ☐ No	y. diabetes	☐ Yes ☐ No
l. bladder disorders	☐ Yes ☐ No	z. liver disorders	☐ Yes ☐ No
m. prostate disorders	☐ Yes ☐ No	aa. respiratory disorders	☐ Yes ☐ No
n. kidney disorders	☐ Yes ☐ No	ab. shortness of breath	☐ Yes ☐ No

Please provide details of any of the above (include item letter and date of onset):