

# REQUEST FOR LONG-TERM CARE COVERAGE INFORMATION



Pennsylvania  
**MEDICAL SOCIETY**  
PENNSYLVANIA MEDICAL SOCIETY INSURANCE AGENCY

This is not an application for insurance. The answers on this form will be used to evaluate against underwriting criteria for long-term care insurance.

After the evaluation has been completed, we will contact you to discuss available long-term care insurance products and to present a proposal if underwriting criteria is satisfied.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Best Time to Call \_\_\_\_\_

Email Address \_\_\_\_\_

Do you and/or your spouse own a business?  Yes  No If so, please explain \_\_\_\_\_

Your Employer \_\_\_\_\_ Occupation/Job Title \_\_\_\_\_  Retired

Spouse's Employer \_\_\_\_\_ Occupation/Job Title \_\_\_\_\_  Retired

**Health history is an important factor in qualifying for Long-Term Care Insurance.**

Q. In the past TEN (10) years, have you (or your spouse) been hospitalized or had surgery for any reason?  Yes  No  
If YES, please list the name of the person who had the hospital stay and/or surgery and the date and reason for the hospital stay/surgery.

NAME	DATE	REASON

