

# REQUEST FOR LONG-TERM CARE COVERAGE INFORMATION



Pennsylvania  
**MEDICAL SOCIETY**<sup>®</sup>

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 \_\_\_\_\_

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

**- Please complete other side -**



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## Insurability Questions

Name: \_\_\_\_\_

1. Have you been medically diagnosed as having or have you been treated for:
  - a)  Yes  No Alzheimer's disease, organic brain syndrome, dementia, frequent or persistent forgetfulness, mental retardation, or senility?
  - b)  Yes  No Parkinson's disease or syndrome, multiple sclerosis, amyotrophic lateral sclerosis (Lou Gehrig's disease) or muscular dystrophy?
  - c)  Yes  No Stroke or any other type of cerebral vascular accident (CVA) or transient ischemic attack (TIA): (a) within the last 5 years; (b) with residual impairment; (c) with multiple events; or (d) in combination with diabetes, circulatory or heart disease, or tobacco use?
  - d)  Yes  No Immune Deficiency Disorder, AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS related complex), any AIDS related condition(s) or tested positive for antibodies to the AIDS virus?
  - e)  Yes  No Cancer with metastasis; or cancer treated in the past 24 months with chemotherapy, radiation, surgery or bone marrow transplant (except basal cell cancer, or early stage breast or prostate cancer)?
  - f)  Yes  No Cirrhosis of the liver?
  - g)  Yes  No Emphysema, chronic obstructive pulmonary disease or any chronic respiratory disease, in combination with smoking?
  - h)  Yes  No Congestive heart failure for which you are currently being treated (including treatment by medication)?
  - i)  Yes  No Diabetes with amputation or complications affecting the kidney?
  - j)  Yes  No Schizophrenia; or any other mental or nervous disorder for which you have been hospitalized in the past 2 years or have had multiple hospitalizations?
2.  Yes  No Have you had or have you ever been advised by a physician to have any organ transplant?
3.  Yes  No Do you currently use a walker, wheelchair, or respirator?
4.  Yes  No Do you currently receive dialysis or oxygen treatment?
5.  Yes  No Are you currently residing in a nursing home or assisted living facility; or are you receiving home health care services or attending adult day care?
6.  Yes  No Do you need assistance or supervision in performing any of the following activities: moving in/out of chair or bed, bathing, dressing, eating, toileting, continence, or walking?

**Please return this form to the Pennsylvania Medical Society Insurance Agency.**

**\*\*If your spouse is also applying for coverage, please have them complete the other side of this form.**

Fax: (717) 561-6077 ■ Phone: (800) 228-7823

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## Insurability Questions (for spouse)

1. Have you been medically diagnosed as having or have you been treated for:
  - a)  **Yes**  **No** Alzheimer's disease, organic brain syndrome, dementia, frequent or persistent forgetfulness, mental retardation, or senility?
  - b)  **Yes**  **No** Parkinson's disease or syndrome, multiple sclerosis, amyotrophic lateral sclerosis (Lou Gehrig's disease) or muscular dystrophy?
  - c)  **Yes**  **No** Stroke or any other type of cerebral vascular accident (CVA) or transient ischemic attack (TIA): (a) within the last 5 years; (b) with residual impairment; (c) with multiple events; or (d) in combination with diabetes, circulatory or heart disease, or tobacco use?
  - d)  **Yes**  **No** Immune Deficiency Disorder, AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS related complex), any AIDS related condition(s) or tested positive for antibodies to the AIDS virus?
  - e)  **Yes**  **No** Cancer with metastasis; or cancer treated in the past 24 months with chemotherapy, radiation, surgery or bone marrow transplant (except basal cell cancer, or early stage breast or prostate cancer)?
  - f)  **Yes**  **No** Cirrhosis of the liver?
  - g)  **Yes**  **No** Emphysema, chronic obstructive pulmonary disease or any chronic respiratory disease, in combination with smoking?
  - h)  **Yes**  **No** Congestive heart failure for which you are currently being treated (including treatment by medication)?
  - i)  **Yes**  **No** Diabetes with amputation or complications affecting the kidney?
  - j)  **Yes**  **No** Schizophrenia; or any other mental or nervous disorder for which you have been hospitalized in the past 2 years or have had multiple hospitalizations?
2.  **Yes**  **No** Have you had or have you ever been advised by a physician to have any organ transplant?
3.  **Yes**  **No** Do you currently use a walker, wheelchair, or respirator?
4.  **Yes**  **No** Do you currently receive dialysis or oxygen treatment?
5.  **Yes**  **No** Are you currently residing in a nursing home or assisted living facility; or are you receiving home health care services or attending adult day care?
6.  **Yes**  **No** Do you need assistance or supervision in performing any of the following activities: moving in/out of chair or bed, bathing, dressing, eating, toileting, continence, or walking?

**Please return this form to the Pennsylvania Medical Society Insurance Agency.**