

# 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
<b>Client:</b> _____	_____	_____
_____	_____	_____
<b>Spouse:</b> _____	_____	_____
_____	_____	_____

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

Medication Name/Dosage	Name of Medical Condition	Treatment Dates From/To	Name/Address/Phone # of Prescribing Physician
<b>Client:</b> _____	_____	_____	_____
_____	_____	_____	_____
<b>Spouse:</b> _____	_____	_____	_____
_____	_____	_____	_____

*(Please attach an extra sheet if needed)*

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

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