

**LONG TERM CARE INSURANCE COVERAGE  
CONFIDENTIAL PERSONAL PROFILE FOR UNDERWRITING QUESTIONNAIRE**



**Applicant Information:**

Applicant's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
(First) (Middle) (Last)  
 Address: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: \_\_\_\_\_ Smoker: \_\_\_\_\_  
(Mo/Day/Year) (Ft/In.) (Lbs.) (M/F) (Y/N)

**Spouse/Applicant #2 Information:**  
 Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Smoker: \_\_\_\_\_  
(First, Middle, Last) (Mo/Day/Yr) (Ft/In.) (Lbs) (Y/N)

**Coverage Information:**

What benefit amount are you considering? \$ \_\_\_\_\_ (Benefits available up to \$300 per day)  
 What length of benefit period would you like? (circle choices)    1 Yr    2 Yrs    3 Yrs    5 Yrs    Lifetime  
 What Waiting Period would you like? (circle choices)    0 days    20 days    30 days    90 days    180 days  
 What Premium Payment Mode would you prefer? (circle choices)    Annual    Semi-Annual    Quarterly    Monthly

- Please check any item that is of interest to you:
- Nursing Home Care
  - Return of Premium Benefit
  - Inflation Protection Benefit
  - Other \_\_\_\_\_
  - Home and Community Based Care
  - Waiver of Premium Benefit
  - Tax Qualified Plan

**Medical Profile:**

Yes	No													
_____	_____	1. Do you currently have, or have you been medically diagnosed as having any of the following conditions: <b>(if "Yes", circle any that apply)</b>												
		<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Acquired Immune Deficiency Syndrome (AIDS)</td> <td style="width: 33%;">ALS (Lou Gehring's Disease)</td> <td style="width: 33%;">Alzheimer's Disease</td> </tr> <tr> <td>HIV Positive</td> <td>Chronic Memory Loss</td> <td>Senility/Dementia</td> </tr> <tr> <td>Organic Brain Syndrome</td> <td>Muscular Dystrophy</td> <td>Huntington's Chorea</td> </tr> <tr> <td>Down's Syndrome</td> <td>Cerebral Palsy</td> <td>Psychosis/Schizophrenia</td> </tr> </table>	Acquired Immune Deficiency Syndrome (AIDS)	ALS (Lou Gehring's Disease)	Alzheimer's Disease	HIV Positive	Chronic Memory Loss	Senility/Dementia	Organic Brain Syndrome	Muscular Dystrophy	Huntington's Chorea	Down's Syndrome	Cerebral Palsy	Psychosis/Schizophrenia
Acquired Immune Deficiency Syndrome (AIDS)	ALS (Lou Gehring's Disease)	Alzheimer's Disease												
HIV Positive	Chronic Memory Loss	Senility/Dementia												
Organic Brain Syndrome	Muscular Dystrophy	Huntington's Chorea												
Down's Syndrome	Cerebral Palsy	Psychosis/Schizophrenia												
_____	_____	2. Do you currently need a Walker or Wheelchair; Oxygen or Kidney Dialysis?												
_____	_____	3. Do you currently need the assistance or supervision of another person in performing any of the following activities: Moving in/out of bed or chair; Bathing; Dressing; Toileting; Bowel/Bladder Control; Eating												

Yes    No  
 \_\_\_\_\_

4. Within the past five (5) years, have you received medical advice or treatment, taken any medications, been diagnosed, been confined to a convalescent care facility, hospital, or nursing facility, for any of the following conditions: (if "Yes", circle any that apply)

- |  |                                  |                    |                                 |                                |
|--|----------------------------------|--------------------|---------------------------------|--------------------------------|
| Paralysis  | Stroke                           | Hodgkin's Disease  | Transient Ischemic Attack (TIA) | Heart Surgery                  |
| Leukemia   | Lymphoma                         | Cancer             | Angioplasty                     | Diabetes                       |
| Heart Attack   | Blacking Out                     | Arthritis          | Skin Ulcers                     | Depression                     |
| Fainting Spells                                      | Brain Disorder                   | Mental Illness     | Alcoholism                      | Drug Addiction                 |
| Epilepsy   | Seizures                         | Convulsions        | Osteoporosis                    | Congestive Heart Failure (CHF) |
| Disabling Back or Spine Injury                       | Injury due to Falls or Imbalance | Multiple Sclerosis | Tremor                          |                                |
| Other conditions causing Crippling or Limited Motion |                                  |                    |                                 |                                |

5. During the past three (3) years have you:

- \_\_\_\_\_ Been medically advised to have surgery which has not been performed?  
 \_\_\_\_\_ Consulted with or been treated by a health professional for any reason not previously stated (excluding eye doctors, podiatrists, chiropractors, and dentists)?  
 \_\_\_\_\_ Received home care; used an adult day care facility; been medically advised to enter a nursing home; or been confined to a hospital or other health care facility? (if "YES," please circle any that apply)

**DETAILS FOR 'YES' ANSWERS TO ANY PART OF QUESTIONS 1 - 5**

Describe sickness, injury and treatment If surgery performed – state type	Dates of		Degree of Recovery	Medication(s) Taken
	Symptoms and/or	Treatment		
	From	To		

*Would you like us to call you and discuss your Long Term Care options?*

Yes Telephone Number: \_\_\_\_\_ Best time to reach you? \_\_\_\_\_

No – please mail information to the above address or email: \_\_\_\_\_

**Please return your completed Personal Profile for a customized plan –**

- Fax to us at: 605-444-7078
- By mail to: Hagan Benefits Inc., PO Box 5090, Sioux Falls SD 57103
- E-mail: [jgries@hagangroup.com](mailto:jgries@hagangroup.com)

**Please contact us with any questions at 1-800-657-4335 (LTC Specialist Jim Bosley)**