LONG-TERM CARE INSURANCE INTAKE FORM

Return via secure method of Fax or Secure Email
Sending this form un-securely can be a violation of HIPAA

Information of individual completing this form:

Name: _____ Company: _____

Address Line 1: _____ Phone: _____

Address Line 2: _____ Facsimile: _____

City/State/Zip: _____ Email: _____

ONCE COMPLETED, RETURN THIS FORM
TO: **Craig Hannus**
Gateway Advisors
Phone: (440) 709-6563 Facsimile: (440) 445-0606
Craig@Gateway-Advisors.net

A. Client Data

Client Name: _____ Spouse/Partner: _____

Sex: ☐ Male ☐ Female Sex: ☐ Male ☐ Female

Street Address: _____

City: _____ State/Zip: _____ / _____

Client's Birth Date: _____ Spouse's Birth Date: _____

Client's Height: _____ Spouse's Height: _____

Client's Weight: _____ Spouse's Weight: _____

B. Health Data

	Client	Spouse
Do you use a wheelchair, walker, quad cane, hospital bed or been prescribed a handicap sticker?	Y ☐ N ☐	Y ☐ N ☐
Are you cognitively impaired, or do you need help with your ADL's?	Y ☐ N ☐	Y ☐ N ☐

	Client	Spouse
Have you had any LTCI policy denied or rated up?	Y ☐ N ☐	Y ☐ N ☐
Are you Receiving disability benefits?	Y ☐ N ☐	Y ☐ N ☐
Have you used tobacco products in the last 5 years?	Y ☐ N ☐	Y ☐ N ☐
Have you been hospitalized in the last 5 years?	Y ☐ N ☐	Y ☐ N ☐
Do you use narcotic pain medication or medical marijuana?	Y ☐ N ☐	Y ☐ N ☐
Have you been treated for Diabetes?	Y ☐ N ☐	Y ☐ N ☐
Insulin	_____	_____
A1c	_____	_____
Has either of your parents been diagnosed with dementia? At what age?	Y ☐ N ☐ _____	Y ☐ N ☐ _____
Have you been treated for cancer in the last 5 years?	Y ☐ N ☐	Y ☐ N ☐
Have you been treated for Heart Disease in the last 5 years?	Y ☐ N ☐	Y ☐ N ☐
Have you been treated for Sleep Apnea in the last 5 years?	Y ☐ N ☐	Y ☐ N ☐
Have you experienced vertigo?	Y ☐ N ☐	Y ☐ N ☐
Have you had any Musculoskeletal disorders?	Y ☐ N ☐	Y ☐ N ☐
Have you been treated for Rheumatoid Arthritis or other auto immune disorder in the last 5 years?	Y ☐ N ☐	Y ☐ N ☐

Please provide details to any questions listed above as “YES”. Please include diagnosis, date, and treatment plan.

Client Additional Details

Spouse Additional Details

CLIENT MEDICATIONS			
Prescription Name	**Dosage**	**Frequency**	**Reason Prescribed**

Have any medications changed within the last 6 months? _____

When was your last complete physical with CBC testing? _____

SPOUSE MEDICATIONS			
Prescription Name	**Dosage**	**Frequency**	**Reason Prescribed**

Have any medications changed within the last 6 months? _____

When was your last complete physical with CBC testing? _____

C. Financial Information

	Husband's Monthly Income	Wife's Monthly Income
Employment Income	$ _____	$ _____
Social Security	$ _____	$ _____
Pension(s) Income (Gross)	$ _____	$ _____
Other Income*	$ _____	$ _____

*If other, please explain:

ASSET INFORMATION		
Asset	**Value**	**Owner**
Retirement Accounts	$	
Roth Retirement Accounts	$	
Stocks & Bonds	$	
Checking & Savings	$	
CD or Money Market	$	
Life Insurance Cash Value	$	
Other	$	
Other	$	

NON-QUALIFIED ANNUITY INFORMATION			
Annuity	**Value**	**How much is gain?**	**Is the annuity owned by you or your spouse/partner?**
Annuity 1	$	$	
Annuity 2	$	$	
Annuity 3	$	$	
Annuity 4	$	$	

D. LTC Policy Information (if client has existing coverage)

Name of Carrier: _____ Date Purchased: _____

Rate Increase? Y ☐ N ☐ % Increase: _____

Daily/Monthly Benefit: $_____ Day/Month

Benefit Period: _____ ☐ Days ☐ Months ☐ Years

Total lifetime benefit/pool of money $_____

Inflation Protection? Y ☐ N ☐

E. Certification

The undersigned hereby represents to Craig Hannus and The Krause Agency that the information contained in this intake form is accurate and complete, and that the undersigned understands that Craig Hannus and The Krause Agency will rely on this information for purposes of developing a Long-Term Care Insurance plan. The undersigned hereby further understands that if information is omitted from this intake form, whether intentionally or unintentionally, that the information omitted may have a direct, and negative, impact on Long-Term Care Insurance Plan.

Dated:

Signature of Client or Client Representative:

By way of this letter, The Krause Agency, and its agents, including its agency affiliate Krause Brokerage Services (d/b/a in California as Krause Insurance Services) are not offering legal advice. The content outlined in this communication may not be suitable for every individual, in every state. As such, before employing or acting upon any one, or more, of the techniques, strategies, or opinions discussed in this letter, the reader should secure the services of a competent elder law attorney in their respective state. Furthermore, no inference is to be drawn that any of the insurance products provided by The Krause Agency have been reviewed or approved by any state Medicaid office. The Krause Agency makes no guarantee that the purchase of any insurance products will result in eligibility for Medicaid or any other assistance program.