LONG TERM CARE FORM

Elite Insurance Associates – Email: Clesta@eiafl.com

Preferred Agent (Optional): _____

GENERAL INFORMATION

First Name: _____ MI: _____ Last Name: _____

Age: _____ DOB: _____ Gender: _____ Height: _____ Weight: _____

Home Address: _____ City: _____ County: _____ State: _____ Zip: _____

Phone Numbers: Best: _____ Secondary: _____

E-mail Address: _____

***If answering "Yes" to any of the questions in this section, you may be requested to provide additional information at the time of application. ***

Do you smoke/ chew Tobacco? ☐ YES ☐ NO
Do you Vape? ☐ YES ☐ NO
Do you use any form of Marijuana? ☐ YES ☐ NO

If so, what type, how often, and is it prescribed?
_____
_____

Do you have any infractions on your Motor Vehicle Report? ☐ YES ☐ NO
Have you been Hospitalized within the past 10 years? ☐ YES ☐ NO
Do you have any felonies, misdemeanors, or Incarcerations? ☐ YES ☐ NO

Are you currently prescribed any medication by a member of a medical profession? If so, please list below. ☐ YES ☐ NO

Medication Name: _____
Condition: _____
_____

Medication Name: _____
Condition: _____
_____

Medication Name: _____
Condition: _____
_____

Medication Name: _____
Condition: _____
_____

COVERAGE INQUIRIES

How much in assets are you trying to protect? _____

Do you have existing long-term care coverage? If so; how much? What type of plan? What company? Do you plan on replacing your current coverage? _____

_____

Have you ever been declined for long-term care or life insurance? _____

Elite Insurance Associates
1710 Shadowood Lane Unit 240, Jacksonville, FL 32207
904-527-1304| www.eiafl.com

LONG TERM CARE FORM

Preferred Agent (Optional): _____

If you answer "Yes" to any of the questions in this Section, we cannot accept this application or offer you Long-Term Care Insurance. Do not continue.

	YES	NO
1. Do you currently use any of the following: • wheelchair • walker • nebulizer • electric scooter • quad cane • oxygen	☐	☐
2. Within the past 6 months have you been confined to, or been advised by a licensed health care practitioner/medical professional to have, any of the following: • residential care, assisted living, or adult day care facility services • nursing home or home health care services • physical, occupational, or speech therapy	☐	☐
3. Do you require the assistance or supervision of another person or a device of any kind for any of the following: • bathing • toileting • dressing • eating • medication management • getting in and out of a chair or bed • your inability to control your bowel or bladder	☐	☐
4. Have you ever consulted with a licensed health care practitioner/medical professional for treatment or diagnosis of any of the following: • Alzheimer's Disease • Amyotrophic Lateral Sclerosis (ALS) • Chronic Hepatitis • Dementia • Huntington's Chorea • Cirrhosis • Memory Loss • Kidney Failure or received Dialysis • Myasthenia Gravis • Mental Retardation • Parkinson's Disease • Paralysis • Schizophrenia • Multiple Sclerosis • Scleroderma • Psychosis • Muscular Dystrophy • Systemic Lupus • Organ Transplant • Ministroke or Transient ischemic Attack (TIA) in the past year, single episode stroke in the past 2 years, two or more strokes or TIAs, or you have not fully recovered or continue to have weakness, decreased sensation or loss of function from a stroke or TIA • Diabetes and currently taking more than 50 units of insulin daily, or with peripheral neuropathy, numbness, tingling, or decreased sensation in your feet, retinopathy, or history of a stroke, ministroke, or a TIA. • Cancer (except basal or squamous cell skin cancers, or stage I/A bladder, thyroid, breast, or prostate cancers) in the past 2 years • Chronic Obstructive Pulmonary Disease (COPD), Emphysema, or Chronic Bronchitis and have used tobacco in the past year	☐	☐
5. Have you ever tested positive for exposure to the HIV infection, or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness, or condition derived from such infection?	☐	☐
6. Are you currently eligible for benefits under, or covered by, Medicaid (not Medicare), disability income, workers' compensation, Social Security disability or any federal or state disability plan?	☐	☐

Elite Insurance Associates
1710 Shadowood Lane Unit 240, Jacksonville, FL 32207
904-527-1304| www.eiafl.com