

If you decide that long term care insurance is right for you, here is some information that will be needed to complete an application.

Name: _____

Date: _____

DOB: _____

Your primary care physician:

Primary Care Physician & Specialty _____

Address: _____

Phone: _____ Date Last Seen: _____ Reason: _____

Other licensed health care providers (except eye doctors, podiatrists and dentists) seen in the last 3 years: (continue on back if needed)

Provider & Specialty _____

Address: _____

Phone: _____ Date Last Seen: _____ Reason: _____

Hospitalizations in the last 10 years: If needed, continue on back

Reason	Dates	Hospital

Prescription medications in the last 3 years, indicating current medications and the reason needed. Continue on back if needed

Prescriptions	Dosage	Reason

Have you ever been treated for high blood pressure, any type of cancer or depression or osteoporosis? no yes If yes, list _____

Have you used tobacco in the last 5 years? no yes

Height: _____ Weight: _____.

Name, address and phone of a person who would always know how to reach you (if, for example, you moved)