America's Long Term Care Insurance Experts
Individual LTCi Health Pre-screen & Quote Request Form

AGENT NAME ____________________ E-Mail _________________Phone _____________________

ADDRESS ____________________ CITY_______________STATE______ZIP_____________________

CLIENT #1		CLIENT #2	
NAME:		NAME:	
DATE OF BIRTH: STATE:		DATE OF BIRTH: STATE:	
MARRIED: Y or N	SPOUSE APPLYING: Y or N	MARRIED: Y or N	SPOUSE APPLYING: Y or N
HEIGHT:	WEIGHT:	HEIGHT:	WEIGHT:
Medications/Dosages/Reason for taking:		Medications/Dosages/Reason for taking:	
Tobacco Use Last 12 months? Yes___ No___		Tobacco Use Last 12 months? Yes____ No____	

INDICATE IF YOU HAVE BEEN MEDICALLY DIAGNOSED OR TREATED FOR ANY OF THE CONDITIONS BELOW:			INDICATE IF YOU HAVE BEEN MEDICALLY DIAGNOSED OR TREATED FOR ANY OF THE CONDITIONS BELOW:		
Abnormal Blood Pressure	Yes	No	Abnormal Blood Pressure	Yes	No
Diabetes	Yes	No	Diabetes	Yes	No
Heart or Circulatory Disorder	Yes	No	Heart or Circulatory Disorder	Yes	No
Cancer	Yes	No	Cancer	Yes	No
Chronic Respiratory Disorder	Yes	No	Chronic Respiratory Disorder	Yes	No
Stroke or TIA	Yes	No	Stroke or TIA	Yes	No
Falling or Unstable Gait	Yes	No	Falling or Unstable Gait	Yes	No
Dizziness or Fainting	Yes	No	Dizziness or Fainting	Yes	No
Confusion or Memory Loss	Yes	No	Confusion or Memory Loss	Yes	No
Weakness or Fatigue	Yes	No	Weakness or Fatigue	Yes	No
Bladder or Bowel Control	Yes	No	Bladder or Bowel Control	Yes	No
Neurological Disorder	Yes	No	Neurological Disorder	Yes	No
Scheduled treatment or surgery	Yes	No	Scheduled treatment or surgery	Yes	No

Upon receipt we will prequalify your applicant(s). Then we will provide you with the following: 3 quotes from the suggested carrier based on LTC costs in your area, sales support material, application, brochure & agent contract.
List additional information or requests here:____

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