TimeSaver™

Long Term Care Supplemental Questionnaire

This is a supplemental questionnaire for Traditional Long Term Care Insurance and Linked Benefit Plans and should be submitted with a completed TimeSaver™. This form is used exclusively to gather specific information required for a Long Term Care Insurance case.

Producer Name ____________________ Client Name ____________________

PREVIOUS APPLICATION HISTORY (specific to applications for long term care insurance or LTC riders)

Have you been declined for Long Term Care Insurance (LTCi) or a LTC Rider in the past? ☐ Yes ☐ No If yes, date of decline

MEDICAL HISTORY (specific to underwriting for long term care)

Do you use any of the following:

☐ Quad Cane ☐ Walker ☐ Wheelchair ☐ Electric Scooter ☐ Stair Lift ☐ Hospital Bed ☐ Respirator ☐ Oxygen (Including supp. CPAP use)

Do you currently need assistance with any of the following:

☐ Bathing ☐ Toileting ☐ Dressing ☐ Eating ☐ Medication Management ☐ Getting In/Out of Bed/Chair ☐ Bowel/Bladder Control

Have you been treated for any of the following:

☐ Alzheimer's ☐ Dementia ☐ Memory Loss ☐ Cognitive Impairment ☐ Organic Brain Syndrome ☐ Huntington's ☐ ALS ☐ Parkinson's ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Paralysis ☐ Multiple Myeloma ☐ Cerebral Palsy ☐ HIV ☐ Organ Transplant (other than a kidney)

Are you currently collecting disability? ☐ Yes ☐ No

If yes, private disability benefit or SSI?

If retired, did you collect SSI and go directly to Social Security?

Are you currently receiving any type of joint injections? ☐ Yes ☐ No

If yes, explain

Have you been diagnosed with Osteoporosis? ☐ Yes ☐ No

If yes, date of diagnosis Treatment

Most recent bone density score

Do you currently take any narcotic medications for pain? ☐ Yes ☐ No

If yes, what is the pain causing condition(s)?

Medication name(s), dosage and frequency?

Have you ever been diagnosed with Depression, Anxiety or Bipolar conditions? ☐ Yes ☐ No

If yes, date of diagnosis

Hospitalizations in last 5 years

Medication name(s), dosage and length

Have you been diagnosed with any of the following?

☐ Crohn's ☐ Colitis ☐ Diverticulitis Date of last flare-up

Date(s) of diagnosis Treatment

Are you currently receiving Physical Therapy? ☐ Yes ☐ No

If yes, explain

Do you have Arthritis? ☐ Yes ☐ No

If yes, what type?

Date of diagnosis? Restrictions?

Joint Replacements? Injections?

Do you have any musculoskeletal conditions? ☐ Yes ☐ No

If yes, what type? Date of diagnosis

Treatment

Have you been diagnosed with fibromyalgia? ☐ Yes ☐ No

Date of diagnosis Limitations

Treatment

Have you been diagnosed with Lupus? ☐ Yes ☐ No

If yes, what type? ☐ SLE ☐ Discoid

Date of diagnosis Treatment

Have you been diagnosed with any of the following?

☐ COPD ☐ Asthma ☐ Bronchitis

Date of diagnosis Hospitalization(s)

Treatment

Additional Information

This questionnaire must be submitted with a completed TimeSaver™. Inquiry cannot be considered unless authorization is signed and initialed by Proposed Insured.

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