LONG-TERM CARE INSURANCE INTAKE FORM

Information of individual completing this form:

Name: ______________________ Company: ______________________

Address Line 1: ______________________ Phone: ______________________

Address Line 2: ______________________ Facsimile: ______________________

City/State/Zip: ______________________ Email: ______________________

RETURN COMPLETED FORM TO:

Krause Financial Services
1234 Enterprise Drive, De Pere, WI 54115
Phone: (866) 605-7437 Facsimile: (866) 605-7438
info@medicaidannuity.com

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 ☐

Question	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?	Y ☐ N ☐	Y ☐ N ☐
At what age?	____________	____________
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 been treated for Rheumatoid Arthritis or other auto immune disorder 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 ☐

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

Client Additional Details

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Spouse Additional Details

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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:

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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 Krause Financial Services that the information contained in this intake form is accurate and complete, and that the undersigned understands that Krause Financial Services will rely on this information for purposes of obtaining quotes for Long-Term Care Insurance and/or other insurance products. The undersigned further understands and represents 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 his or her ability to obtain the desired coverage.

Dated: ______________________

Signature of Client or Client Representative: ______________________

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