



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: _____

Are you, or are you completing this form on behalf of, a licensed insurance agent? Yes No

RETURN COMPLETED FORM TO:

Krause Group

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

A. Applicant Data

Applicant Name: _____ Is the applicant Married? Y N

Applicant's Gender: Male Female If yes, is the applicant's spouse seeking coverage? Y N

Street Address: _____

City: _____ State/Zip: _____ / _____

Applicant's Birth Date: _____ Co-Applicant's Name: _____

Co-Applicant's Gender: Male Female Co-Applicant's Birth Date: _____

B. Applicant Questions

	<u>Applicant</u>	<u>Co-Applicant</u>
Has the individual had a weight change in the last 12 months?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

Does the individual own a business?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
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Does the individual use tobacco?
Check all that apply.

Applicant

Co-Applicant

- Cigarettes
- Cigars
- E-cigarettes
- Vaping

- Chew
- Marijuana
- None

- Cigarettes
- Cigars
- E-cigarettes
- Vaping
- Chew
- Marijuana
- None

C. Medications

List all medications taken or prescribed within the past 12 months. If the dosage of the medication has changed within the last 12 months, please explain why and when.

APPLICANT MEDICATIONS

Medication	Reason for Taking	Frequency	Dosage	Date Started

CO-APPLICANT MEDICATIONS

Medication	Reason for Taking	Frequency	Dosage	Date Started

D. Health History

APPLICANT

Has the applicant been diagnosed with any of the following health conditions? If yes, please provide additional details.

Diabetes
 A1C: _____
 Type: _____
 Diagnosis Date: _____
 Insulin Units: _____

Arthritis (Osteo, Rheumatoid, etc.)
 Type: _____
 Any Steroid Injections: _____
 Joints Affected: _____
 Diagnosis Date: _____

Cancer
Type: _____
Stage: _____
Last Date of Treatment: _____
Lymph Nodes Affected: _____

Heart Disease
Type: _____
Bi-Pass or Stents: _____
Diagnosis Date: _____
History of diabetes, stroke, TIA, or COPD:

Nebulizer or Oxygen Use: _____

Please list any additional conditions, details, and diagnosis dates. _____

CO-APPLICANT

Has the co-applicant been diagnosed with any of the following health conditions? If yes, please provide additional details.

Diabetes
A1C: _____
Type: _____
Diagnosis Date: _____
Insulin Units: _____

Arthritis (Osteo, Rheumatoid, etc.)
Type: _____
Any Steroid Injections: _____
Joints Affected: _____
Diagnosis Date: _____

Cancer
Type: _____
Stage: _____
Last Date of Treatment: _____
Lymph Nodes Affected: _____

Heart Disease
Type: _____
Bi-Pass or Stents: _____
Diagnosis Date: _____
History of diabetes, stroke, TIA, or COPD:

Nebulizer or Oxygen Use: _____

Please list any additional conditions, details, and diagnosis dates. _____

ADDITIONAL HEALTH QUESTIONS

	Applicant	Co-Applicant	If Yes, Provide Details
Has a medical professional referred the applicant to a specialist for additional consultation, test, or surgery in the last three years?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Has the applicant had surgery performed in the last 12 months?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Has the applicant had two or more immediate family members (biological parents or siblings) diagnosed with dementia?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Has the applicant received physical, occupational, or speech therapy in the past six months?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Is the applicant currently receiving disability income?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Has the applicant been prescribed a handicap sticker?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Has the applicant been previously declined for Long-Term Care Insurance or Life Insurance?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	

E. Financial Information

APPLICANT

Social Security: \$ _____ Pension: \$ _____

Other Income: \$ _____ Total Income: \$ _____

CO-APPLICANT

Social Security: \$ _____ Pension: \$ _____

Other Income: \$ _____ Total Income: \$ _____

ASSET INFORMATION

Please enter the applicant and co-applicant’s assets and liabilities

Asset Type	Owner	Value	Liability
Total Assets and Liabilities:			

E. Certification

The undersigned hereby represents to Krause Group that the information contained in this intake form is accurate and complete, and that the undersigned understands that Krause Group will rely on this information for purposes of developing a Medicaid Annuity plan. The undersigned hereby further understands 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 Medicaid eligibility.

Dated: _____

Signature of Applicant or Applicant Representative: _____

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