

**Insurance Designers/Gorham Insurance
Long Term Care Insurance Pre-Screen**

Applicant's Date of Birth: _____

Height: _____ **Weight:** _____

1. Have you used any tobacco products in the last five years? Yes No

2. Do you currently require assistance with any of the following activities? (Circle if yes)

Bathing	Dressing	Walking
Toileting	Eating	Continence

3. Have you ever been confined to a nursing or rehabilitation facility? Yes No (Circle One)

4. If you answered yes to #3, please explain when and for what reason: _____

5. Have you experienced symptoms or difficulties from, been diagnosed with, or treated or consulted by a medical professional for any of the following conditions in the last five years? (Circle if yes)

Heart Disease	Liver Disease	Seizure
High Blood Pressure	Kidney Disease	Arthritis
Cancer	Depression	Diabetes
Paralysis	Alcoholism	Dementia
Muscular Dystrophy	COPD	AIDS
Multiple Sclerosis	ALS	Alzheimer's
Stroke, TIA	Parkinson's	Osteoporosis

6. If you answered yes to any of the questions above, please explain when you were diagnosed, received care, and what type of treatment you received: _____

7. If you have been hospitalized, consulted with or been treated by a medical professional for any reasons not listed above, please list and explain: _____

8. List the names, reason for the medication, and dosages of all medications you take that have been prescribed for you by a medical professional in the last ten years :

*This is NOT an application for Long Term Care Insurance.
No offer for insurance will be made from the inquiry.
A preliminary opinion will be provided within 24 hours.
Please fax or e-mail completed form to Melody Weaver
949-724-1245 or gorham@pacbell.net*