ELDER CARE FUNDING

solving your long term care problems

Policy Owner Application | Long Term Care Benefit Plan - Part 1

PERSONAL INFORMATION OF INSURED

Name:______________________________ Social Security #:______________

DOB:________________ Gender:____________ Marital Status:____________

Address:____

City:______________________ State:________ Zip Code:____________

Phone:______________________ Cell:______________________

Email address:______________________ Best time to reach you:____________

Best contact person:______________________ Phone:______________________

Relationship to Insured:______________________ Best time to reach you:____________

PERSONAL INFORMATION OF POLICY OWNER (only if different than insured)

Name:____

DOB:________________ Gender:____________ Marital Status:____________

Relationship to Insured:____

Address:____

City:______________________ State:________ Zip Code:____________

Phone:______________________ Cell:______________________

Email address:______________________ Best time to reach you:____________

PLEASE PROVIDE THE FOLLOWING:

☐ Copy of policy ☐ Policy Illustration ☐ Authorization ☐ Medical Records ☐ Power of Attorney

POLICY INFORMATION

Face amount (Death Benefit):______________________ Annual Premium:______________________

Outstanding Loan:______________________ Beneficiary:______________________

TYPE OF POLICY: ☐ Universal Life ☐ Whole Life ☐ Term Life ☐ Group Life ☐ Other

The information contained herein is complete and accurate and may be relied upon to determine eligibility and pricing factors for an intended Long-Term Care Benefit Plan.

______________________________ ______________________________

Agent of Record Date

______________________________ ______________________________

Phone Number Email

____

Writing Number

Policy Owner Application | Long Term Care Benefit Plan - Part 2

MEDICAL INFORMATION

Primary Care Physician's name and phone number:

Other physicians and specialists, please include their phone numbers:

List primary medical conditions and medications**:

NEED FOR LONG-TERM CARE SERVICES:

☐ Assisted Living ☐ Homecare: Private Duty ☐ Homecare: Family Caregiver ☐ Skilled Nursing ☐ Memory Care ☐ Hospice

TIMEFRAME FOR CARE: ☐ Immediate ☐ Within 3 months ☐ Within 6 months ☐ Longer

If living or moving in to a facility or receiving home care - please indicate name and address of care provider:

Current resident of above? ☐ Yes ☐ No

History of any significant life events such as death or serious injury/illness of spouse/family member, divorce/separation, etc.

Please indicate event and date of event.

RECENT WEIGHT CHANGE (in last 6 months - please indicate weight gained/lost):

DOES THE INSURED HAVE ANY OF THE FOLLOWING DOCUMENTS IN PLACE?

☐ Advanced Medical Directive/Living Will ☐ DNH (Do Not Hospitalize) Order ☐ Power of Attorney

☐ DNR (Do Not Resuscitate) Order ☐ Receiving Hospice Care

Policy Owner Application | Long Term Care Benefit Plan - Part 3

ABILITY TO PERFORM THE FOLLOWING ACTIVITIES OF DAILY LIVING (check all that apply):

Walk

☐ Independent ☐ Walker Assisted ☐ Wheelchair ☐ Verbal Assistance/Reminders ☐ Physical Assistance
☐ Standby Assistance (within arms reach)

Dress

☐ Independent ☐ Supervision ☐ Physical Assistance ☐ Verbal Assistance/Reminders ☐ Standby Assistance (within arms reach)

Grooming (combing and shampooing hair, shaving, brushing teeth)

☐ Independent ☐ Supervision ☐ Physical Assistance ☐ Verbal Assistance/Reminders ☐ Standby Assistance (within arms reach)

Transfer (ability to get in and out of a chair and/or bed)

☐ Independent ☐ Supervision ☐ Physical Assistance ☐ Verbal Assistance/Reminders ☐ Standby Assistance (within arms reach)

Bath/Shower

☐ Independent ☐ Supervision ☐ Physical Assistance ☐ Verbal Assistance/Reminders ☐ Standby Assistance (within arms reach)

Toileting (on and off, to and from)

☐ Independent ☐ Supervision ☐ Physical Assistance ☐ Verbal Assistance/Reminders ☐ Standby Assistance (within arms reach)

Incontinent

☐ Bladder ☐ Bowel ☐ Wears Protective Undergarments

Eating (does not include meal preparation)

☐ Independent ☐ Set Up and Supervision ☐ Some Physical Assistance ☐ Verbal Assistance/Reminders
☐ Total Assistance (unable to feed self/needs to be fed)

Manage and take medications

☐ Independent ☐ Supervision ☐ Verbal Assistance/Reminders ☐ Total Assistance (unable to feed self/needs to be fed)

ABLE TO PERFORM THE FOLLOWING FUNCTIONAL ACTIVITIES WITHOUT ASSISTANCE (check all that apply):

☐ Shop ☐ Cook ☐ Telephone use ☐ Drive ☐ Money Management ☐ Housekeeping

Sensory and Communication

☐ Vision Loss ☐ Hearing Loss ☐ Speech difficulty ☐ Able to communicate needs and make self understood

Fall History

☐ Last 6 months ☐ Last 3 months ☐ Last 30 days

Smoking

☐ Less than a pack a day ☐ Greater than a pack a day ☐ Quit within 5 years ☐ Quit over 5 years ago

Drink alcohol

☐ History of alcohol abuse ☐ Current use (provide # of alcoholic drinks per day/week)