KRAUSE AGENCY

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

ONCE COMPLETED, RETURN THIS FORM TO:

Krause Agency
1234 Enterprise Drive, De Pere, WI 54115
Phone: (800) 255-1932 Facsimile: (805) 683-6313
ltcsales@krause.com

A. Applicant Data

Applicant's First Name: _____ Is the applicant Married? ☐ Y ☐ N

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

Applicant's Height: _____ Applicant's Weight: _____

Age Nearest Birthday: _____ Resident State: _____

B. Co-Applicant Data

Co-Applicant's First Name: _____ Co-Applicant's Gender: ☐ Male ☐ Female

Co-Applicant's Height: _____ Co-Applicant's Weight: _____

Age Nearest Birthday: _____ Resident State: _____

C. Applicant Questions

	Applicant	Co-Applicant
Has the individual had a weight change in the last 12 months?	☐ Y ☐ N	☐ Y ☐ N
Does the individual own a business?	☐ Y ☐ N	☐ Y ☐ N

Does the individual use tobacco?

Check all that apply.

Applicant		Co-Applicant	
☐ Cigarettes	☐ Chew	☐ Cigarettes	☐ Chew
☐ Cigars	☐ Marijuana	☐ Cigars	☐ Marijuana
☐ E-cigarettes	☐ None	☐ E-cigarettes	☐ None
☐ Vaping		☐ Vaping	

D. 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

E. 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: _____

If checked yes, complete the corresponding **Diabetes Questionnaire**.

☐ **Arthritis (Osteo, Rheumatoid, etc.)**

Type: _____

Any Steroid Injections: _____

Joints Affected: _____

Diagnosis Date: _____

If checked yes, complete the corresponding **Arthritis Questionnaire**.

☐ **Cancer**

Type: _____

Stage: _____

Last Date of Treatment: _____

Lymph Nodes Affected: _____

If checked yes, complete the corresponding **Cancer Questionnaire.**

☐ **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: _____

If checked yes, complete the corresponding **Diabetes Questionnaire.**

☐ **Arthritis (Osteo, Rheumatoid, etc.)**

Type: _____

Any Steroid Injections: _____

Joints Affected: _____

Diagnosis Date: _____

If checked yes, complete the corresponding **Arthritis Questionnaire.**

☐ **Cancer**

Type: _____

Stage: _____

Last Date of Treatment: _____

Lymph Nodes Affected: _____

If checked yes, complete the corresponding **Cancer Questionnaire.**

☐ **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 ☐ N ☐	Y ☐ N ☐	
Has the applicant had surgery performed in the last 12 months?	Y ☐ N ☐	Y ☐ N ☐	
Has the applicant had two or more immediate family members (biological parents or siblings) diagnosed with dementia? If yes, please complete the corresponding **Family History of Dementia Questionnaire.**	Y ☐ N ☐	Y ☐ N ☐	
Has the applicant received physical, occupational, or speech therapy in the past six months?	Y ☐ N ☐	Y ☐ N ☐	
Is the applicant currently receiving disability income?	Y ☐ N ☐	Y ☐ N ☐	
Has the applicant been prescribed a handicap sticker?	Y ☐ N ☐	Y ☐ N ☐	
Has the applicant been previously declined for Long-Term Care Insurance or Life Insurance?	Y ☐ N ☐	Y ☐ N ☐	

F. Financial Information

Is your household income more than $50,000 annually? ☐ Y ☐ N

Not counting your home, are all your assets worth more than $50,000? ☐ Y ☐ N

G. Authorization

Authorization for Use and Disclosure of Protected Health and Personal Information

By signing below, I authorize Krause Brokerage Services, LLC d/b/a Krause Group and its affiliated entities, agents, and service providers to use and disclose my protected health information ("PHI") and personally identifiable information ("PII"), including medical history, functional assessments, prescription information, and financial information provided by me or obtained in connection with this intake and evaluation process, to insurance carriers, underwriting entities, reinsurers, and other third parties as necessary to evaluate my eligibility for and facilitate the placement of extended care planning solutions, including long-term care insurance and related products and services. I understand that I may revoke this authorization at any time by written notice to Krause Group, that revocation will not affect disclosures already made in reliance on this authorization, that declining to sign may limit Krause Group's ability to assist me, and that PHI disclosed to third-party recipients may no longer be protected by HIPAA once received by those parties.

Dated: _____

Signature of Applicant or Applicant Representative: _____