

Life Plans Unlimited

While not all conditions are insurable, this checklist may make shopping easier

Broker Name: _____ E-mail: _____

Medical History Checklist

Client Name _____

Date of Birth _____

Height _____ Weight _____

Spouse/Partner Name _____

Spouse/Partner Date of Birth _____

Spouse/Partner Height _____ Weight _____

State(s) of Residence _____

Tobacco Products – Date last used _____

Medications – Dosages and why taken? _____

Any changes in medication in the last 6-12 months? _____

Do you have any health conditions? _____

How often do you see your doctor? _____

When did you last see your doctor? _____

What were the results of the visit? _____

What was the treatment? _____

Is the condition still being evaluated? _____

Does the doctor feel your condition is stable? _____

Has surgery, test or procedure been discussed or planned? _____

Do you see any specialists? If yes, why? _____

Do you have any physical limitations? If yes, describe _____

Any hospitalizations in the last 5 years? If so, why and details _____

Do you use any assistive devices? Describe _____

Is physical therapy planned, in process or completed? If yes, describe _____

Any previous LTC declines? If yes, when and what carrier? _____

Plan Design:

Elimination Period _____

Benefit Period _____

Inflation Option _____

Daily/Monthly Benefit _____

Limited Pay: 10-Pay _____

Paid @ age 65 _____