

LTC Prequalification Form

Please return via email to quotes@truluma.com or fax to 206.632.3838



M. Williamson Insurance Services
12211 NW 49th Street
Coral Springs, FL 33076
mbwinsurance.com

TODAY'S DATE (MM/DD/YYYY)	Before use, save file with applicant's name in filename. When complete, save file before returning via email.
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Advisor Information	
NAME	EMAIL
PHONE	FAX

Applicant Information		
FULL NAME (Last, First, Middle)	DATE OF BIRTH (MM/DD/YYYY)	STATE OF RESIDENCE
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	GENDER (M/F)	HEIGHT (FT/IN)
MARIJUANA USE? <input type="checkbox"/> YES <input type="checkbox"/> NO	# OF TIMES MARIJUANA IS USED PER WEEK: _____	WEIGHT (LBS)
Has applicant previously applied for LTC and been declined, postponed, or rated? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, explain:	Is applicant currently receiving any disability benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please check all that apply: <input type="checkbox"/> Social Security <input type="checkbox"/> Group <input type="checkbox"/> Individual	TOBACCO/NICOTINE USE IN LAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Has applicant had a complete medical exam, including labs, within the past 24 months? <input type="checkbox"/> YES <input type="checkbox"/> NO	

MEDICAL HISTORY	Within the last 5 years, has applicant consulted with a member of the medical profession or received medical advice, diagnosis, or treatment for any of the following conditions? <i>If yes, please check all conditions that apply within each category and complete 'Medical History Detail' section below.</i>	
<i>Circulatory Disorders</i>	<input type="checkbox"/> Aneurysm <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Carotid Artery Disease <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Heart Arrhythmias <input type="checkbox"/> Embolisms <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Transient Ischemic Attack <input type="checkbox"/> Valvular Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
<i>Endocrine/Pituitary Disorders</i>	<input type="checkbox"/> Diabetes <input type="checkbox"/> Pancreatitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
<i>Cancers</i>	<input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Melanoma <input type="checkbox"/> Sarcomas <input type="checkbox"/> Squamous Cell <input type="checkbox"/> Tumors	<input type="checkbox"/> YES <input type="checkbox"/> NO
<i>Genitourinary Disorders</i>	<input type="checkbox"/> Bladder Disorders <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Prostate Disorders <input type="checkbox"/> Renal Insufficiency	<input type="checkbox"/> YES <input type="checkbox"/> NO
<i>Gastrointestinal Disorders</i>	<input type="checkbox"/> Cirrhosis <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Liver Disorders <input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
<i>Neurological Disorders</i>	<input type="checkbox"/> Anxiety <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Depression <input type="checkbox"/> Mental Illness <input type="checkbox"/> Neuropathy <input type="checkbox"/> Seizures <input type="checkbox"/> Tremors	<input type="checkbox"/> YES <input type="checkbox"/> NO
<i>Blood Disorders</i>	<input type="checkbox"/> Anemia <input type="checkbox"/> Hemochromatosis <input type="checkbox"/> Polycythemia Vera <input type="checkbox"/> Thrombocytopenia	<input type="checkbox"/> YES <input type="checkbox"/> NO
<i>Musculoskeletal Disorders</i>	<input type="checkbox"/> Arthritis <input type="checkbox"/> Degenerative Joint Disease <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Fractures <input type="checkbox"/> Lupus <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Paralysis <input type="checkbox"/> Polymyalgia Rheumatica <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Scoliosis <input type="checkbox"/> Spinal Stenosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
<i>Respiratory Disorders</i>	<input type="checkbox"/> Asbestosis <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Bronchitis <input type="checkbox"/> Chronic Obstructive Pulmonary Disease <input type="checkbox"/> Emphysema <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> YES <input type="checkbox"/> NO
<i>Eye/Ear Disorders</i>	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Meniere's Disease <input type="checkbox"/> Vertigo <input type="checkbox"/> Retinitis Pigmentosa	<input type="checkbox"/> YES <input type="checkbox"/> NO
<i>Substance Abuse</i>	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug dependency <input type="checkbox"/> Illicit drug use	<input type="checkbox"/> YES <input type="checkbox"/> NO

Medical History Detail Please skip this section if no 'yes' boxes were checked in the 'MEDICAL HISTORY' section above. If 'yes' was checked in the 'MEDICAL HISTORY' section, please complete this section for each corresponding condition checked above.

Condition	Diagnosis	Date of Diagnosis	Treatment Dates: <input type="checkbox"/> IN TREATMENT <i>note start date only</i> START: FINISH:
Condition	Diagnosis	Date of Diagnosis	Treatment Dates: <input type="checkbox"/> IN TREATMENT <i>note start date only</i> START: FINISH:
Condition	Diagnosis	Date of Diagnosis	Treatment Dates: <input type="checkbox"/> IN TREATMENT <i>note start date only</i> START: FINISH:

If any response below is a 'yes', please use the space below each response to explain. Does/Has/Is the applicant:

have a 1st-degree relative, living or deceased, who had/had dementia and/or Alzheimer's Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, explain:	currently use any assistive or mechanical devices? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, explain:	require human assistance or supervision in performing any daily living activities (bathing, transferring, dressing, toileting, continence, eating)? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, explain:	ever received home health care, been confined to a nursing home, or rehab center? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, explain:	currently see any specialist(s)? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, explain:	currently receiving or been advised to receive physical therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, explain:	have any pending surgeries, tests, or treatments? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, explain:
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Is applicant currently taking medications? NO YES, If yes, please list med(s), reason(s) for use, dosage(s), frequency, and length of usage:

MED NAME	REASON FOR USE	DOSAGE	FREQUENCY	LENGTH OF USAGE
MED NAME	REASON FOR USE	DOSAGE	FREQUENCY	LENGTH OF USAGE
MED NAME	REASON FOR USE	DOSAGE	FREQUENCY	LENGTH OF USAGE
MED NAME	REASON FOR USE	DOSAGE	FREQUENCY	LENGTH OF USAGE

Please feel free to accompany this form with an additional document should any field or explanation require more room.