Long Term Care Insurance Medical History Form

LWT
Leisure Werden & Terry

Please print legibly. If husband and wife are both applying, please complete a form for each client.
Should you need to provide more detail on any medical condition, please attach additional sheets.

Agent Information

Name:_____

Email:_____

Phone:_____ Fax:_____

Client Information

Name:_____ Date of Birth:_____/_____/_____ Age:_____

Resident State:_____ Martial Status:_____

Height:_____ Weight:_____ ❑ Male ❑ Female

Smoker: ❑ Yes ❑ No If client has quit, how long has it been:_____

Medical Condition:_____ Date of Onset:_____/_____/_____

Medical Condition:_____ Date of Onset:_____/_____/_____

Medical Condition:_____ Date of Onset:_____/_____/_____

Medical Condition:_____ Date of Onset:_____/_____/_____

Medications Currently Taken

Medication:_____ Taken for:_____ Dosage:_____ Times/Day:_____

Medication:_____ Taken for:_____ Dosage:_____ Times/Day:_____

Medication:_____ Taken for:_____ Dosage:_____ Times/Day:_____

Medication:_____ Taken for:_____ Dosage:_____ Times/Day:_____

Medication:_____ Taken for:_____ Dosage:_____ Times/Day:_____

Medication:_____ Taken for:_____ Dosage:_____ Times/Day:_____

Date of Hospitalization:_____/_____/_____ to _____/_____/_____ Reason for Hospitalization:_____

Result:_____

Date of Hospitalization:_____/_____/_____ to _____/_____/_____ Reason for Hospitalization:_____

Result:_____

Date of Hospitalization:_____/_____/_____ to _____/_____/_____ Reason for Hospitalization:_____

Result:_____

Special Notes:_____

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Please email completed form to LTCsales@lwtsolutioncenter.com or fax completed form to 800.486.6585.
Questions? Contact us at 800.998.3382, Option 3, then Option 1 for Sales; Option 2 for New Business.