LONG-TERM CARE INSURANCE PRE-SCREEN

Please use a separate sheet for each person.

Have you used any tobacco products in the previous five years? Yes No

Height _____ **Weight** _____

Do you currently require assistance with any of the following activities? (Circle if yes)

Bathing	Dressing	Walking
Toileting	Eating	Continence

Have you ever been confined to a nursing or rehabilitation facility? If Yes, please explain when and for what reason:_____

_____

5. Have you experienced symptoms or difficulties from, been diagnosed with, or treated or consulted by a medical professional for any of the following conditions in the last five years? (Circle if yes)

Heart Disease	Liver Disease	Seizure
High Blood Pressure	Kidney Disease	Arthritis
Cancer	Depression	Diabetes
Paralysis	Alcoholism or Drug addiction	Dementia
Muscular Dystrophy	COPD	AIDS
Multiple Sclerosis	ALS	Alzheimer's
Stroke, TIA	Parkinson's	Osteoporosis

6. If you answered yes to any of the questions above, please explain when you were diagnosed, received care, and what type of treatment you received: _____

_____

_____

_____

7. If you have been hospitalized, consulted with or been treated by a medical professional for any reasons not listed above, please list and explain:_____

_____

_____

_____

8. List the names, reason for the medication, and dosages of all medications you take that have been prescribed for you by a medical professional in the last ten years :

_____

_____

_____

_____

Office of Selwyn Miller, CFP®, ChFC. 805-494-4868. selwyn@millerfp.net

This is not an insurance application. No offer of insurance will be made from this inquiry. Please email or fax (805-494-6657) this completed form to the above. Thank you.