Long Term Care Insurance Medical History Form

long term care

Please print legibly. If spouses are both applying, please complete a form for each client.
Should you need to provide more details on any medical conditions, please attach additional sheets.

Date: _____

AGENT INFORMATION

Name: _____ Telephone: _____ Fax: _____

Email: _____

CLIENT INFORMATION

Name: _____ Date of Birth: _____ Age_____

Resident State: _____ Marital Status: _____

Height: _____ Weight: _____ Gender: ☐ Male ☐ Female

Smoker: ☐ Yes ☐ No If client has quit smoking, how long has it been since last use?: _____

Medical Condition: _____ Date of Onset: _____

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Medical Condition: _____ Date of Onset: _____

CURRENT MEDICATIONS AND HOSPITALIZATION HISTORY

Medication: _____ Taken For: _____ Dosage: _____ Frequency: _____

Medication: _____ Taken For: _____ Dosage: _____ Frequency: _____

Medication: _____ Taken For: _____ Dosage: _____ Frequency: _____

Medication: _____ Taken For: _____ Dosage: _____ Frequency: _____

Medication: _____ Taken For: _____ Dosage: _____ Frequency: _____

Medication: _____ Taken For: _____ Dosage: _____ Frequency: _____

Medication: _____ Taken For: _____ Dosage: _____ Frequency: _____

Date of Hospitalization: _____ to _____ Reason: _____

Result: _____

Date of Hospitalization: _____ to _____ Reason: _____

Result: _____

Date of Hospitalization: _____ to _____ Reason: _____

Result: _____

Date of Hospitalization: _____ to _____ Reason: _____

Result: _____

Special Notes: _____

_____

RIN RISK INSURANCE NETWORK

Please FAX to: (210) 341-7909