Long Term Care Fact Finder

(use to assist in preparing a good proposal)

Client _____ M F D.O.B. _____

Spouse _____ M F D.O.B. _____

Address & Zip Code _____ (zip code is necessary)

Total Assets (exclude primary residence if a couple) _____

MONTHLY INCOME

(of individual or total couple)

Dividends _____ Source _____

Interest _____ Source _____

TSA / IRA _____ Source _____

401k Plan _____ Source _____

Keogh _____ Source _____

Alimony _____

Pension _____

Social Security _____

Rental Income _____

Other _____ Source _____

Total Monthly Income _____

Fixed _____ Flexible _____

SEE REVERSE SIDE FOR IMPORTANT HEALTH QUESTIONS

Shipp Financial Services, Inc.
16 Sage Estate, Suite 206
Albany, NY 12204-2250
ph 518-462-5645 fax 518-462-5348
www.shippfinancial.com

Broker's Name
Address

Phone
Fax
Email

Preliminary Underwriting Screening Sheet

Thank you for considering long term care insurance. While we make every effort to accept as many applicants as possible for this coverage, some medical histories present too great a risk. Some of these conditions are listed below. Please review the following to determine if you should proceed with the application process.

If you answer **YES** to any of the questions below **DO NOT** submit an Application!

1. Have you ever had, been diagnosed, treated or had symptoms of any of the following:

_____ a. Alzheimer's Disease, Dementia, Organic Brain Syndrome, Chronic Memory Loss, Chronic Forgetfulness, Senility?

_____ b. Stroke, TIA, (multiple or any within the past 3 years)?

_____ c. Lou Gehrig's Disease, Parkinson's Disease, Multiple Sclerosis?

_____ d. Cancer for which you are currently receiving Chemotherapy or Metastatic Cancer (spread from original organ/site) within the last 5 years?

_____ e. Diabetic Neuropathy and/or Retinopathy?

_____ 2. With in the last 3 months, have you used oxygen equipment, a respirator, walker, wheelchair or kidney dialysis?

_____ 3. Have you had a transplant for the lung, heart, kidney, or liver?

4. Have you had:

_____ a. Heart bypass surgery, angioplasty, or knee replacement within the last 3 months?

_____ b. Hip replacement in the last 6 months?

_____ c. Diabetes with fasting blood sugars averaging over 200 within the last 12 months?

5. Are you currently:

_____ Residing in a Nursing Home?

_____ Receiving Home Health Care?

_____ 6. Are you eligible for benefits under Medicaid (not Medicare)?

Final approval is dependent on qualifying, based on the underwriting guidelines for the company where your application is placed.

THIS IS NOT AN APPLICATION FOR INSURANCE
This is a preliminary screening tool **ONLY**.

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