CONFIDENTIAL HEALTH QUESTIONNAIRE

MAGA
Long Term Care Planning
Since 1975

Referred by: _____

Contact Information:

Name: _____

Phone: _____

Email: _____

Address: _____

_____

City: _____

State: _____ Zip: _____

Send completed form to:

MAGA Limited
2610 Lake Cook Rd, #250
Riverwoods, IL 60015
800.533.6242
Fax: 847.940.8870
maga@magaltc.com

Attn:

- Brian I. Gordon, CLTC
  brian@magaltc.com
- Peter R. Florek, CLTC
  peter@magaltc.com

1. BASIC INFORMATION AND PRESCRIPTION MEDICATIONS

APPLICANT A

Name: _____

DOB: _____ /_____ /_____

Height: _____ Weight: _____

APPLICANT B

Name: _____

DOB: _____ /_____ /_____

Height: _____ Weight: _____

Applicant A or B	Prescription(s)	Dosage	Medical Reason and Treatment Dates

2. HEALTH HISTORY AND OTHER INFORMATION Please check all that apply.

Applicant:	A	B
Do you currently have a long term care insurance policy?	☐	☐
Used tobacco in the past 36 months?	☐	☐
Been hospitalized in the last 10 years? If yes, why? _____	☐	☐
Had any type of cancer? If yes, type, course of treatment and dates: _____	☐	☐
Had any type of stroke or mini-stroke? If yes, when and any residual effects? _____	☐	☐
Had any major injuries, falls or broken bones in the last 5 years? If yes, details: _____	☐	☐
Is there a family history of cognitive impairment? (i.e., Alzheimer's, dementia) _____	☐	☐
Do you have any form of diabetes? If yes, date of onset, type and treatment: _____	☐	☐
Do have any other chronic illnesses? (i.e., heart disease, arthritis, sleep apnea, hypertension, osteoporosis)	☐	☐
Do you have any pending or recommended surgeries or are you currently in physical therapy?	☐	☐
Is there longevity in your family?	☐	☐
Have you previously been denied for long term care insurance coverage?	☐	☐