MAGA
Long Term Care Planning
Murray A. Gordon & Associates

Name: _____

Date of Birth: _____ State of Residence: ___

Phone Number: _____

Email: _____

Referral Source: _____

Agent (circle): Brian I. Gordon (Brian@magaltc.com)

or Peter Florek (Peter@magaltc.com)

Long Term Care Insurance Eligibility Worksheet

1) Please provide your height: _____ and weight: _____ and gender: _____

2) Have you used Tobacco in the last 3 Years (circle): Yes or No
If yes, please provide quit date:_____

3) Have you used Marijuana in the last 3 Years (circle): Yes or No
If yes, please provide frequency: _____ per week or _____ per month

4) List of all Medications, including name, dosage, frequency taken and reason taken:

Name	Dosage	Frequency	Reason

5) Have you ever been diagnosed with Cancer, Stroke, Heart Disease or other Chronic Illness (circle): Yes or No
If yes, please provide name of condition, approximate date of diagnosis and treatment type and dates.

6) Have you been hospitalized in the last 10 years (circle): Yes or No
If yes, please provide approximate date, reason/diagnosis and treatment type and dates.

7) Have you had any injuries, falls or broken bones in the last 5 years (circle): Yes or No
If yes, please provide approximate date, reason/diagnosis and treatment type and dates.

8) Has a family member been diagnosed with a Cognitive Impairment (circle): Yes or No
If yes, please select:
_____ Mother _____ Father _____ Sibling and provide the age they were diagnosed
_____ Age _____ Age _____ Age

9) Do you have Diabetes (circle): Yes or No
If yes, which Type? Please also provide date of diagnosis, meds and most current A1C.

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Name: _____

Long Term Care Insurance Eligibility Worksheet Continued

10) Have you been diagnosed with Sleep Apnea (circle): Yes or No
If yes, provide date of diagnosis: _____ and device used to control apnea: _____

11) Do you have any pending or recommended surgeries (circle): Yes or No
If yes, please provide details.

12) Any Physical Therapy in the last 5 years (circle): Yes or No
If yes, please provide approximate date, reason for treatment and approximate date you completed PT.

13) Are you on Social Security Disability or any type of Disability (circle): Yes or No

14) Need assistance with Dressing, Bathing, Transferring, Continence, Eating or Toileting (circle): Yes or No

15) Have you ever been diagnosed or received medical advice/care for the following (check all that apply):

___	AIDS	___	Cirrhosis	___	Kidney Failure/Dialysis	___	Oxygen Use
___	Alcoholism	___	Connective Tissue Disease	___	Macular Degeneration (wet)	___	Paralysis
___	ALS/Lou Gehrig's	___	Down Syndrome	___	Memory Loss	___	Parkinson's Disease
___	Alzheimer's/Dementia	___	Drug Addiction	___	Multiple Myeloma	___	Pregnancy (current)
___	Balance Disorder	___	HIV	___	Multiple Sclerosis	___	Psychosis
___	Cerebral Palsy	___	Huntington's Disease	___	Organ Transplant	___	Scleroderma
___	Chronic Hepatitis	___	Hydrocephalus	___	Osteoporosis with Fractures	___	Systemic Lupus

16) Have you ever been declined Long Term Care Insurance (circle): Yes or No
If yes, please provide the carrier that declined you, the approximate date and reason for decline.

17) Do you have a handicap placard or use a wheelchair, walker or cane (circle): Yes or No

18) Do you consume Alcoholic Beverages (circle): Yes or No
If yes, please provide approximate frequency: _____ drinks per week or _____ drinks per month

19) Did you have a positive test result for COVID-19 (circle): Yes or No
If yes, please provide date of diagnosis _____ and details on treatment and recovery.

Please provide details on any health history items not listed above (use a supplemental page if needed). Sharing details up front helps determine if you are eligible for LTCI, therefore allowing us to provide accurate quotes.

What are your biggest concerns/goals?

__ Asset Preservation
__ Don't want to burden my family
__ I want to be able to choose the type of care I receive
__ I want to make sure I'm taken care of in my later years
__ Protect retirement funds
__ I'm worried the cost of care is more than I've put aside
__ Other (please specify): _____

Please return completed form via fax to 847-940-8870 or directly to your agent via email.

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