KRAUSE AGENCY

LONG-TERM CARE INSURANCE INTAKE FORM

Information of individual completing this form:

Name: _____ Company: _____

Address Line 1: _____ Phone: _____

Address Line 2: _____ Facsimile: _____

City/State/Zip: _____ / _____ / _____ Email: _____

Are you, or are you completing this form on behalf of, a licensed insurance agent? ☐ Yes ☐ No

ONCE COMPLETED, RETURN THIS FORM TO:

Krause Agency
1234 Enterprise Drive, De Pere, WI 54115
Phone: (800) 255-1932 Facsimile: (805) 683-6313
underwriting@krause.com

A. Applicant Data

Applicant Name: _____ Is the applicant Married? ☐ Y ☐ N

Applicant's Gender: ☐ Male ☐ Female If yes, is the applicant's spouse seeking coverage? ☐ Y ☐ N

Applicant's Height: _____ Applicant's Weight: _____

Street Address: _____

City: _____ State/Zip: _____

Applicant's Birth Date: _____ Co-Applicant's Name: _____

Co-Applicant's Gender: ☐ Male ☐ Female Co-Applicant's Birth Date: _____

Co-Applicant's Height: _____ Co-Applicant's Weight: _____

B. Applicant Questions

	Applican	Co-Applicant
Has the individual had a weight change in the last 12 months?	☐ Y ☐ N	☐ Y ☐ N
Does the individual own a business?	☐ Y ☐ N	☐ Y ☐ N

Does the individual use tobacco? Check all that apply.

Applicant		Co-Applicant	
☐ Cigarettes	☐ Chew	☐ Cigarettes	☐ Chew
☐ Cigars	☐ Marijuana	☐ Cigars	☐ Marijuana
☐ E-cigarettes	☐ None	☐ E-cigarettes	☐ None
☐ Vaping		☐ Vaping	

C. Medications

List all medications taken or prescribed within the past 12 months. If the dosage of the medication has changed within the last 12 months, please explain why and when.

APPLICANT MEDICATIONS				
Medication	Reason for Taking	Frequency	Dosage	Date Started

CO-APPLICANT MEDICATIONS				
Medication	Reason for Taking	Frequency	Dosage	Date Started

D. Health History

APPLICANT
Has the applicant been diagnosed with any of the following health conditions? If yes, please provide additional details.

☐ **Diabetes**

A1C: _____

Type: _____

Diagnosis Date: _____

Insulin Units: _____

☐ **Arthritis (Osteo, Rheumatoid, etc.)**

Type: _____

Any Steroid Injections: _____

Joints Affected: _____

Diagnosis Date: _____

☐ **Cancer**

Type: _____

Stage: _____

Last Date of Treatment: _____

Lymph Nodes Affected: _____

☐ **Heart Disease**

Type: _____

Bi-Pass or Stents: _____

Diagnosis Date: _____

History of diabetes, stroke, TIA, or COPD:

_____

Nebulizer or Oxygen Use: _____

Please list any additional conditions, details, and diagnosis dates. _____

_____

_____

_____

CO-APPLICANT

Has the co-applicant been diagnosed with any of the following health conditions? If yes, please provide additional details.

☐ **Diabetes**

A1C: _____

Type: _____

Diagnosis Date: _____

Insulin Units: _____

☐ **Arthritis (Osteo, Rheumatoid, etc.)**

Type: _____

Any Steroid Injections: _____

Joints Affected: _____

Diagnosis Date: _____

☐ **Cancer**

Type: _____

Stage: _____

Last Date of Treatment: _____

Lymph Nodes Affected: _____

☐ **Heart Disease**

Type: _____

Bi-Pass or Stents: _____

Diagnosis Date: _____

History of diabetes, stroke, TIA, or COPD:

_____

Nebulizer or Oxygen Use: _____

Please list any additional conditions, details, and diagnosis dates. _____

_____

_____

_____

_____

ADDITIONAL HEALTH QUESTIONS			
	Applicant	Co-Applicant	If Yes, Provide Details
Has a medical professional referred the applicant to a specialist for additional consultation, test, or surgery in the last three years?	Y ☐ N ☐	Y ☐ N ☐	
Has the applicant had surgery performed in the last 12 months?	Y ☐ N ☐	Y ☐ N ☐	
Has the applicant had two or more immediate family members (biological parents or siblings) diagnosed with dementia?	Y ☐ N ☐	Y ☐ N ☐	
Has the applicant received physical, occupational, or speech therapy in the past six months?	Y ☐ N ☐	Y ☐ N ☐	
Is the applicant currently receiving disability income?	Y ☐ N ☐	Y ☐ N ☐	
Has the applicant been prescribed a handicap sticker?	Y ☐ N ☐	Y ☐ N ☐	
Has the applicant been previously declined for Long-Term Care Insurance or Life Insurance?	Y ☐ N ☐	Y ☐ N ☐	

E. Financial Information

APPLICANT

Social Security: $_____ Pension: $_____

Other Income: $_____ Total Income: $_____

CO-APPLICANT

Social Security: $_____ Pension: $_____

Other Income: $_____ Total Income: $_____

ASSET INFORMATION
Please enter the applicant and co-applicant's assets and liabilities

Asset Type	Owner	Value	Liability
		0	0
Total Assets and Liabilities:		0	0

E. Certification

The undersigned hereby represents to The Krause Agency that the information contained in this intake form is accurate and complete, and that the undersigned understands that The Krause Agency will rely on this information for purposes of developing a Medicaid Annuity plan. The undersigned hereby further understands that if information is omitted from this intake form, whether intentionally or unintentionally, that the information omitted may have a direct, and negative, impact on Medicaid eligibility.

Dated: _____

Signature of Applicant or Applicant Representative: _____

By way of this letter, The Krause Agency and its agents, including its agency affiliate Krause Brokerage Services (d/b/a in California as Krause Insurance Services) are not offering legal advice. The content outlined in this communication may not be suitable for every individual, in every state. As such, before employing or acting upon any one, or more, of the techniques, strategies, or opinions discussed in this letter, the reader should secure the services of a competent elder law attorney in their respective state. Furthermore, no inference is to be drawn that any of the insurance products provided by The Krause Agency have been reviewed or approved by any state Medicaid office. The Krause Agency makes no guarantee that the purchase of any insurance products will result in eligibility for Medicaid or any other assistance program.