Long Term Care Insurance Medical History Form

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: _____

Medical condition: _____ Date of onset: _____

Medical condition: _____ Date of onset: _____

Medical condition: _____ Date of onset: _____

Current Medications and Hospitalization History

Medication: _____ Taken for: _____ Dosage: _____ Frequency: _____

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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: _____

_____

Please send this completed Medical History Form in an encrypted email to ltcquotes2@crump.com. For more information, please contact the Crump LTC Solution Center Sales Desk at 800.678.4582, option 4.

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