LTC Prequalification Form

Please return via email to quotes@truluma.com or fax to 206.632.3838

Seattle Corporate Office
1702 N. 34th Street
Seattle, WA 98103
877.455.9580

www.truluma.com | quotes@truluma.com

TODAY'S DATE (MM/DD/YYYY)	Before use, **save file with applicant's name in filename**. When complete, save file before returning via email.

Advisor Information

NAME	EMAIL
PHONE	FAX

Applicant Information

FULL NAME (Last, First, Middle)	DATE OF BIRTH (MM/DD/YYYY)		STATE OF RESIDENCE
MARITAL STATUS ☐Single ☐Married ☐Domestic Partnership ☐Divorced ☐Widowed	GENDER (M/F)	HEIGHT (FT/IN)	WEIGHT (LBS)
MARIJUANA USE? ☐YES ☐NO # OF TIMES MARIJUANA IS USED PER WEEK: _____	TOBACCO/NICOTINE USE IN LAST 12 MONTHS? ☐YES ☐NO		
Has applicant previously applied for LTC and been declined, postponed, or rated? ☐YES ☐NO If yes, explain:	Is applicant currently receiving any disability benefits? ☐YES ☐NO If yes, please check all that apply: ☐Social Security ☐Group ☐Individual Has applicant had a complete medical exam within the past 18 months? ☐YES ☐NO		

MEDICAL HISTORY	Within the last 5 years, has applicant consulted with a member of the medical profession or received medical advice, diagnosis, or treatment for any of the following conditions? *If yes, please check all conditions that apply within each category and complete 'Medical History Detail' section below.*	
Circulatory Disorders	☐Aneurysm ☐Cardiomyopathy ☐Carotid Artery Disease ☐Congestive Heart Failure ☐Coronary Artery Disease ☐Heart Arrhythmias ☐Embolisms ☐High Blood Pressure ☐Peripheral Vascular Disease ☐Stroke ☐Transient Ischemic Attack ☐Valvular Disease	☐YES ☐NO
Endocrine/Pituitary Disorders	☐Diabetes ☐Pancreatitis	☐YES ☐NO
Cancers	☐Leukemia ☐Lymphoma ☐Melanoma ☐Sarcomas ☐Squamous Cell ☐Tumors	☐YES ☐NO
Genitourinary Disorders	☐Bladder Disorders ☐Incontinence ☐Kidney Failure ☐Prostate Disorders ☐Renal Insufficiency	☐YES ☐NO
Gastrointestinal Disorders	☐Cirrhosis ☐Crohn's Disease ☐Hepatitis ☐Liver Disorders ☐Ulcerative Colitis	☐YES ☐NO
Neurological Disorders	☐Anxiety ☐Chronic Fatigue Syndrome ☐Depression ☐Mental Illness ☐Neuropathy ☐Seizures ☐Tremors	☐YES ☐NO
Blood Disorders	☐Anemia ☐Hemochromatosis ☐Polycythemia Vera ☐Thrombocytopenia	☐YES ☐NO
Musculoskeletal Disorders	☐Arthritis ☐Degenerative Joint Disease ☐Fibromyalgia ☐Fractures ☐Lupus ☐Osteoarthritis ☐Osteopenia ☐Osteoporosis ☐Paralysis ☐Polymyalgia Rheumatica ☐Rheumatoid Arthritis ☐Scoliosis ☐Spinal Stenosis	☐YES ☐NO
Respiratory Disorders	☐Asbestosis ☐Asthma ☐Bronchiectasis ☐Bronchitis ☐Chronic Obstructive Pulmonary Disease ☐Emphysema ☐Sarcoidosis ☐Sleep Apnea	☐YES ☐NO
Eye/Ear Disorders	☐Glaucoma ☐Macular Degeneration ☐Meniere's Disease ☐Vertigo ☐Retinitis Pigmentosa	☐YES ☐NO
Substance Abuse	☐Alcoholism ☐Drug dependency ☐Illicit drug use	☐YES ☐NO

Medical History Detail Please skip this section if no 'yes' boxes were checked in the 'MEDICAL HISTORY' section above. If 'yes' was checked in the 'MEDICAL HISTORY' section, please complete this section for each corresponding condition checked above.

Condition	Diagnosis	Date of Diagnosis	Treatment Dates: ☐ IN TREATMENT *note start date only* START: FINISH:
Condition	Diagnosis	Date of Diagnosis	Treatment Dates: ☐ IN TREATMENT *note start date only* START: FINISH:
Condition	Diagnosis	Date of Diagnosis	Treatment Dates: ☐ IN TREATMENT *note start date only* START: FINISH:

If any response below is a 'yes', please use the space below each response to explain. **Does/Has/Is the applicant:**

have a 1st-degree relative, living or deceased, who had/has dementia and/or Alzheimer's Disease? ☐YES ☐NO If yes, explain:	currently use any assistive or mechanical devices? ☐YES ☐NO If yes, explain:	require human assistance or supervision in performing any daily living activities (bathing, transferring, dressing, toileting, continence, eating)? ☐YES ☐NO If yes, explain:	ever received home health care, been confined to a nursing home, or rehab center? ☐YES ☐NO If yes, explain:	currently see any specialist(s)? ☐YES ☐NO If yes, explain:	currently receiving or been advised to receive physical therapy? ☐YES ☐NO If yes, explain:	have any pending surgeries, tests, or treatments? ☐YES ☐NO If yes, explain:

Is applicant currently taking medications? ☐NO ☐YES, If yes, please list med(s), reason(s) for use, dosage(s), frequency, and length of usage:

MED NAME	REASON FOR USE	DOSAGE	FREQUENCY	LENGTH OF USAGE
MED NAME	REASON FOR USE	DOSAGE	FREQUENCY	LENGTH OF USAGE
MED NAME	REASON FOR USE	DOSAGE	FREQUENCY	LENGTH OF USAGE
MED NAME	REASON FOR USE	DOSAGE	FREQUENCY	LENGTH OF USAGE

Please feel free to accompany this form with an additional document should any field or explanation require more room.