Section D HEALTH INSURABILITY QUESTIONS

If you answer "Yes" to any of the questions in this Section D, we are unable to accept this application or offer you Long-Term Care Insurance. Do not continue.

		Applicant A		Applicant B	
		Yes	No	Yes	No
1	Are you age 65 or older and has it been more than 2 years since you have had a doctor's visit which included a head to toe physical examination with blood work (basic metabolic chemistry panel)?	☐	☐	☐	☐
2	Do you currently use any of the following? • quad cane • walker • wheelchair • electric scooter • stairlift • hospital bed • respirator • nebulizer • oxygen (including supplemental CPAP use)	☐	☐	☐	☐
3	Within the past 6 months have you been confined to, used, or been advised to have, any of the following? • residential care, assisted living or adult day care facility services • nursing home or home health care services	☐	☐	☐	☐
4	Do you require the assistance or supervision of another person or a device of any kind for any of the following? • bathing • toileting • dressing • eating • medication management • getting in and out of a chair or bed • your inability to control your bowel or bladder	☐	☐	☐	☐
5	Have you ever had, been diagnosed as having, or received medical advice or medical care from a physician or health care provider for any of the following? • Alzheimer's Disease • Huntington's Chorea • Parkinson's Disease • Dementia • Chronic Hepatitis • Systemic Lupus • Memory Loss • Cirrhosis • Multiple Sclerosis (MS) • Mild Cognitive Impairment • Hydrocephalus • Muscular Dystrophy • Organic Brain Syndrome • Multiple Myeloma • Myasthenia Gravis • Schizophrenia • Psychosis • Scleroderma • Mental Retardation • Organ Transplant • Paralysis • Connective Tissue Disease • Amyotrophic Lateral Sclerosis (ALS, Lou Gehrig's Disease) • Kidney Failure or received Dialysis • Ministroke or Transient Ischemic Attack (TIA) in the past year, single episode stroke in the past 2 years, 2 or more strokes or TIAs, or you have not fully recovered or continue to have weakness, decreased sensation or loss of function from a stroke or TIA • Diabetes and currently taking more than 50 units of insulin daily, or with peripheral neuropathy, numbness, tingling or decreased sensation in your feet, retinopathy or history of a stroke, ministroke or a TIA • Cancer (except basal or squamous cell skin cancers, or stage I/A bladder, thyroid, breast or prostate cancers) in the past 2 years • Chronic Obstructive Pulmonary Disease (COPD), Emphysema or Chronic Bronchitis and have used tobacco in the past year	☐	☐	☐	☐
6	Have you been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic)?	☐	☐	☐	☐
7	Do you currently qualify for payment or are you receiving payment benefits under Medicaid (not Medicare), disability income plan, workers' compensation, Social Security disability or any federal or state disability plan?	☐	☐	☐	☐

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Section E PRIMARY PHYSICIAN INFORMATION AND MEDICATION

Applicant A	Applicant B
1 **Provide the name, address and phone number of your primary physician if you have consulted within the last 10 years:** Primary Name Address City, State, ZIP Code Phone Number	**1** **Provide the name, address and phone number of your primary physician if you have consulted within the last 10 years *(If Different than Applicant A)*:** Primary Name Address City, State, ZIP Code Phone Number
2 **Date of Last Visit:** ☐☐ / ☐☐☐☐ Month Year	**2** **Date of Last Visit:** ☐☐ / ☐☐☐☐ Month Year
3 **Why did you last see this physician?**	**3** **Why did you last see this physician?**
4 **Date of last complete physical exam and blood work (basic metabolic chemistry panel) in the last 2 years:** ☐☐ / ☐☐☐☐ Month Year	**4** **Date of last complete physical exam and blood work (basic metabolic chemistry panel) in the last 2 years:** ☐☐ / ☐☐☐☐ Month Year
5 **Medication:** Are you taking or have you taken any prescription medication(s) within the past 12 months, or are you currently taking any over-the-counter medication(s) on a weekly basis or more frequently? ☐ Yes, details provided on next page. ☐ No	**5** **Medication:** Are you taking or have you taken any prescription medication(s) within the past 12 months, or are you currently taking any over-the-counter medication(s) on a weekly basis or more frequently? ☐ Yes, details provided on next page. ☐ No

If "Yes," to question 5, please list on the next page all the medication name(s) using pharmacy label, dosage, how often you take, how long have you taken, prescribed by, why you take, when and why for any dosage increase or decrease. (Attach additional signed page(s) if more space is needed.)

Section F MEDICATION INFORMATION

Please list all over-the-counter or prescription medications you have taken in the past 12 months in the table below.

Applicant A

Medication Name (copy off pharmacy label)	Dosage	How often do you take?	How long have you taken?	Prescribed by Primary Physician? If no, provide below.	Why do you take this medication? (Diagnosis/Condition)
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Explain when and why if your dosage was increased or decreased in the past 12 months on any medications you listed above. Also provide medication name and prescribing physician name, address and phone number if other than your primary physician.

Applicant B

Medication Name (copy off pharmacy label)	Dosage	How often do you take?	How long have you taken?	Prescribed by Primary Physician? If no, provide below.	Why do you take this medication? (Diagnosis/Condition)
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Explain when and why if your dosage was increased or decreased in the past 12 months on any medications you listed above. Also provide medication name and prescribing physician name, address and phone number if other than your primary physician.

Section G ADDITIONAL HEALTH QUESTIONS

		Applicant A Yes	Applicant A No	Applicant B Yes	Applicant B No
1	Have you ever received any advice, treatment, consultation or diagnosis from a physician or health care provider for any of the following conditions?				
	The following conditions require a stability period ranging from 3 months to 5 years to be eligible for coverage. Refer to our Underwriting Guidelines to insure the stability period has been met.				
	(a) Vision Disorder	☐	☐	☐	☐
	(b) Dizziness/Vertigo or Fainting	☐	☐	☐	☐
	(c) Head Injury, Nerve Damage or other Neurological Disease/Disorder	☐	☐	☐	☐
	(d) Fibromyalgia, Weakness or Fatigue	☐	☐	☐	☐
	(e) Stroke, Transient Ischemic Attack, Aneurysm, Carotid or Circulatory Disease/Disorder	☐	☐	☐	☐
	(f) Seizure, Epilepsy or Tremors	☐	☐	☐	☐
	(g) Depression, Anxiety or other Mental Disorder	☐	☐	☐	☐
	(h) Lung Disease/Disorder	☐	☐	☐	☐
	(i) Heart Rhythm, Heart Valve, Coronary Artery or Heart Disease/Disorder	☐	☐	☐	☐
	(j) High Blood Pressure	☐	☐	☐	☐
	(k) Anemia, Blood Clotting or Blood Disease/Disorder	☐	☐	☐	☐
	(l) Arthritis, Broken Bone, Back, Spinal Stenosis, Scoliosis, Bone or Joint Disorder	☐	☐	☐	☐
	(m) Chronic Pain, Amputation or Polymyalgia Rheumatica	☐	☐	☐	☐
	(n) Osteoporosis or Osteopenia	☐	☐	☐	☐
	(o) Balance Disorder, Difficulty Walking or Falls	☐	☐	☐	☐
	(p) Cancer, Leukemia or Lymphoma	☐	☐	☐	☐
	(q) Diabetes	☐	☐	☐	☐
	(r) Immune System Disease/Disorder	☐	☐	☐	☐
	(s) Kidney Disease/Disorder	☐	☐	☐	☐
	(t) Hepatitis or Liver Disease/Disorder	☐	☐	☐	☐
	(u) Shingles	☐	☐	☐	☐
	(v) Incontinence or other Bowel or Bladder Disease/Disorder	☐	☐	☐	☐
2	In the past 5 years have you been diagnosed with, treated for, had testing for, or consulted with a medical professional for conditions or symptoms not listed above?	☐	☐	☐	☐
3	Do you have, for your use, a handicap parking sticker or handicap license plate?	☐	☐	☐	☐
4	In the past 3 years has a medical professional referred you to a specialist for additional consultation, testing, or surgery?	☐	☐	☐	☐
5	Are you scheduled for a visit with a medical professional within the next 6 months?	☐	☐	☐	☐
6	Have you been seen by your physician, health care provider or any specialist more than three times in the past 12 months?	☐	☐	☐	☐
7	Have you received inpatient or outpatient treatment at a hospital, surgical center, or rehabilitation facility in the past 12 months?	☐	☐	☐	☐
8	What is your height?	' "		' "	
9	What is your weight?	lbs		lbs	
10	Have you had an unplanned weight change in the past 12 months?	☐	☐	☐	☐

Section G (continued) ADDITIONAL HEALTH QUESTIONS

If "Yes," to any additional health questions in Section G, please provide the following details for each "Yes" answer below.
(Attach additional signed page(s) if more space is needed.)

Applicant A

	Health Condition/Details	Month/ Year Diagnosed	Month/ Year for Last Visit	Reason for Last Visit	Month/ Year for Next Visit	Reason for Next Visit	Physician or Facility Name, Address and Phone Number
Ques # ____							
Ques # ____							
Ques # ____							
Ques # ____							

Applicant B

Ques # ____							
Ques # ____							
Ques # ____							
Ques # ____							

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Section H MEDICAL HEALTH HISTORY

Applicant A	Applicant B
1 To the best of your knowledge has your biological mother, father, or sibling been diagnosed with Alzheimer's Disease or other form of dementia? ☐ Yes ☐ No	1 To the best of your knowledge has your biological mother, father, or sibling been diagnosed with Alzheimer's Disease or other form of dementia? ☐ Yes ☐ No
2 Have you been hospitalized or had surgery in the past 3 years? ☐ Yes ☐ No If **"Yes,"** Why? _____ When? _____	2 Have you been hospitalized or had surgery in the past 3 years? ☐ Yes ☐ No If **"Yes,"** Why? _____ When? _____
3 Have you been advised by a member of the medical profession in the last 5 years to have surgery which has not yet been completed? ☐ Yes ☐ No If **"Yes,"** Why? _____ When? _____	3 Have you been advised by a member of the medical profession in the last 5 years to have surgery which has not yet been completed? ☐ Yes ☐ No If **"Yes,"** Why? _____ When? _____
4 Have you received physical, occupational or speech therapy in the past 6 months? ☐ Yes ☐ No If **"Yes,"** Why? _____ Date of last therapy? _____ Has a member of the medical profession advised that additional therapy will be needed? ☐ Yes ☐ No	4 Have you received physical, occupational or speech therapy in the past 6 months? ☐ Yes ☐ No If **"Yes,"** Why? _____ Date of last therapy? _____ Has a member of the medical profession advised that additional therapy will be needed? ☐ Yes ☐ No
5 Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for sleep apnea? ☐ Yes ☐ No If **"Yes,"** Do you use CPAP, BiPAP, or a dental device? ☐ Yes ☐ No If **"Yes,"** How often do you use it? _____	5 Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for sleep apnea? ☐ Yes ☐ No If **"Yes,"** Do you use CPAP, BiPAP, or a dental device? ☐ Yes ☐ No If **"Yes,"** How often do you use it? _____
6 Have you used insulin in the past 6 months? ☐ Yes ☐ No If **"Yes,"** Units used each day? _____ Year insulin was first prescribed? _____	6 Have you used insulin in the past 6 months? ☐ Yes ☐ No If **"Yes,"** Units used each day? _____ Year insulin was first prescribed? _____
7 Have you ever used tobacco? ☐ Yes ☐ No If **"Yes,"** date last used? _____	7 Have you ever used tobacco? ☐ Yes ☐ No If **"Yes,"** date last used? _____
8 During the last 10 years, have you ever used unlawful drugs, or used prescription medications other than as prescribed by your doctor? ☐ Yes ☐ No If **"Yes,"** Substance? _____ Date last used? _____	8 During the last 10 years, have you ever used unlawful drugs, or used prescription medications other than as prescribed by your doctor? ☐ Yes ☐ No If **"Yes,"** Substance? _____ Date last used? _____
9 Have you ever received medical treatment, counseling or been hospitalized for drug use? ☐ Yes ☐ No If **"Yes,"** date last treatment, consultation or hospitalization? _____	9 Have you ever received medical treatment, counseling or been hospitalized for drug use? ☐ Yes ☐ No If **"Yes,"** date last treatment, consultation or hospitalization? _____
10 Do you regularly consume 4 or more alcoholic beverages per day, or do you drink 5 or more drinks per day, 1 or more days per week? ☐ Yes ☐ No	10 Do you regularly consume 4 or more alcoholic beverages per day, or do you drink 5 or more drinks per day, 1 or more days per week? ☐ Yes ☐ No
11 Have you ever received medical treatment, counseling or been hospitalized for alcohol use? ☐ Yes ☐ No If **"Yes,"** Month and year of treatment, consultation or hospitalization? _____ Month and year you last consumed alcohol? _____	11 Have you ever received medical treatment, counseling or been hospitalized for alcohol use? ☐ Yes ☐ No If **"Yes,"** Month and year of treatment, consultation or hospitalization? _____ Month and year you last consumed alcohol? _____