NORTHSTAR NETWORK INSURANCE AGENCY

California Long Term Care Insurance Services, Inc.

Print and Fax to: 650-692-5204

Click below to submit via Email to: donna@cltcinsurance.com or jim@cltcinsurance.com

Office 800-303-1527

Ⓐ APPLICANT A INFORMATION * *Print Clearly – Use Black Ink*

☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Other Title: _____

☐Married ☐Single ☐Widowed ☐ Domestic Partner

Name _____
(as it should appear on your policy)

Birthdate ___/___/___ Age _____ Birthplace (state) _____

Sex: ☐ Male ☐ Female Height: ft. ____ in. _____ Weight: lbs. _____

Daytime Phone ( ) _____

Evening Phone ( ) _____

Best time to call _____ ☐a.m. ☐p.m.

APPLICANT B INFORMATION *(If applying)*

☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Other Title: _____

☐Married ☐Single ☐Widowed ☐ Domestic Partner

Name _____
(as it should appear on your policy)

Birthdate ___/___/___ Age _____ Birthplace (state) _____

Sex: ☐ Male ☐ Female Height: ft. ____ in. _____ Weight: lbs. _____

Daytime Phone ( ) _____

Evening Phone ( ) _____

Best time to call _____ ☐a.m. ☐p.m.

Street Address _____
(No P.O. Box please)

City _____ State _____ Zip _____

Broker Name _____ Broker Phone _____

Broker Email _____

Ⓑ INSURABILITY PROFILE

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
☐	☐	1. Are you covered by Medi-Cal (not Medicare)?	☐	☐
☐	☐	2. Do you use a Walker or Wheelchair; Oxygen; Respirator; or Kidney Dialysis; or need assistance or supervision by another person in performing any of the following: Moving in/out of bed or chair; Bathing; Dressing; Eating; Toileting; Bowel/Bladder control; Walking?	☐	☐
☐	☐	3. Have you had, do you currently have, or have you ever been medically diagnosed as having any of the following? If YES place an "X" next to those that apply to the particular applicant.	☐	☐
☐	☐	4A. In the past 6 months have you had: Open Heart Surgery?	☐	☐
☐	☐	4B. In the past 6 months have you had: Back or Spine Surgery?	☐	☐
☐	☐	5. In the past 4 years have you had Cancer of the: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas, Stomach, or Testes?	☐	☐

Applicant A	Applicant B		Applicant A	Applicant B		Applicant A	Applicant B	
☐	☐	Acquired Immune Deficiency Syndrome (AIDS)	☐	☐	Congestive Heart Failure (CHF) combined with Tuberculosis (TB)	☐	☐	Memory Loss
☐	☐	AIDS Related Complex (ARC)	☐	☐	Cirrhosis of the Liver	☐	☐	Metastatic Cancer (spread from original site/location)
☐	☐	ALS (Lou Gehrig's Disease)	☐	☐	Dementia	☐	☐	Multiple Sclerosis (MS)
☐	☐	Alzheimer's Disease	☐	☐	Diabetes under treatment with Insulin	☐	☐	Muscular Dystrophy
☐	☐	Congestive Heart Failure (CHF) combined with Heart Attack or Angina	☐	☐	Emphysema/COPD combined with current smoking	☐	☐	Organic Brain Syndrome
☐	☐	Congestive Heart Failure (CHF) combined with Emphysema/ (COPD)	☐	☐	Emphysema/COPD combined with Congestive Heart Failure (CHF)	☐	☐	Parkinson's Disease
☐	☐	Congestive Heart Failure (CHF) combined with Angioplasty or Heart Surgery	☐	☐	Emphysema/COPD combined with Asthma	☐	☐	Senility
☐	☐	Congestive Heart Failure (CHF) combined with Asthma or Chronic Bronchitis	☐	☐	Emphysema/COPD combined with Chronic Bronchitis	☐	☐	Stroke
☐	☐	Congestive Heart Failure (CHF) combined with Diabetes	☐	☐	Frequent or persistent Forgetfulness	☐	☐	Transient Ischemic Attack (TIA) within the past 5 years
						☐	☐	TIA combined with Diabetes or Heart Surgery
						☐	☐	TIA two or more times

Do NOT complete the application for any applicant answering "YES" to any part of questions 1 through 5.

Print Name of Applicant **A** _____ Print Name of Applicant **B** _____

C MEDICAL PROFILE

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
☐	☐	6. In the past 5 years (10 years for cancer) have you: received medical advice or treatment; been medically diagnosed; or consulted with a health professional for any of the following conditions? If YES, place an "X" next to those that apply and explain under **DETAILS**.	☐	☐

Applicant A	Applicant B		Applicant A	Applicant B		Applicant A	Applicant B		Applicant A	Applicant B	
☐	☐	Alcoholism	☐	☐	Convulsions	☐	☐	Injury due to Falls or Imbalance	☐	☐	Skin Ulcers
☐	☐	Amputation	☐	☐	Depression	☐	☐	Joint Replacement Surgery	☐	☐	Spine Condition
☐	☐	Angina	☐	☐	Diabetes not treated with Insulin	☐	☐	Leukemia	☐	☐	Tremor
☐	☐	Angioplasty	☐	☐	Disabling Back Condition	☐	☐	Lymphoma	☐	☐	Tuberculosis (TB)
☐	☐	Asthma	☐	☐	Drug Addiction	☐	☐	Mental Illness	☐	☐	Other Conditions causing Crippling
☐	☐	Atrial Fibrillation	☐	☐	Emphysema/COPD	☐	☐	Osteoporosis	☐	☐	Other Conditions causing Limited Motion
☐	☐	Blacking Out	☐	☐	Epilepsy	☐	☐	Paralysis	☐	☐	Other Conditions requiring Adaptive Devices
☐	☐	Brain Disorder	☐	☐	Fainting Spells	☐	☐	Rheumatoid Arthritis			
☐	☐	Cancer (excluding basal cell of skin)	☐	☐	Heart Attack	☐	☐	Seizures			
☐	☐	Chronic Bronchitis	☐	☐	Heart Surgery	☐	☐	Shortness of Breath			
☐	☐	Congestive Heart Failure (CHF)	☐	☐	Hodgkin's Disease						

☐	☐	7. Have you smoked or used other tobacco products within the past 3 years?	☐	☐
☐	☐	8. A. Do you use a quad cane, hospital bed, or other physical assistance device?	☐	☐
☐	☐	B. Do you need assistance with managing medications?	☐	☐
☐	☐	C. Do you need assistance with shopping?	☐	☐
☐	☐	D. Do you need assistance with using transportation?	☐	☐
☐	☐	E. Do you need assistance with housekeeping/cooking?	☐	☐
		If YES, explain under **DETAILS.**		
		9. In the past 3 years have you:		
☐	☐	A. Received home care?	☐	☐
☐	☐	B. Used an adult day care facility?	☐	☐
☐	☐	C. Been confined to or advised to enter a nursing home, assisted care facility, or other long term care facility?	☐	☐
		If YES, explain under **DETAILS**.		
☐	☐	10. In the past 3 years have you taken any prescription medications for High Blood Pressure and/or Osteoarthritis? If YES, explain under **DETAILS**.	☐	☐
☐	☐	11. Are you currently taking *any* prescription medications? List each medication *and why it is needed* under **DETAILS**.	☐	☐
		12. In the past 3 years have you:		
☐	☐	A. Been medically advised to have surgery which has not been performed? If YES, explain under **DETAILS**.	☐	☐
☐	☐	B. Been medically advised to enter or been confined to a hospital or other health care facility? If YES, explain under **DETAILS**.	☐	☐
☐	☐	C. Consulted with or been treated by a licensed health care practitioner (including osteopaths, chiropractors, physical therapists, and medical doctors, but excluding eye doctors, podiatrists, and dentists) *other than* your primary care doctor for any reason not previously stated? If YES, explain under **DETAILS**.	☐	☐
☐	☐	13. Have 2 or more years passed since your last office visit, treatment, or examination by *any* doctor?	☐	☐

DETAILS for YES answers. Provide name of medications and name, address and phone # of prescribing physician.

Details for Applicant **A** Ques.#		Details for Applicant **B** Ques.#	

Use this page only if you need more room to provide information requested in the Medical Profile.

⓫ ADDITIONAL NOTES

Print Name of Applicant A _____ Print Name of Applicant B _____

DETAILS for YES answers. | Provide name of medications and name, address and phone # of prescribing physician.

Details for Applicant A Ques.#		**Details for Applicant B** Ques.#	

CLICK TO SUBMIT