



Minnesota Benefit Association  
6701 Upper Afton Road  
Woodbury, MN 55125

# LONG TERM CARE ILLUSTRATION REQUEST FORM

info@minnesotabenefitassociation.org fax to 651-739-3265

<b>AGENT NAME:</b> Agent name must be provided.		<b>Return via Fax or Secure Email</b> Sending this form un-securely can be a violation of HIPAA		
<b>BASIC CLIENT INFORMATION</b> - This form is designed for one individual. Please complete a form for each individual in need of a quote.				
First Name		Initial of Last Name	Gender	Date of Birth
Resident State				
MARRIED or have a PARTNER? <input type="checkbox"/> Yes <input type="checkbox"/> No	Exact Height: Exact Weight:	Have you had a weight change in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco Use: Check all that apply <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigar <input type="checkbox"/> E-Cig <input type="checkbox"/> Vaping <input type="checkbox"/> Chew <input type="checkbox"/> Marijuana	
<b>MEDICATIONS</b> - List ALL Medications taken or prescribed within the last 12 months - Explanation of any dosage changes increased /decreased				
Medication/Steroid	Reason for Taking Medication	Frequency	Dosage	Date Started
<b>HEALTH HISTORY</b> - Indicate any health conditions you have been diagnosed with and details				
<input type="checkbox"/> <b>Diabetes</b> - provide details below		<input type="checkbox"/> <b>Arthritis (Osteo, Rheumatoid, etc)</b> - provide details below		
A1C: Type: Diagnosis Date: Insulin Units:		Type: Any Steroid Injections: Joints Affected: Diagnosis Date:		
<input type="checkbox"/> <b>Cancer</b> - provide details below		<input type="checkbox"/> <b>Heart Disease</b> - provide details below		
Type: Stage: Treatment Type: Last date of Treatment: Lymph nodes affected:		Type: Bi-Pass or Stents: Diagnosis Date: History of diabetes, stroke, TIA or COPD: Nebulizer or Oxygen Use:		
<b>ADDITIONAL HISTORY</b> - List Additional Conditions & Details: (Depression, COPD, Blood Clot, Dizziness, etc) Diagnosed Date:				
<b>ADDITIONAL HEALTH HISTORY</b> - If checked, please provide all additional information regarding the condition.				
<input type="checkbox"/> Has a medical professional referred you to a specialist for additional consultation, testing or surgery in the last 3 years? If CHECKED, provide details:		<input type="checkbox"/> Have you received physical, occupational or speech therapy in the past 6 months? If CHECKED, provide details:		
Details:		Details:		
<input type="checkbox"/> Have you had surgery performed in the last 12 months? If CHECKED, provide details:		<input type="checkbox"/> Currently on disability income? If CHECKED, provide details:		
Details:		Details: (Type & percent)		
<input type="checkbox"/> Have had 2 or more immediate family members (biological parents or siblings) diagnosed with dementia? If CHECKED, provide details:		<input type="checkbox"/> Have you been previously declined for LTC or Life Insurance? If CHECKED, provide details below:		
Details:		Details:		

Your client's health history is an important factor in determining eligibility for coverage. All information provided is confidential. It will be used solely for the purpose of determining if submission of an application to an insurance company is appropriate. Nothing herein constitutes coverage, nor is to be considered an offer of insurance.