Questionnaire: DI & LTC Health Prequalification

Berkshire Advisor Resource, Inc.

Following is a series of questions to ask your client to obtain correct and necessary medical information.

1. Name: _____ Applicant's DOB: _____ Height: _____ Weight: _____

Factor	Date of Occurrence	Treatment	Date of Last Treatment
Any Surgeries (last 5 yrs or pending)			
Heart Surgery/ Bypass/ Angioplasty/ Arterial Stints			
Joint Replacement			
Cancer			
Arthritis			
Stroke or TIA			
Diabetes (Type 1 or 2)			

2. How often do you see your doctor? When did you last see your doctor?

3. Has your doctor advised you that your condition is unstable? (An example of instability would be a response such as "My doctor has told me he/she would like to see my blood pressure lower.")

4. What medications are you currently taking? Ask to see the bottles and write down prescription names. Follow up by asking "Why are you taking these medications?"

5. With the illnesses such as cancer, find out how long they have been cancer free. Find out the grade or stage of the cancer, if there were any reoccurrences and if it metastasized or spread.

6. For Diabetes, ask about their fasting blood sugar level, AIC score and units of insulin or any other co-morbid factors.

7. For Osteoporosis, please ask about the latest bone density scores (T or Z scores), stability or medications.

8. Generally, we need to see control or stability. If someone has had an operation in the last five years we need to know why, when and how long was the very last treatment. We need information about reoccurrences of illnesses or accidents and how they are affecting independence.

9. For depression, we need medications, treatments and actual diagnosis. What brought the depression on and was it situational or ongoing?

10. Be sure you ask if they have ever been on oxygen, if they use tobacco and if they need assistance with ADLs.

11. Do you see any specialists? If so, for what reason?

Medications	Reason	Amount/Dosage	Frequency	How Long

12. Do you have any significant illnesses or any hospitalizations that we have not discussed?

Berkshire Advisor Resource, Inc.

Questionnaire: Back History

Please complete the following questions with as many details as possible. In this application supplement, "you" and "your" mean the Proposed Insured.

This application supplement is part of application(s) for insurance on: _____
Proposed Insured (please print)

1. In the last 10 years, have you had any symptoms, complaints, disorders, medical consultations or treatments concerning any of the following regions of the back? If you answer yes, insert dates of first and last symptoms.

Upper (neck/cervical region) ☐ Yes ☐ No Dates: _____

Middle (thoracic region) ☐ Yes ☐ No Dates: _____

Lower (lumbosacral region) ☐ Yes ☐ No _____

2. Describe your symptoms and reasons for medical consultations: _____

_____

_____

3. Name and address of physicians, chiropractors, or other therapists and month/year each was last seen:

_____

_____

4. Have you ever had surgery for any of these conditions: ☐ Yes ☐ No

If yes, give dates, reasons and name and address of hospital or facility: _____

_____

5. Describe other type(s) of treatment received (manipulation, heat, physical therapy): _____

_____

_____

6. Has treatment included the use of prescription medications: ☐ Yes ☐ No List medications and start/stop dates:

_____

7. Name prescribing physician (include address) if not shown in item 3 above: _____

8. Have you missed work more than 4 consecutive work days for any of the above conditions? ☐ Yes ☐ No

If yes, give dates and details: _____

Signature of Proposed Insured: _____ Date: _____

Berkshire Advisor Resource, Inc.

Questionnaire: Sleep Apnea

This application supplement is part of application(s) for insurance on: _____
Proposed Insured (please print)

1. Date of diagnosis: _____

2. The sleep apnea was diagnosed as: ☐ Obstructive ☐ Central ☐ Mixed ☐ Unknown

3. Date of last sleep study: _____

(Please attach a copy of the report)

4. How is the sleep apnea being treated? ☐ Observation alone ☐ Weight loss ☐ Surgery

☐ CPAP mask ☐ Other: _____

5. Has surgery been performed? Dates and results, and date of follow up sleep study: _____

_____

_____

6. Do you use a CPAP regularly? How long? _____

7. Please list any medications you are taking and the dosage: _____

_____

8. Do you have a history of: ☐ Lung disease ☐ Chest Pain or coronary artery disease

☐ Depression ☐ Overweight ☐ Arrhythmia ☐ Stroke ☐ Cancer

Comments or other major health problem which should be noted: _____

_____

_____

_____

9. Have you smoked cigarettes in the last 12 months? ☐ Yes ☐ No

Signature of Proposed Insured: _____ Date: _____

Berkshire Advisor Resource, Inc.

Questionnaire: Mental/Nervous History

Please complete the following questions with as many details as possible:

Name of Proposed Insured: _____

1. Describe your symptoms occurring within the last 10 years, and reasons for your consultations or use of medications:

_____

_____

2. Date of first appointment/consultation: _____ Date of last appointment/Consultation: _____

3. Specific diagnosis: _____ Date diagnosed: _____

4. Name, address and phone number of physician or therapist: _____

_____

5. Describe type or treatment: _____

_____

6. Has treatment included the use of prescription medications? ☐ Yes ☐ No If yes, list medications including first and last dates each medication was taken and dosages (indicate any change in dosages):

_____

7. Name and address of prescribing physician, if other than as named in Item 4 above: _____

_____

Have you missed work for more than 4 consecutive work days for any of the above conditions? ☐ Yes ☐ No

If yes, give dates and details: _____

9. Have you been an in-patient for any of the above conditions? ☐ Yes ☐ No If yes, give dates, reasons including name and address of hospital or facility: _____

_____

Use the space below for any additional information which may be helpful for the underwriting of you application:

_____

_____

_____

Signature of Proposed Insured: _____ Date: _____

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