Extended Care Health Needs Assessment

Agent Information

Agent Name:	Agent Phone Number:	Agent Email Address:

Proposed Policy

Monthly Benefit:	Benefit Duration:	Riders Requested:	Resident State:
			Partnership: Yes ◯ No ◯

Client Information

Client's Name: _____

State: _____

◯ Male ◯ Female

DOB: ___/___/____ Height: _____ Weight: _____

Tobacco User: ◯ Yes ◯ No

If so, please indicate the type and frequency. If quit, indicate last use.

_____

Does the client have a spouse or significant other with whom they reside?

◯ Yes ◯ No

Medications

☐ Check here if you DO NOT TAKE ANY MEDICATIONS

Record all medications you currently take including **prescription medications** and any **over the counter drugs**.

Name of Drug	Dosage	Frequency	When Prescribed	Reason for Taking

Do you have any surgeries planned or recommended?

◯ Yes ◯ No Provide details of Type of Surgery and when it is scheduled: _____

_____

Have you ever been on disability?

◯ Yes ◯ No Provide details: _____

_____

Additional Information

Please include any Health History, additional information and details that was not covered in above areas.

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