



Please fill in the requested information. Return the completed form to life@dplfp.com.

Agent Information

Agent Name:

Phone:

State:

Email:

Client Information

Client Name:

Spouse Name:

Date of Birth:

Date of Birth:

Height:

Height:

Weight:

Weight:

Gender:

Male

Female

Gender:

Male

Female

Resident State:

Resident State:

Policy Information

Benefit Amount:

Coverage Type:

Hybrid

Benefit Period:

Traditional

1. Please list any prescription medication, who for, reason, & date started taking.
2. Are either of you currently using (or have used in the last 12 months) oxygen, wheelchair, crutches, cane? Are either of you currently receiving (or have received in the last 12 months) physical therapy or injections? Provide details.
3. Have either of you been declined for LTCL?
4. Have either of you used tobacco in the last 36 months? Provide details.
5. Do either of you have surgery scheduled in the next 6 months, or has surgery been recommended? Provide details.
6. Have either of you been hospitalized in the last 10 years? Provide details.
7. Have either of you received treatment for any medical conditions (including but not limited to: anxiety, high blood pressure, diabetes, Arthritis, etc.)? If yes, provide details.



8. Have you applied for, or are you eligible for, Medicaid?

Please reference any details above to the appropriate person. Any additional details can be provided below

9. Please refer to the list of Underwriting Considerations and review. If you have ever received a medical diagnosis or have any of the medical conditions listed, please provide the following information:

- | | | |
|-------------------------------|-----------------------------------|---|
| • Name of diagnosis/condition | • Date of last treatment | • Treatment received (including medication and non-medication such as injections, physical therapy, etc.) |
| • Date of diagnosis | • Current Medications being taken | |



10. Please refer to the Medication Guidelines and review. If you have are currently taking or have taken any of the medications listed below, please provide the following information:

- | | | |
|------------------------------------|---------------------------|------------------------------|
| • Name of medication | • Reason for prescription | • Dates medication was or is |
| • Prescription or over the counter | • Dosage | being taken |