

Section I: General Information

Personal & Contact Information

Date of Application ____/____/____

Applicant 1

SSN

Date of Birth

Phone (Cell)

Email

Applicant 2

SSN

Date of Birth

Phone (Cell)

Email

Address

Phone (Home)

City

State

Zip

Alternate Contact

Relationship to Applicant(s)

Address

Phone (Home)

Phone (Cell)

Email

Does this person hold power of attorney for the applicant(s) ☐ Yes ☐ No

Did this person assist with preparing the application? ☐ Yes ☐ No

Possession of Vehicles

Please list any vehicles you intend to keep.

Make

Model

License No.

Make

Model

License No.

Section II: Financial Information

Sources of Income & Assets

Please list the bank or brokerage company for all assets and investments.

Documentation of all income and non-real estate investments must accompany the application.

Type of Asset	Applicant 1 (jointly held)	Applicant 2	Jointly Held	Type of Income	Applicant 1	Applicant 2	Death Benefit
Checking, Savings, Money Market Accounts	\$ _____ \$ _____ \$ _____	\$ _____ \$ _____ \$ _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Social Security (net per month)	\$ _____	\$ _____	
Certificates of Deposit	\$ _____ \$ _____ \$ _____	\$ _____ \$ _____ \$ _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pensions	\$ _____ \$ _____ \$ _____	\$ _____ \$ _____ \$ _____	_____% _____% _____%
Non-Retirement Investments	\$ _____ \$ _____ \$ _____	\$ _____ \$ _____ \$ _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Other Income	\$ _____ \$ _____ \$ _____	\$ _____ \$ _____ \$ _____	
Retirement Investments	\$ _____ \$ _____ \$ _____	\$ _____ \$ _____ \$ _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				
Real Estate	\$ _____ \$ _____	\$ _____ \$ _____	<input type="checkbox"/> <input type="checkbox"/>				

Section II: Financial Information

Anticipated Liabilities & Ongoing Expenses

If loan or mortgage payments are due, please include documentation showing the remaining balance.

Type of Liability	Applicant 1	Applicant 2	Jointly Held	Total Balance Remaining
Monthly Mortgage Payments _____	\$ _____	\$ _____	<input type="checkbox"/>	\$ _____
Monthly Loan/Credit Card Payments _____	\$ _____	\$ _____	<input type="checkbox"/>	\$ _____
Ongoing Expenses				
Monthly Health Insurance Premium(s) _____	\$ _____	\$ _____	<input type="checkbox"/>	
Annual Long-Term Care Insurance Premium(s) _____	\$ _____	\$ _____	<input type="checkbox"/>	
Annual Life Insurance Premium(s) _____	\$ _____	\$ _____	<input type="checkbox"/>	
Monthly Prescription Costs _____	\$ _____	\$ _____	<input type="checkbox"/>	
Monthly Medical Supplies _____	\$ _____	\$ _____	<input type="checkbox"/>	
Contracted Medical Services _____	\$ _____	\$ _____	<input type="checkbox"/>	
Annual Car Insurance Premium(s) _____	\$ _____	\$ _____	<input type="checkbox"/>	
Annual Misc. Insurance Premium(s) (RV, Boat, Etc.) _____	\$ _____	\$ _____	<input type="checkbox"/>	

Section II: Financial Information

Insurance Coverage

Please attach copies of all cards and/or long-term care policy declaration pages.

Applicant 1

Do you have a Medicare Part B Premium deducted from your Social Security?

☐ Yes ☐ No Amount \$_____

Do you have a Medicare Part D Premium deducted from your Social Security?

☐ Yes ☐ No Amount \$_____

Do you have a Medicare Supplemental Premium? ☐ Yes ☐ No

Is your Medicare Supplemental Premium paid for by a previous employer? ☐ Yes ☐ No

If Yes, does the reimbursement continue to your spouse upon your death? ☐ Yes ☐ No

Applicant 2

Do you have a Medicare Part B Premium deducted from your Social Security?

☐ Yes ☐ No Amount \$_____

Do you have a Medicare Part D Premium deducted from your Social Security?

☐ Yes ☐ No Amount \$_____

Do you have a Medicare Supplemental Premium? ☐ Yes ☐ No

Is your Medicare Supplemental Premium paid for by a previous employer? ☐ Yes ☐ No

If Yes, does the reimbursement continue to your spouse upon your death? ☐ Yes ☐ No

Section III: Health Information

Personal Health Questionnaire

A release for medical records may be requested in the future.

Applicant 1

1. Rate your overall health at the present time: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. Does your health limit daily activities? ☐ Not at all ☐ A little ☐ A great deal
3. How is your health compared to last year? ☐ Better ☐ Same ☐ Worse
4. Do you regularly see a primary care physician or specialist? ☐ Yes ☐ No

If specialist, for what _____

5. Have you been hospitalized in the past 12 months? ☐ Yes ☐ No
6. Are you receiving physical, occupational or speech therapy? ☐ Yes ☐ No
7. Please list any chronic diseases or physical limitation: _____

8. Please list any allergies: _____

Applicant 2

1. Rate your overall health at the present time: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. Does your health limit daily activities? ☐ Not at all ☐ A little ☐ A great deal
3. How is your health compared to last year? ☐ Better ☐ Same ☐ Worse
4. Do you regularly see a primary care physician or specialist? ☐ Yes ☐ No

If specialist, for what _____

5. Have you been hospitalized in the past 12 months? ☐ Yes ☐ No
6. Are you receiving physical, occupational or speech therapy? ☐ Yes ☐ No
7. Please list any chronic diseases or physical limitation: _____

8. Please list any allergies: _____