John Hancock
LONG-TERM CARE INSURANCE

Underwriting Prequalification Form

Complete this form and email it to our Prequalification Team at LTCPrequal@jhancock.com, to receive a preliminary underwriting opinion within 24 hours. For a verbal opinion please call the Prequalification Team at 888-604-7296, Option 3. **NOTE:** If attaching medical records please include a Long-Term Care HIPAA compliant medical authorization form signed and dated by the applicant.

1 Applicant's Date of Birth _____

2 Height _____ Weight _____

3 Has the applicant used tobacco products in the last 12 months?
☐ Yes ☐ No

4 Has any surgery been performed or recommended within the past 5 years?
☐ Yes ☐ No If yes, Date/Reason _____

5 Has the applicant been hospitalized within the past 24 months?
☐ Yes ☐ No If yes, Date/Reason _____

6 Does the applicant use a cane, crutches, walker, wheelchair, scooter, stairlift, oxygen, dialysis, and/or hospital bed?
☐ Yes ☐ No If yes, type _____

7 Has the applicant been declined LTC coverage at any time?
☐ Yes ☐ No If yes, Date/Reason _____

8 Does the applicant currently receive disability benefits?
☐ Yes ☐ No If yes, %_____ Type _____
Reason _____

9 With the last 5 years, has the applicant received medical advice, diagnosis, treatment, or consulted with a member of the medical profession for any of the following conditions?

CONDITION	YES	NO	CONDITION	YES	NO
Heart Disease	☐	☐	Kidney Disease	☐	☐
High Blood Pressure	☐	☐	Liver Disorders/Hepatitis	☐	☐
Carotid Artery Disease/Peripheral Vascular Disease	☐	☐	Crohn's Disease/Ulcerative Colitis/Gastric Bypass	☐	☐
Transient Ischemic Attack (TIA)	☐	☐	Osteoarthritis	☐	☐
Stroke/CVA	☐	☐	Back Disorder/Degenerative Disc Disease/Spinal Stenosis	☐	☐
Embolisms/Blood Clots	☐	☐	Rheumatoid Arthritis	☐	☐
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	☐	☐	Osteoporosis	☐	☐
Depression/Anxiety/Bipolar Disorder	☐	☐	Joint Replacement	☐	☐
Memory Loss or Forgetfulness	☐	☐	Chronic Fatigue Syndrome/Fibromyalgia	☐	☐
Substance Abuse	☐	☐	Fractures	☐	☐
Seizures/Neuropathy/Paralysis/Tremor	☐	☐	Anemia/Blood Disorder	☐	☐
Cognitive Impairment/Alzheimer's Disease/Dementia	☐	☐	Cancer/Leukemia/Lymphoma/Sarcoma	☐	☐
Diabetes	☐	☐	Visual Impairment/Vision Loss	☐	☐

If any conditions are answered "Yes," please provide details:

Condition: _____ Diagnosis Date: _____ Treatment: _____

Condition: _____ Diagnosis Date: _____ Treatment: _____

Condition: _____ Diagnosis Date: _____ Treatment: _____

10 In the past 5 years, has the applicant received medical advice, diagnosis, treatment, or consulted with a member of the medical profession for any other reason not stated?

Condition: _____ Diagnosis Date: _____ Treatment: _____

Condition: _____ Diagnosis Date: _____ Treatment: _____

List all prescription medication taken over the past 12 months and reason taken:

MEDICATION	REASON TAKEN	MEDICATION	REASON TAKEN

Preliminary Decision: _____

_____ Date: _____

This is a tentative opinion based on the information provided. Our final underwriting decision is reserved and is subject to review of a properly completed application, advance payment, all other required forms and necessary underwriting requirements for age, benefits, and medical history.

Long-term care insurance is underwritten by John Hancock Life Insurance Company (U.S.A.), Boston, MA 02117 (not licensed in New York) and in New York by John Hancock Life & Health Insurance Company, Boston, MA 02117.
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