LIFE INSURANCE ADVISORS, INC.

FEE-ONLY INSURANCE CONSULTING
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Questionnaire for Initial Review of a New Long-Term Care Insurance Policy

Your answers to the questionnaire below will enable Life Insurance Advisors, Inc. to determine whether you will likely benefit from a more complete review of a new long-term insurance policy or proposal. We need contact information for you and a few details about the insured and the insured's objectives.

If some of the information is not known, please provide as much of it as is conveniently available. For example, the insured will know information about their health and activities that another person answering this questionnaire, such as an advisor, may not know.

A. Your Contact Information

1. Please indicate whether you are (circle any that apply): the insured, policy owner, premium payor, client advisor, other (please specify if other).

2. If you are a client advisor, please indicate whether you are (circle any that apply): attorney, accountant, trustee of an insurance trust owning the policy, independent financial advisor, insurance agent or broker, other.

3. Your Name: _____
   First Middle Initial Last

4. Preferred address: _____
   Employer/Firm Name (if applicable)

   _____
   Number and Street

   _____
   City State Zip

5. Preferred Phone # _____

6. E-mail Address:_____

7. Name, sex, date of birth, and state of residence of proposed insured(s) (Please provide the same information for your spouse if you are both considering insurance):

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8. If only you are applying for insurance, please provide the name of a spouse or partner or family member of the same generation living with you for the past 5 years (the premium may be lower if you have a spouse or partner or such family member residing with you).

9. What is the proposed insurance company, if any, so far?
(If you have any policy illustrations already, please provide them along with as detailed a description of the policy's contractual features as you have).

10. What is the amount of long-term care insurance you are considering purchasing and the duration of the benefit?

11. Please describe your financial situation: total approximate net worth, approximate investment assets, other sources of income (e.g., current earned income and if so for how long; possible additional savings before retirement if applicable; defined benefit pension income, if any; possible inheritance or trust income, if any, etc.).

12. In today's dollars, what is the maximum <u>total</u> out-of-pocket cost you would be willing to incur on long-term care expenses if you need such care? (Please provide the total combined cost for you and your spouse or partner, if applicable, that you would be willing to absorb).

13. What is the maximum annual premium expense in today's dollars that you are willing and able to pay for long-term care insurance coverage? (Please provide the total combined premium for you and your spouse or partner, if applicable).

    a. Would you be able and willing to pay a higher premium for a limited period of years, such as 10 years) in order to limit the premium payment period <u>and</u> to assure that the premium will not increase? ____ Yes ____ No

14. If a particular insurance company and policy has already been proposed, will you:

    a. Consider an alternative company or policy that an independent consultant, who does not sell insurance, might recommend if the recommended alternative appears to provide a better value? Yes No

    b. If the answer to Question (a) is "yes," would you consider this alternative even if the agent or broker making the original proposal cannot offer the alternative policy because he or she cannot be licensed with the company that issues it? Yes No

15. Please specify any health conditions that <u>MIGHT</u> influence the health classification of a long-term care policy. Please provide details, including but not limited to, height, weight, blood pressure,

cholesterol, any heart history, cancer, diabetes, stroke back aches or problems, arthritis or any other conditions or diagnoses affecting or potentially affecting mobility or mental acuity, treatment for depression, and visits to physicians within the previous 5 years that might be relevant, etc.

a. Your approximate height and weight:

Height _____ Weight _____

b. Do any of your family members have, or have they had, a history of: diababetes, heart disease, stroke, Parkinson's, Alzheimer's, or dementia. If so, please provide details (e.g., age of onset, diagnosis, history of treatment and results).

16. Do you smoke cigarettes, pipes, or cigars or use of tobacco in any way?

If not, have you ever done so, and when did you last use tobacco.

If you are a cigar smoker, specify approximately how many cigars you smoke in a week, month or year.

17. What specific questions about, or objectives for, your long-term care insurance coverage do you have?

18. Please indicate the amount and type (individual or group) of any existing long-term care insurance you own:

When the questionnaire is completed, either e-mail it to david@lifeinsuranceadvisorsinc.com with the completed questionnaire attached as a Word document, or fax it to 815-377-3631. If you have a policy illustration of the policy you are considering, please include it.