PLEASE RETURN COMPLETED PACKET TO:

brandon.melnick@nm.com

Please be sure to **completely** fill out the information on all pages of the packet. **If any information is missing** – our team will follow up, but this will slow the process down.

If you have any questions, please reach out to Al Batson or Brandon Melnick directly – Contact information below

Once our team has received your completed information, a member of our team will reach out to review and finalize all information for signatures and submission to underwriting.

Al Batson
Financial Representative
12939 E Pinecroft Way, Ste 200, Spokane Valley, WA 99216
P: 509.838.5246
C: 509.879.2596
E: al.batson@nm.com
Click here to Schedule Meeting with Al

Brandon Melnick
Financial Representative
12939 E Pinecroft Way, Ste 200
Spokane Valley, WA 99216
P: 509.838.5246
C: 509.496.2397
E: brandon.melnick@nm.com
Meet with Brandon Melnick

Name (First, M.I., Last):	
State of Birth:	
Cell Phone:	Email:
Are you married or in a relationship that is granted the legal rights of marriage?	☐YES ☐NO
If you answered "no" to the question above, are you in a committed relationship with an unrelated person or a family member of the same generation, with whom you have been living together for at least the last two years and intend to continue to do so?	☐YES ☐NO
- If not an existing client of our firm, provide the following -	
Date of Birth:	Social Security Number:
Primary Address:	

ANSWER ALL QUESTIONS BELOW	
Do you have any existing Long-Term Care Insurance?	☐YES ☐NO
Have you ever had life, disability, health, or long-term care insurance declined, rated, modified, issued with an exclusion rider, cancelled, rescinded, or not renewed? (By the insurer, not by your choice.)	☐YES ☐NO
What is your annual income? ☐Under $10,000 ☐$10,000 - $24,999 ☐$25,000 - $49,999 ☐$50,000 - $99,999 ☐$100,000 - $149,999 ☐$150,000 - $249,999 ☐$250,000 or more	
How do you expect your income to change over the next 10 years? ☐No Change ☐Increase ☐Decrease	
Not counting your home, what is the approximate value of your assets (your savings, investments, etc.)?	
☐Under $30,000 ☐$30,000 - $99,999 ☐$100,000 - $249,999	
☐$250,000 - $499,999 ☐$500,000 - $999,999 ☐ $1,000,000 or more	

Payer:					
Mode: ☐Monthly ☐Quarterly ☐Semi-Annually ☐Annually				Ongoing: ☐EFT	☐Direct
Bank Name:					
Routing #:		Account #:		☐Checking	☐Savings
TIN (if other than SSN):					
Address (if other than personal):					
Notes:					

NORTHWESTERN LONG TERM CARE INSURANCE COMPANY
P.O. BOX 3124, MILWAUKEE, WI 53201-3124

LONG-TERM CARE INSURANCE **Part B**

Complete Part B for all applications

MEDICAL QUESTIONNAIRE - Each question must be individually asked and answered.

Policy Number _____

(For NLTC Administration Office Use Only)

INSURED'S NAME: (First, MI, Last) *please print*

FORMER NAME *(if changed within 5 years)* _____

GENERAL INFORMATION

1. Who is your regular physician or other health care provider? ☐ None

PHYSICIAN NAME _____ TELEPHONE NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

DATE LAST SEEN (MM/DD/YYYY) _____ REASON _____

	YES	NO
2. a. Are you currently employed on a full time basis? (If "Yes," please continue to 2b. and 2c.)	○	○
b. Are you employed inside or outside of the home?	○ Inside ○ Outside	
c. Have your hours been limited in the past 24 months for health reasons?	○	○

GENERAL PROFILE

	YES	NO
3. Do you currently, or in the past **12 months** did you require human assistance or receive help in any way with:		
a. Moving into or out of a bed or a chair?	○	○
b. Bathing?	○	○
c. Eating?	○	○
d. Dressing?	○	○
e. Using the toilet?	○	○
f. Controlling bowel or bladder?	○	○
g. Taking your medications?	○	○
4. Do you currently receive, or in the past **12 months** have you received:		
a. Care in a nursing home or extended care unit of a hospital?	○	○
b. Home health care (including visiting nurse therapist, and home health aide)?	○	○
c. Adult day care services?	○	○
5. Do you currently use, or in the past **12 months** have you used:		
a. Oxygen equipment?	○	○
b. Cane or quad cane?	○	○
c. Walker?	○	○
d. Wheelchair?	○	○
e. Motorized scooter?	○	○
f. A hospital bed in your home?	○	○

Provide full details for all "Yes" responses:

- Identify question numbers.
- State signs, symptoms, and diagnosis of each illness or injury.
- List the details and results of tests and treatment.
- **For each health care provider consulted,** list the name, full address, telephone number, and dates.

DETAILS

GENERAL PROFILE - *continued*	YES	NO	DETAILS
6. Have you had, been told you had, or been treated by a medical professional for:			
a. Metastatic cancer (cancer that has spread from the original site)?	○	○	
b. Alzheimer's disease, dementia or memory loss?	○	○	
c. Parkinson's disease?	○	○	
d. Stroke, mini-stroke, or transient ischemic attack (TIA)?	○	○	
e. Multiple sclerosis?	○	○	
f. Kidney dialysis or chronic kidney failure?	○	○	
g. Amputation due to diabetes or peripheral vascular disease?	○	○	

MEDICAL HISTORY	YES	NO
7. a. What is your current height? ____ ft. ___ in.		
b. What is your current weight. _____ lbs.		
c. Have you lost weight in the past 6 months?	○	○
If "Yes," indicate how many pounds and the reason for the weight loss. _____ lbs. Reason: _____		
8. Have you used tobacco or nicotine in any form in past 10 years, including cigarette, pipe, snuff, chewing tobacco, cigar, nicotine gum, or nicotine patch?	○	○
If "Yes," date last used (MM/DD/YYYY) _____		
9. In the past 5 years, have you requested or received payments, benefits, or a pension because of an injury, accident, sickness, or disability?	○	○
10. Do you plan to retire due to health reasons, or have you been advised to retire, change jobs or limit your hours due to health reasons?	○	○
11. Have you ever tested positive for the Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immune Deficiency Syndrome (AIDS)?	○	○
12. Do you currently take, or have you in the past **12 months** taken, **any** prescription medicines?	○	○

If "Yes," list each medication, why it is needed, and the name and address of prescribing physician.
If more space is needed, please attach an additional sheet of paper.

Name of Medication	Dosage	Frequency	Reason Prescribed	Physician Name

MEDICAL HISTORY - *continued*		YES	NO	DETAILS
13. In the last 5 years, have you had, been told you had, or been treated by a medical professional for:				
	a. Any problems with balance or coordination?	○	○	
	b. Huntington's chorea?	○	○	
	c. Any muscle weakness or paralysis?	○	○	
	d. Muscular dystrophy?	○	○	
	e. Myasthenia gravis?	○	○	
	f. Amyotrophic lateral sclerosis (ALS)?	○	○	
	g. Seizures?	○	○	
	h. Tremor?	○	○	
	i. Macular degeneration or other disorder of the eye?	○	○	
	j. Any problem, disease, or disorder of the brain or nervous system?	○	○	
Heart Vessels	**k.** Angina?	○	○	
	l. Congestive heart failure?	○	○	
	m. Heart attack or myocardial infarction (MI)?	○	○	
	n. Irregular heart rhythm?	○	○	
	o. Any other disorder or disease of the heart?	○	○	
Blood	**p.** High blood pressure or hypertension?	○	○	
	q. Peripheral vascular disease?	○	○	
	r. Any other disorder or disease of the blood vessels, including problems with circulation?	○	○	
Musculo-skeletal	**s.** Osteopenia or Osteoporosis?	○	○	
	t. Falls?	○	○	
	u. Fractures?	○	○	
	v. Arthritis?	○	○	
	w. Any disorder or disease of the neck, back or spine?	○	○	
General Medical Conditions	**x.** Cancer?	○	○	
	y. Enlarged lymph node?	○	○	
	z. Any disorder or disease of the blood?	○	○	
	aa. Diabetes or elevated blood sugar?	○	○	
	bb. Any disorder or disease of the kidney or urinary bladder?	○	○	
	cc. Asthma, wheezing or shortness of breath?	○	○	
	dd. Emphysema or chronic obstructive lung disease (COPD)?	○	○	
	ee. Cystic Fibrosis?	○	○	
	ff. Any disorder or disease of the liver?	○	○	
	gg. Any disorder or disease of the stomach or bowels?	○	○	
Mental Health	**hh.** Anxiety?	○	○	
	ii. Depression?	○	○	
	jj. Psychosis?	○	○	
	kk. Alcohol abuse?	○	○	
	ll. Illegal drug use or excess use of prescription medication?	○	○	

NORTHWESTERN LONG TERM CARE INSURANCE COMPANY
P.O. BOX 3124, MILWAUKEE, WI 53201-3124

LONG-TERM CARE INSURANCE Part B

Complete Part B for all applications

MEDICAL HISTORY - *continued*	**YES**	**NO**	**DETAILS**
14. Other than as previously provided on this form, in the past ***5 years:***			
a. have you seen or consulted with any other health care provider, including a psychologist, chiropractor, counselor, therapist, or other health care provider?	○	○	
b. have you had surgery?	○	○	
c. have you been a patient at a hospital, clinic, or other health care facility?	○	○	
d. have you been advised to have any tests, consultations, hospitalizations, surgery or diagnostic studies that have not been completed?	○	○	
FAMILY HISTORY			
15. a. Do you have a family history of heart or kidney disease, stroke, diabetes, cancer, melanoma, or any hereditary disease?	○	○	

b. Always complete the first three columns. Complete the last two columns if **15a** is answered "Yes."

	Age if Living	Age at Death	Cause of Death	Condition	Age at Onset/ Event
Father					
Mother					
Brothers					
Sisters					

The Insured declares that the answers and statements are correctly recorded, complete, and true to the best of the Insured's knowledge and belief. Statements in this application are representations and not warranties.

X _____
Print Name of **INSURED**

X _____
Signature of **INSURED**

X _____
Date Signed by **INSURED** (MM/DD/YYYY)

X _____
(City, County & State) Signed by **INSURED**

X _____
Signature of **LICENSED AGENT**

PLEASE READ CAREFULLY

Included below are prices for estimating and informational purposes only and do not reflect actual pricing. For actual pricing please contact Al Batson or Brandon Melnick directly.

All costs (below) include both the 20% spousal discount (i.e. both spouses get a policy otherwise it is a 5% discount) and the 5% multi life discount (at least 3 SKSD EEs get a policy and a non-SKSD spouse can still use the 5% discount) for a total of 25% off the retail price. If someone is married, but their spouse does not get a policy, then that person would receive a 5% spousal discount plus the 5% multi-life discount for a total of 10% off the retail price. If a person is not married/companion, then this person would only get a 5% multi life discount.

Contract is $3,100/mo for 3 years starting after 6 weeks with a 5% inflation compounded annually. I use this as the proposal as my belief/thought is that the policy someone purchases has to be "equal to or better than" the State of WA plan in all 4 areas that make up a contract (benefit amount, benefit period, elimination period and inflation). The state of WA plan is $100/day, 1 year benefit period 45 day start and CPI inflation (i.e. 3%).

The table below reflects ages in 5 year increments for illustrative purposes

****ALL PRICES BASED ON ANNUAL PRICING****

Male:
Age 30 = $476.16
Age 35 = $523.28
Age 40 = $570.40
Age 45 = $629.18
Age 50 = $695.15
Age 55 = $815.18
Age 60 = $1,027.22

Female:
Age 30 = $636.12
Age 35 = $713.99
Age 40 = $805.75
Age 45 = $921.32
Age 50 = 1,051.02
Age 55 = $1,241.74
Age 60 = $1,557.44