



FACT FINDING LTC PLAN QUESTIONNAIRE

*LTC planning is crucial to ensure your retirement years are worry free for you and your family.
Determining the right plan for you is essential. Pls answer these questions to help your LTC specialist
design a customized plan for you.*

Name: _____ Phone# _____

1. Where do you see yourself retiring?
 - ☐ Surrounded by family and friends
 - ☐ Travelling
 - ☐ Spending half the time out of the country
 - ☐ Out of the US
2. How much do you think LTC is going to cost?
(write a number for you and your spouse)
3. Where do you want to receive care?
 - ☐ At Home
 - ☐ Nursing Home
 - ☐ Assisted Living
 - ☐ Board and Care
4. Who do you plan will take care of you? If its family, have you discussed that with them?
 - ☐ Children
 - ☐ Neighbor
 - ☐ Friends
 - ☐ Paid
 - ☐ Unpaid
5. What payout option would you prefer?
 - ☐ Reimbursement (Services rendered by a licensed health care professional)
 - ☐ Cash Indemnity (informal caregiver or family member-benefit paid to plan owner)
 - ☐ Indemnity (may require some services fr a licensed HC prof &may use informal CG)
6. Do you have family members that needed LTC? ☐ Yes ☐ No
7. How long did they need the care? ____ yrs
8. Do you have a family history of Alzheimer's Disease or Sever Dementia? ☐ Yes ☐ No
9. Do you have a Retirement Plan ☐ Yes ☐ No



QUESTIONNAIRE FOR LTC POLICY REVIEW

Understanding your plan and what you are paying for is key. Knowing the features and benefits it has will ensure you that when you need to use it, it is going to deliver exactly what you want and expect. Call HR and ask for the information of your LTC plan provider. If possible ask for a copy of your policy with the details of the plan and have it in your file.

Call the LTC provider company and ask the questions below. Share the answers to your LTC Specialist who handed you this questionnaire for review, interpretation and analysis:

Name of LTC PLAN Company _____ Contract # _____

Customer Service Tel no _____

Monthly Payment: \$ _____ Single plan ☐ Joint Plan (spouse included) ☐

Monthly Maximum LTC Benefit Amt: \$ _____ Monthly Cash Benefit \$ _____ What % _____

Policy Limit: \$ _____

Inflation Option: ____ Yes ____ No . What percent ____ %

Elimination Period: _____

Benefit Period: _____

Benefit Options: ☐ Reimbursement ☐ Indemnity ☐ Cash Indemnity

Who can Care for me with my plan: ☐ Licensed Care Provider ☐ Informal Caregiver ☐ Family

Return of Premium: Yes ____ No ____

Years to Pay: ____ single pay ____ 10 years ____ 20 years ____ whole pay

Will the premium payments ever increase? Yes ____ No ____ Is it guaranteed? Yes ____ No ____

When I leave the company, will my premiums change? _____

If me & my spouse dies and never used the plan, will my family get a death benefit? Y ____ N ____

Care Options: Where can I receive care?

☐ Home

Are there restrictions or reduction in benefit if I receive care at home? ____ yes ____ no

☐ Nursing home

☐ Assisted Living

☐ Board and Care

☐ Adult Day Care

☐ International

What are the conditions if I do decide to retire internationally?

LTC Specialist: _____ Contact info: _____

Name:

Pre-interview Worksheet

Doctors you have visited in the last five years, including primary care physician

Name		Specialization
Address		
Date of visit	Reason for visit	
Treatment or test received		

Name		Specialization
Address		
Date of visit	Reason for visit	
Treatment or test received		

Prescription and over-the-counter medications

Name	Dosage	Reason for taking	Length taken	Date last taken

Medical history

All diagnoses including but not limited to coronary conditions, cancers, diabetes, heart disease, retinopathy, hypertension, neuropathy, kidney disease, insulin reaction, urine protein/microalbumin, cerebrovascular/peripheral vascular disease.

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