Ohio Long Term Care Brokers
LTC Pre-Certification Information

Agent Name: ____________________
Email Address: __________________
Phone: _________________________
Fax: ____________________________

APPLICANT **State of Residence** ______

Name: ____ **D.O.B.:** _________________________

Height: _________ **Weight:** _________ **Smoker:** _________ **Marital Status:** ___________________

Have you been in the hospital in the last 5 years? If yes, please provide details:

____

____

Have you ever had: ***Cancer:*** _______ ***Stroke:*** _______ ***Diabetes:*** _______ **If yes, please provide details:**

____

____

Name of Medication(s), Dosage, and what Conditions it Treats:

____ ____

____ ____

____ ____

SPOUSE

Name: ____ **D.O.B.:** _________________________

Height: __________ **Weight:** __________ **Smoker:** __________ **Marital Status:** ________________

Have you been in the hospital in the last 5 years? If yes, please provide details:

____

____

Have you ever had: ***Cancer:*** ______ ***Stroke:*** ______ ***Diabetes:*** ______ **If yes, please provide details:**

____

____

Name of Medication(s), Dosage, and what Conditions it Treats:

____ ____

____ ____

____ ____

Please Quote the Following: ***Daily/Monthly Benefit $:*** ______________ ***Home Health Care %:*** ___________

Elimination Period: _______________ ***Benefit Period:*** ______________ ***Inflation:*** ________________

Delivery Method (check one) **Email:** _____ **Regular Mail:** _______ **Fax:** _________

Send Your Request to: Ohio Long Term Care Brokers, Inc.

Fax to 440-461-4503, email to ohioltc@core.com or call 440-461-5131

Additional copies of this form can be found at www.ohioltcbrokers.com or email us at ohioltc@core.com