ForeCare Annuity Application – Medical Questionnaire

Forethought Life Insurance Company
One Forethought Center
P.O. Box 246
Batesville, IN 47006

Email or fax this completed form and signed HIPAA to forecare@gafg.com or (855) 206-8731

Proposed Insured (First, Middle Initial, Last)			Date of Birth (mm/dd/yyyy)	
Mailing Address			Height	Weight
City	State	Zip	Social Security Number	
Highest Level of Education				

Proposed Insured Health Questions (any questions 1-5 answered 'Yes" will be an automatic decline)

1. **Are you currently hospitalized, confined to a bed, or residing in an Assisted Living Facility?** ☐ **Yes** ☐ **No**

2. **To the best of your knowledge, in the last 12 months have you applied for any long term care policy or long term care rider that was declined or postponed?** ☐ **Yes** ☐ **No**

3. **Are you currently using, or in the past 12 months have you used or been medically advised by a licensed Healthcare Professional to use any of the following?**

☐ **Yes**	☐ **No**	Care in a nursing facility	☐ **Yes**	☐ **No**	Motorized Scooter
☐ **Yes**	☐ **No**	Home Health care services	☐ **Yes**	☐ **No**	Hospital bed
☐ **Yes**	☐ **No**	Adult Day Care services	☐ **Yes**	☐ **No**	Stair Lift
☐ **Yes**	☐ **No**	Walker	☐ **Yes**	☐ **No**	Oxygen
☐ **Yes**	☐ **No**	Wheelchair	☐ **Yes**	☐ **No**	Dialysis machine
☐ **Yes**	☐ **No**	Multi-prong cane	☐ **Yes**	☐ **No**	Hospice Care

4. **Do you require assistance or supervision in performing any of the following activities?**

☐ **Yes**	☐ **No**	Taking medication	☐ **Yes**	☐ **No**	Eating
☐ **Yes**	☐ **No**	Bathing	☐ **Yes**	☐ **No**	Toileting
☐ **Yes**	☐ **No**	Dressing	☐ **Yes**	☐ **No**	Managing your bowel or bladder
☐ **Yes**	☐ **No**	Getting in or out of a chair or bed	☐ **Yes**	☐ **No**	Walking

5. **In the last 7 years, have you been diagnosed or treated by a licensed Health Care Professional, been prescribed or taken medication for any of the following?**

☐ **Yes**	☐ **No**	Alzheimer's disease or dementia	☐ **Yes**	☐ **No**	Muscular dystrophy
☐ **Yes**	☐ **No**	Recurrent memory loss	☐ **Yes**	☐ **No**	Lou Gehrig's disease (ALS)
☐ **Yes**	☐ **No**	Mild cognitive impairment (MCI)	☐ **Yes**	☐ **No**	Huntington's disease
☐ **Yes**	☐ **No**	Organic brain syndrome	☐ **Yes**	☐ **No**	Hepatitis
☐ **Yes**	☐ **No**	Mental incapacity or retardation	☐ **Yes**	☐ **No**	Cirrhosis
☐ **Yes**	☐ **No**	Multiple sclerosis	☐ **Yes**	☐ **No**	Smoking in conjunction with Emphysema, COPD
☐ **Yes**	☐ **No**	Parkinson's disease			
☐ **Yes**	☐ **No**	Paralysis	☐ **Yes**	☐ **No**	Stroke or Multiple Transient Ischemic Attack (TIA)
☐ **Yes**	☐ **No**	Organ transplant other than cornea or kidney			
☐ **Yes**	☐ **No**	Spinal Stenosis or Chronic Back pain with use of narcotic medication			
☐ **Yes**	☐ **No**	Autoimmune disorder/disease, Systemic Lupus, Systemic Scleroderma, CREST Syndrome, Connective Tissue disease, Mixed Connective Tissue disease (excluding HIV/AIDS/ARC)			

ForeCare Annuity Application – Medical Questionnaire *(continued)*

6. **In the last 12 months have you been diagnosed or treated by a licensed Healthcare Professional, or been prescribed or taken medication for any of the following?**

- ☐ **Yes** ☐ **No** Aneurysm
- ☐ **Yes** ☐ **No** Heart bypass surgery
- ☐ **Yes** ☐ **No** Heart valve replacement
- ☐ **Yes** ☐ **No** Vascular surgery
- ☐ **Yes** ☐ **No** Been hospitalized overnight 2 or more times
- ☐ **Yes** ☐ **No** Any fall resulting in a fracture
- ☐ **Yes** ☐ **No** Seizure or convulsion
- ☐ **Yes** ☐ **No** Multiple falls
- ☐ **Yes** ☐ **No** Tremors
- ☐ **Yes** ☐ **No** Congestive heart failure
- ☐ **Yes** ☐ **No** Cardiomyopathy

7. **In the last 5 years, have you been diagnosed or treated by a licensed Healthcare Professional, or been prescribed or taken medication for any of the following?**

- ☐ **Yes** ☐ **No** Leukemia
- ☐ **Yes** ☐ **No** Hodgkin's disease or other lymphoma
- ☐ **Yes** ☐ **No** Any cancer other than non-melanoma skin cancer?
- ☐ **Yes** ☐ **No** Alcohol or drug abuse or dependency
- ☐ **Yes** ☐ **No** Hospitalization for depression, bi-polar disorder or any other psychiatric disorder
- ☐ **Yes** ☐ **No** Blood clotting deficiency, Factor V, VII, VIII, IX, X,
- ☐ **Yes** ☐ **No** Idiopathic thrombocytopenic purpura (ITP) or essential thrombocythemia
- ☐ **Yes** ☐ **No** Von Willebrand disease
- ☐ **Yes** ☐ **No** Smoking with peripheral vascular disease, diabetes, or renal disease

8. **In the last 7 years, have you been diagnosed or treated by a licensed Healthcare Professional, or been prescribed or taken medication for any of the following?**

- ☐ **Yes** ☐ **No** TIA with a history of heart disease
- ☐ **Yes** ☐ **No** Diabetes currently treated with insulin
- ☐ **Yes** ☐ **No** Rheumatoid arthritis with joint deformity
- ☐ **Yes** ☐ **No** Rheumatoid arthritis with joint replacement
- ☐ **Yes** ☐ **No** Kidney or cornea transplant
- ☐ **Yes** ☐ **No** Myasthenia gravis
- ☐ **Yes** ☐ **No** Rheumatoid arthritis requiring use of narcotic medication
- ☐ **Yes** ☐ **No** Bipolar disorder, schizophrenia or other psychosis
- ☐ **Yes** ☐ **No** Chronic kidney failure
- ☐ **Yes** ☐ **No** Diabetes with a history of TIA, Stroke, Neuropathy, kidney disease, peripheral vascular disease or congestive heart failure

9. **Have you been medically advised by a licensed Healthcare Professional to have any surgery, non-routine diagnostic test or medical evaluation that has not yet been completed?** ☐ **Yes** ☐ **No**

10. **Additional Information *(If any of the above questions are answered "Yes," please list all medications)***

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ForeCare Annuity Application – Medical Questionnaire *(continued)*

Proposed Insured Statement and Representations

I agree that no insurance shall be in effect until: (a) a contract has been issued; and (b) the premium is paid while my insurability as stated in this application remains unchanged.

I agree that the answers set forth on this Application are true and complete to the best of my knowledge and belief. All statements made by me shall be deemed to be representations and not warranties.

I agree that this application will be part of the policy for which I apply and that I will notify the Insurer if any statements or answers given in this Application change prior to delivery of the policy.

I agree that verbal confirmation may be requested for this Application during a telephone interview.

I understand that the decision to issue the annuity contract and Long-Term Care Rider will be based, in part, on my responses obtained during a telephone interview. By signing below, I authorize Forethought Life Insurance Company to call me for a telephone interview. I agree to respond honestly and complete any interview to the best of my ability and understand that final authorization may be requested during the telephone interview.

CAUTION: If your answers on this Application are incorrect or untrue, Forethought Life Insurance Company may have the right to deny benefits or rescind the contract.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature of Proposed Insured	Printed Name of Proposed Insured	Date

Licensed Agent Information

Florida Licensed Agent's Signature	Florida Licensed Agent's Printed Name	Date
Florida License Identification Number	Business Name and Branch Number	

Additional Licensed Agent Information *(if applicable)*

Florida Licensed Agent's Signature	Florida Licensed Agent's Printed Name	Date
Florida License Identification Number	Business Name and Branch Number	

Additional Licensed Agent Information *(if applicable)*

Florida Licensed Agent's Signature	Florida Licensed Agent's Printed Name	Date
Florida License Identification Number	Business Name and Branch Number	

Additional Licensed Agent Information *(if applicable)*

Florida Licensed Agent's Signature	Florida Licensed Agent's Printed Name	Date
Florida License Identification Number	Business Name and Branch Number	

ForeCare Annuity Application – Medical Questionnaire *(continued)*

Telephone Interview Information *(For Ages 70 – 80)*	
Date for Interview:	Location: ☐ Home ☐ Other _____
Time:	Phone Number:
Special Instructions: _____	

Advisor Information			
Printed Name:			
Marketing Organization:			
Address:	City:	State:	Zip:
Email Address:	Phone number to call with results:		

Advisor Information *(if applicable)*			
Printed Name:			
Marketing Organization:			
Address:	City:	State:	Zip:
Email Address:	Phone number to call with results:		

Advisor Information *(if applicable)*			
Printed Name:			
Marketing Organization:			
Address:	City:	State:	Zip:
Email Address:	Phone number to call with results:		

Advisor Information *(if applicable)*			
Printed Name:			
Marketing Organization:			
Address:	City:	State:	Zip:
Email Address:	Phone number to call with results:		

Global Atlantic
FINANCIAL GROUP

HIPAA Authorization
Contracts Issue By:
Forethought Life Insurance Company

In connection with my application for a single premium deferred annuity contract with a long-term care insurance rider ("Long-term Care Insurance Rider"), I authorize Forethought Life Insurance Company (the "Company"), or its affiliates or other persons or entities authorized to obtain such information on the Company's behalf, to obtain protected health information from any licensed physician, medical practitioner, hospital, clinic, the Veteran's administration, laboratory, other medical or medically related facility, any pharmacy, pharmacy benefit manager, the Medical Information Bureau, Inc (MIB) or other insurance companies.

Protected health information includes but is not limited to: hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescription history, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection (unless such information is excluded below in the section on state-specific limitations), sexually transmitted diseases, information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco. This authorization has a dual purpose as a general authorization and an authorization for the release of confidential HIV related information. This authorization does not seek access to psychotherapy notes.

I understand that unless otherwise prohibited by state and/or federal law, the Company seeks such protected health information so that the Company may underwrite my application for a Long-term Care Insurance Rider, making coverage, eligibility, risk rating, policy issuance and enrollment determinations; and conduct other legally permissible activities that relate to such purposes.

I understand that I am under no obligation to sign this form. *If I refuse to sign this authorization, however, my application may be denied.* Protected health information disclosed pursuant to this authorization remains protected under HIPAA privacy rules while in our possession, or in the possession of those acting on our behalf to evaluate your application for insurance coverage. If we are required or permitted by law to disclose the information under the privacy rules, however, your protected health information may be subject to redisclosure that may not be protected by the privacy rules. A photographic copy of this authorization shall be as valid as the original.

This authorization shall be valid for *two years* from the date of my signature unless otherwise specified below and may be revoked by sending written notice to Forethought Life Insurance Company at the address listed above. I am aware that my revocation will not be effective: (a) as to uses and/or disclosures of my health information that the person(s) and/or organization(s) identified above have already made in reliance upon this authorization; or (b) because the authorization was obtained as a condition of obtaining Long-term Care Insurance coverage, if other law provides the Company with the right to contest the contract of coverage or a claim under such contract.

STATE-SPECIFIC LIMITATIONS APPLICABLE TO THIS AUTHORIZATION

FOR RESIDENTS OF THE DISTRICT OF COLUMBIA AND MAINE: This authorization shall be valid for *one year* after the date of my signature.

FOR RESIDENTS OF MAINE: This authorization excludes the disclosure of the result of a test for HIV, which must be the subject of a separate disclosure.

FOR RESIDENTS OF NEW JERSEY: New Jersey residents are aware of the statutory privilege accorded by section 28 of P.L.1966, c. 282 (C.45:14B-28) to confidential communications between a patient and a licensed psychologist.

FOR RESIDENTS OF OKLAHOMA: The information authorized for release may include records that may indicate the presence of a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

FOR RESIDENTS OF WISCONSIN: The reporting of AIDS/HIV test results is limited only to the results of FDA-licensed tests and that the consumer need not report the results of the tests conducted at an anonymous counseling testing site, or home test kit.

Please *sign and keep a copy for your records*. The Company also will provide you a copy upon request.

I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the protected health information described above.

Full Name of Proposed Insured *(please print)*	Date *(mm/dd/yyyy)*
Signature of Proposed Insured	Date of Birth of Proposed Insured *(mm/dd/yyyy)*

This HIPAA Authorization form can be submitted as follows:

U.S. Mail
Forethought Life Insurance Company
P.O. Box 246
Batesville, IN 47006-0246

Private Express Carrier:
Forethought Life Insurance Company
One Forethought Center
Batesville, IN 47006-0246

Via Fax
Requests may be submitted via fax to (855) 206-8731 provided your signature is already on file.

Questions? Please Call: (877) 272-0578

This information is intended to provide educational information about the features and mechanics of the product. It should not be considered, and does not constitute, personalized investment advice. The issuing insurance company is not an investment adviser. It's not acting in any fiduciary capacity with respect to any contract and/or investment.

Who We Are

Welcome to Sarasota Financial Group, Inc.
We are committed to helping people pursue their financial goals with over 40 years of experience in the financial service industry.

SFG Federal is contracted with the Federal Government and pride themselves on a unique, comprehensive and educational approach to financial planning.

We specialize in Long-Term Care (LTC) Insurance solutions. Our product portfolio includes both Standalone and Hybrid Life/LTC Insurance and we represent over 10 different insurance companies.

Our mission is simple - we want to make the process of planning for Long-Term Care easy for you.

For more information, visit:
www.LTCToolbox.com
www.SarasotaFinancial.com

For more information, please contact:

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Bill@LTCToolbox.com
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Long Term Care 4 Veterans
Our Team Serves You, Because You Served U.S.

SCHEDULE YOUR OWN LONG TERM CARE MEETING

SCHEDULE NOW

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CAGE Number: 84R68
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