

# Supplemental Answers for the FLTCIP 2.0 Full Underwriting Application

Complete this form only if you need additional space to answer any of the following questions on your application. For assistance, call **1-800-LTC-FEDS** (1-800-582-3337) TTY 1-800-843-3557.

First Name		M.I.		Last Name
<b>Home phone</b>		<b>Social Security number</b>		<b>Date of birth</b>
				Month    Day    Year
This form is part of the application I signed on				
Signature _____				
Date				
Month    Day    Year				

**Part C, questions 1–5: If the answer to any of questions 1–5 is “Yes,” explain below.**

Name, address, and phone number of treating health professional	Question number	Diagnosis or disorder	Date of onset (mm/yyyy)	Date of last treatment (mm/yyyy)
Name Address Phone				
Name Address Phone				
Name Address Phone				

**Part C, question 6: Medications: List all prescription medications taken over the past six months.**

Name, address, and phone number of treating health professional	Name of medication <small>Check box if taking currently</small>	Dosage <small>(e.g., 10 mg)</small>	Frequency <small>(e.g., 2 x a day)</small>	Reason prescribed
Name Address Phone	<input type="checkbox"/>			
Name Address Phone	<input type="checkbox"/>			
Name Address Phone	<input type="checkbox"/>			
Name Address Phone	<input type="checkbox"/>			

You may use as many additional forms as you need to provide your complete information. Attach completed forms to your application.



**Part D, questions 8–11: If the answer to any of questions 8–11 is “Yes,” explain below.**

Name, address, and phone number of treating health professional	Question number	Diagnosis or disorder	Date of onset (mm/yyyy)	Date of last treatment (mm/yyyy)
_____ Name _____ Address _____ _____ Phone				
_____ Name _____ Address _____ _____ Phone				
_____ Name _____ Address _____ _____ Phone				
_____ Name _____ Address _____ _____ Phone				
_____ Name _____ Address _____ _____ Phone				
_____ Name _____ Address _____ _____ Phone				

