



# Application process: how to prepare for your personal history interview

Thank you for considering Nationwide YourLife CareMatters<sup>SM</sup> for your long-term care and life insurance coverage needs. Now that you've met with your life insurance professional, an interviewer will contact you. He or she will gather information about your personal and medical history, which will be recorded and used to help complete your application.

This worksheet was designed to help you prepare for that interview. Filling it out ahead of time is optional, though it will save you time and hassle to have all the information you need for the interview right at your finger tips.

## Helpful tips about what to expect:

- The phone interview usually takes about 45 minutes, but it can run longer, depending on your specific history
- You may want to choose somewhere private to complete the interview because of the personal nature of the information being discussed
- The interviewer will be asking you very specific questions, especially about your medical and prescription history, including details about your occupation, hobbies, sports, travels, citizenship/immigration status, Social Security number verification, social history (alcohol/tobacco use) and daily living activities
- Nationwide<sup>®</sup> will need to verify your prescription information, so please be sure to supply the most accurate information available; once the phone interview is completed, you'll be asked to give a voice signature to confirm the accuracy of all the information you've provided
- A cognitive assessment may also be included; although such an assessment is routine for age 55 and older, it could be requested at any age, depending on our findings — no preparation is needed ahead of time, though you can expect the interview to last 15 to 20 minutes longer

### Social Security number

### Driver's license number

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### Physician details

Name	Phone number	Address

## Medications

Please be prepared to provide and discuss details of all prescription medications that you're currently taking, as well as those you've been prescribed, have taken or been give in the past 3 years. Also, list any **over-the-counter medications, aspirin or supplements** you've taken for two or more weeks at a time within the last 12 months.

Medication name	Dosage	When started	Currently taking	Reason for taking	Physician
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		

## Daily living activities

Have you needed assistance or supervision while performing any of the following activities in the last 24 months? (Check all that apply):

<input type="checkbox"/> Bathing	<input type="checkbox"/> Meal preparation	<input type="checkbox"/> Toileting
<input type="checkbox"/> Bowel or bladder control	<input type="checkbox"/> Managing your finances	<input type="checkbox"/> Use of transportation
<input type="checkbox"/> Cleaning	<input type="checkbox"/> Moving in or out of a chair or bed	<input type="checkbox"/> Telephone use
<input type="checkbox"/> Dressing	<input type="checkbox"/> Shopping	<input type="checkbox"/> Walking
<input type="checkbox"/> Eating	<input type="checkbox"/> Taking or managing your medications	

## What recreational activities, volunteer work or exercise regimens do you participate in?

Provide details of potentially hazardous activities for discussion.

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## Social history

Have you used tobacco or nicotine products — such as cigarettes, cigars, electronic cigarettes, pipe, smokeless tobacco, snuff, other tobacco products, nicotine products (gum, patch, etc.) — in any form?

In the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	In the last 36 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If “yes”, please specify the type:

<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Cigars	<input type="checkbox"/> Electronic cigarettes	<input type="checkbox"/> Pipe	<input type="checkbox"/> Smokeless tobacco	<input type="checkbox"/> Snuff	<input type="checkbox"/> Other tobacco products
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Amount and frequency: last 12 months: \_\_\_\_\_ last 36 months: \_\_\_\_\_

Date tobacco or nicotine product last used: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (mm/dd/year)

Social history (continued)

Do you consume alcoholic beverages?   ☐ Yes   ☐ No

If “yes,” please specify the type, amount and frequency: \_\_\_\_\_

Date alcohol last used: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/year)

Medical history

Please list all medical conditions (past and current) for which you've been diagnosed. And keep in mind that the interviewer may have additional questions based on the information you provide.

Condition	Date of diagnosis	Symptoms	Tests done — including results	Type and date of treatment	Name, address and phone number of the physician, hospital and/or treatment facility

If you have or have had any of the following conditions, please be prepared to provide the following information:

Cancer	Diagnosis/date of diagnosis _____  Type, location, stage of cancer or any lymph node involvement or metastasis _____  Treatment (including date of last treatment) and any residuals/side effects _____ _____  Outcome _____
Diabetes	Type _____  Have you had any of the following conditions related to diabetes? <input type="checkbox"/> Eye problems or retinopathy <input type="checkbox"/> Foot sores or ulcers <input type="checkbox"/> Amputations <input type="checkbox"/> Kidney problems or nephropathy <input type="checkbox"/> Neuropathy  Do you check your blood sugar levels? <input type="checkbox"/> Yes <input type="checkbox"/> No  Date last checked ____/____/____ (mm/dd/year)   Average reading _____  Have you had a hemoglobin A1C test (HgA1C)? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, date of last test ____/____/____ (mm/dd/year)   Results _____

Medical history (continued)

Heart disease/ heart attack	<p>Date of last occurrence ____/____/____ (mm/dd/year)</p> <p>Have you had any procedures or surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes):</p> <p>Type (bypass — include how many vessels, angioplasty, stent placement, etc.) _____</p> <p>Date completed ____/____/____ (mm/dd/year)</p> <p>Facility/physician name, city and state: _____</p> <p>If you have had more than one instance, please be prepared with the details of that as well</p>
High blood pressure	<p>How often is your blood pressure taken? _____</p> <p>Who takes your blood pressure readings? _____</p> <p>Results/readings:</p> <p>Date of last blood pressure reading ____/____/____ (mm/dd/year)</p> <p>Results of the last blood pressure reading _____</p> <p>Average readings _____</p>

Application history

Please list all life, long-term care or disability insurance applications for which you have been declined, postponed, rated, etc.

Product type	Date applied for	Outcome	Reason for outcome	Company

YOU'RE ALL SET

Now that you know what information is needed, you're ready for your interview. Thank you, again, for considering Nationwide YourLife CareMatters. And if you have any additional questions about our product or the interview, please feel free to contact your insurance professional.

The insurance professional or company may contact you in response to your request for additional information.

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Nationwide YourLife CareMatters may not be available in every state. Please contact Nationwide to determine product availability in your state.

Life insurance is issued by Nationwide Life and Annuity Insurance Company, Columbus, Ohio.

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