

**REFERENCES: PLEASE LIST TWO CARE GIVING REFERENCES - NOT RELATED TO YOU
 IF YOU HAVE NOT BEEN A CAREGIVER PROVIDE WORK REFERENCES**

Full Name	Relationship
Company or Client	Phone

Address

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Address

CURRENT POLICY HOLDER SERVICES

Extent of Care You are Providing	ADL	Describe your experience providing these services
Bathing		
Bowel Management		
Bladder Management		
Continence Care		
Dressing		
Feeding		
Toileting		
Transferring		
Medication Management		
Other		

Average Number of Hours worked a day	Average Number of days worked a week
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If you are no longer able to provide the kind of care needed will you seek assistance from a licensed Health Care Provider?
 Yes No
 If so, when? _____

I certify that I do not live with the insured and am therefore eligible as a caregiver to be approved under the "Care by Family Member" benefit.

DISCLAIMER AND SIGNATURE

I Certify that my answers are true and complete to the best of my knowledge.

Signature _____ Date _____