Long Term Care Quote Request

Date: ____________

Agent: ____________________________________Company: ____

Address: ____________________________City/State/Zip: ____

Phone: _______________________Fax:____________________Email:_______________________________

Proposal should be: Faxed____________________ or emailed ______________________________________

LTC Carriers you represent? ____

Prospect Information:

Name:____ DOB:___________________

State of Residence: _________________ Single Married Living together 3 yrs or more

Tobacco in the last 6 mos? Yes No Gender: Male Female Hgt/Wgt ________________

Spouse Name: ____ DOB:___________________

Tobacco in the last 6 mos? Yes No Gender: Male Female Hgt/Wgt ________________

(If quoting one person, ask if there is a spouse. Even though they are not applying, this would qualify the person quoted for a discount.)

Health Conditions/Hospitalizations/Surgeries:

High Blood pressure | Arthritis (list type)

Cancer Treatment | Diabetes

Mental/Nervous Treatment | Heart/Circulatory

Other, Please Specify ____

Details for any of the above: ____

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List of Medications for each with dosage (if known):

____________________________________ ____

____________________________________ ____

____________________________________ ____

Coverage:

Daily or Monthly Benefit: ______________ Elim Period: ____________ Benefit Period: __________________

COLA: Compound / Simple ____________________________ Share Care: _________________________

Waiver of Home Health Care Elim. Period: ____________________________

Premium amount allocated for Long Term Care policy _________________________