

Long Term Care Quote Request

Fill in the form below to receive an LTC Product Quote:

Fields marked with * are required

Long Term Care Quote Request Form

* Broker Name: _____

* Address: _____

* City: _____

* State: * Zip: _____

Phone #: Fax #: _____

Return Method: E-mail

Fax

Mail

Insurance Company Preference if any: _____

Plan: _____

State: _____

Client:

* Name: _____

* Birthdate: _____

* Sex: Male Female

Rate Class : Preferred Standard

Daily Benefit Amount: _____

Home Care: 50% 75% 100%

Benefit Period: 2 year 4 year Lifetime Other:

Elimination Period (days): 0 30 90 Other:

Inflation: Simple Compound COLI

Spouse:

Name: _____

Birthdate: _____

Sex: Male Female

Rate Class: Preferred Standard

Duplicate Benefits From Above?: Yes No

If No, please complete the following:

Daily Benefit Amount: _____

Home Care: 50% 75% 100%

Benefit Period : 2 year 4 year Lifetime Other:

Elimination Period (days) : 0 30 90 Other:

Inflation: Simple Compound COLI

Pre-Underwriting:

Please list any additional comments, as well as any significant health conditions, associated medications AND/OR hospitalizations in the last 5 years.