Long-Term-Care Quote Request

Agent Name:

Name: _____

Client Information:

Name: _____ (Single / Married) DOB: _____

Resident State: _____ Height: _____ Tobacco Use: Y / N

Sex: _____ Weight: _____ Rick Class: Preferred / Standard / Rated

Medical Conditions: _____

_____

Medications (Name, Dosage): _____

_____

Spouse Information:

Name: _____ (Single / Married) DOB: _____

Resident State: _____ Height: _____ Tobacco Use: Y / N

Sex: _____ Weight: _____ Rick Class: Preferred / Standard / Rated

Medical Conditions: _____

_____

Medications (Name, Dosage): _____

_____

Policy Information:

Benefit Amount: _____ (Daily / Monthly)

Elimination Period - days: 30 / 60 / 90 / 180 / 365

Benefit Period - years: 2 / 3 / 4 / 5 / 6 / 7 / 8 / 10 / Lifetime

Inflation: None / Simple / Compound / 3% / 5%

Home Care Amount: _____ 50% / 75% / 100%

Additional Options/Riders: _____

Comments: _____

_____

_____

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