QUOTE REQUEST FORM

LONG TERM CARE

Producer & client info:

Producer Name: ___________________________________ Phone: __________________ Date _________

Client Name: ___________________________________ Date of Birth: __________________ Gender: _________

Smoker? ☐ Y ☐ N

If married, will the client's spouse also be applying? If yes, complete spouse information portion

Client Name: ___________________________________ Date of Birth: __________________ Gender: _________

Smoker? ☐ Y ☐ N

Policy Options

Policy type:

☐ Individual policy ☐ Shared Policy

Benefit type:

☐ Monthly ☐ Daily

Desired benefit amount: _____________________________ Desired benefit duration: ____________________________________

Elimination period (days): _____________________________

Premium funding/lump sum: _____________________________

Inflation protection option:

☐ Simple interest ☐ Compounding interest (specify): _______%

Notes and/or additional specifications:

In the space below, please list all medical conditions and the date of diagnosis:

In the space below, please list all medications, dosages and what they're prescribed for: