Request for Long Term Care Insurance Proposal

Agent Information:

Name: ________________________________ City: ______________________ ST: ______ Zip: _________

Telephone: ____________________ Fax Number: ____________________ Email: _____________________

Client Information: State of Residence: _________ Tobacco Use: _____ Type: _________________

Name: ____________________________ DOB: _______________ Height: __________ Weight: __________

Health Issues: ____

Treatment & Medications: ____

Married or Partner: ▪ No ▪ Yes

If Partner, have cohabitated how many years? _________________

Spouse or Partner Applying: ▪ No ▪ Yes If yes, please complete Spouse or Partner Information section

Spouse or Partner Information: Tobacco Use: _______ Type: ___________

Name: ____________________________ DOB: _______________ Height: __________ Weight: __________

Health Issues: ____

Treatment & Medications: ____

Plan Design:

Benefit Amount (Daily or Monthly): $____________

Elimination Period (Days): ▪ 30* ▪ 60* ▪ 90 ▪ 180 ▪ 365

* Not available ages 80 through 84

Benefit Period (Years): ▪ 2 ▪ 3 ▪ 4* ▪ 5* ▪ 6* ▪ 10*

* Not available ages 80 through 84

Inflation Protection: ▪ CPI ▪ Compound ____% ▪ Simple ____% ▪ None/Carrier Default

Shared Benefit: ▪ YES ▪ NO

Riders:
▪ ▪ Restoration of Benefits
▪ Waiver of Home Care Elimination Period
▪ Survivorship
▪ ▪ Return of Premium
▪ Additional Cash Benefit
▪ ▪ Nonforfeiture
▪ ▪ Other: ____