Long-Term Care Quote Request

***Agent's Name*:** _______________________________ State: ______ Date: __________
(must be writing agent's name)

Agent Phone: ________________ Fax: _______________Email: ____________________

Applicant Info: **Tobacco Use less than 5 years?**

State of residence: _____

Applicant 1: ____ Last use ______
Male or Female DOB Height & Weight

Applicant 2: ____ Last use ______
Male or Female DOB Height & Weight

Please circle one: Married, Single, or Cohabitating, if so how long? Describe relationship: __________

Medical/Health Notes

Applicant #	Condition	Date of Diagnosis	Medication & Dosage	Comments

Coverage Info:* *(circle your choices below)

Benefit Amount: $_____________ *Daily or Monthly*

Benefit Period: 2yr 3yr 4yr 5yr 6yr 10yr

Home Health Care (can be less than 100% of the benefit amount): 100% 75% 50%

Inflation Protection (COLA): 3 or 5% Compound 5% Simple None Other: __________

Elimination Period: 0 day 30 day 60 day 90 day 180 day 365 day

Optional Riders: *Shared Care Rider* *Return of Premiu*m Other: _________________

Premium Mode/Billings: Annual Semi Annual Quarterly Monthly EFT

***Company preference or other info that will help us prepare your quote*.**

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Fax to: 414-427-8330, or Call Mike, John, or Debbie at 1-800-657-0736.