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Agent: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Fax: \_\_\_\_\_ Date: \_\_\_\_\_  
 Affiliation: \_\_\_\_\_

**INFORMATION FOR DISABILITY QUOTE:**

Client Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Male / Female \_\_\_\_\_  
 State of Issue \_\_\_\_\_  
 Tobacco / Non-Tobacco \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Job Activities \_\_\_\_\_

Self Employed? \_\_\_\_\_  
 Number of Employees \_\_\_\_\_  
 Office in Home? \_\_\_\_\_  
 Annual Income \$ \_\_\_\_\_  
 Who will Pay Premium? \_\_\_\_\_  
 Type of Coverage \_\_\_\_\_

Existing Individual Coverage \$ \_\_\_\_\_  
 Existing Group Coverage \$ \_\_\_\_\_  
 Monthly Benefit Wanted \$ \_\_\_\_\_  
 Benefit Period \_\_\_\_\_  
 Elimination Period \_\_\_\_\_

**Options:** COLA \_\_\_\_\_  
 Non-cancelable \_\_\_\_\_  
 Own Occupation \_\_\_\_\_  
 Return of Premium \_\_\_\_\_  
 Residual Disability \_\_\_\_\_  
 Future Purchase Option \_\_\_\_\_  
 LTC-Guaranteed Purchase \_\_\_\_\_  
 Lifetime Benefit Period \_\_\_\_\_

**Other Comments** \_\_\_\_\_

**FOR AGENT USE ONLY**

**INFORMATION FOR LTC QUOTE:**

**Client #1 Name** \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Male / Female \_\_\_\_\_  
 Marital Status \_\_\_\_\_  
 Existing LTC Coverage \$ \_\_\_\_\_  
 State of Issue \_\_\_\_\_  
 Tobacco / Non-Tobacco \_\_\_\_\_  
 Health Issues / RX \_\_\_\_\_

Monthly / Daily Benefit Wanted \$ \_\_\_\_\_  
 Home Health Care Percentage \_\_\_\_\_  
 Benefit Period \_\_\_\_\_  
 Elimination Period \_\_\_\_\_  
 Inflation, Zero HHC EP, \_\_\_\_\_  
 ROP, Shared Care, etc. \_\_\_\_\_

**Client #2 Name** \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Male / Female \_\_\_\_\_  
 Marital Status \_\_\_\_\_  
 Existing LTC Coverage \$ \_\_\_\_\_  
 State of Issue \_\_\_\_\_  
 Tobacco / Non-Tobacco \_\_\_\_\_  
 Health Issues / RX \_\_\_\_\_

Monthly / Daily Benefit Wanted \$ \_\_\_\_\_  
 Home Health Care Percentage \_\_\_\_\_  
 Benefit Period \_\_\_\_\_  
 Elimination Period \_\_\_\_\_  
 Inflation, Zero HHC EP, \_\_\_\_\_  
 ROP, Shared Care, etc. \_\_\_\_\_