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Request for LTCI Recommendation

AGENT INFORMATION

Agent Name: _____ Number & Street: _____ City & State: _____
 Affiliation: _____ Phone: _____ Fax: _____ Email: _____ Website: _____

CLIENT

Name: _____ Male Female
 State where Policy will be Written: _____
 Date of Birth: _____ Height: _____ Weight: _____
 Has client used tobacco in the past 5 years? Yes No
 Has client ever been turned down for LTCi? Yes No

SPOUSE/PARTNER (if also seeking coverage)

Name: _____ Male Female
 State where Policy will be Written: _____
 Date of Birth: _____ Height: _____ Weight: _____
 Has client used tobacco in the past 5 years? Yes No
 Has client ever been turned down for LTCi? Yes No

Hospitalized in the past 5 yrs? If yes, list conditions and dates below.

Client: _____

Spouse/Partner: _____

Please list all prior and current medical conditions, dates of onset and dates of recovery.

Client: _____

Spouse/Partner: _____

Please list prior and current medications, why taken, dosages and the dates you started taking them.

Client: _____

Spouse/Partner: _____

Do you need help or supervision with bathing, toileting, dressing, housekeeping, preparing meals, eating, managing medications or moving about? If yes, give details below.

Client: _____

Spouse/Partner: _____

PROPOSAL INFORMATION

CLIENT

Coverage: Facilities & Home Care Facilities Only Home Only
 If both, Home Care at: 50% 75% or 100% of Facilities Care
 Type of Plan: Tax Qualified Non-Tax Qualified
 Elimination Period: 0 days 30 days 90 days Other: _____
 Benefit Period: 3yrs 5yrs Lifetime Other: _____
 Maximum Daily Benefit Amount: \$ _____
 Benefit Type: Reimbursement Indemnity Cash Payment
 Premium Payments: lifetime 10yrs to age 65 Other: _____
 Riders: Simple Inflation Compound Inflation Shared Benefits
 Guaranteed Purchase Home Care Elimination Period Waiver
 Return of Premium Survivorship Restoration of Benefits

SPOUSE/PARTNER (if also seeking coverage)

Coverage: Facilities & Home Care Facilities Only Home Only
 If both, Home Care at: 50% 75% or 100% of Facilities Care
 Type of Plan: Tax Qualified Non-Tax Qualified
 Elimination Period: 0 days 30 days 90 days Other: _____
 Benefit Period: 3yrs 5yrs Lifetime Other: _____
 Maximum Daily Benefit Amount: \$ _____
 Benefit Type: Reimbursement Indemnity Cash Payment
 Premium Payments: lifetime 10yrs to age 65 Other: _____
 Riders: Simple Inflation Compound Inflation Shared Benefits
 Guaranteed Purchase Home Care Elimination Period Waiver
 Return of Premium Survivorship Restoration of Benefits