

# Long-Term Care Quote Request Sheet

Agent Name: \_\_\_\_\_

Agent Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

<b>Client Name:</b> _____	<b>Spouse:</b> _____
D/O/B _____ Ht. _____ Wt. _____	D/O/B _____ Ht. _____ Wt. _____
Smoker _____ Marital Status _____	Smoker _____ Marital Status _____

**Any Medical History of:**

- Insulin dep. Diabetes  Stroke/TIA  Memory Loss
- Osteoporosis  Parkinson's  Alzheimer's  Sleep Apnea

**Client Medical History Last 10 yrs:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Prescriptions / Dosage / Freq. / Onset:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any RX Changes in Last 12 Months? Yes  No

**Any Medical History of:**

- Insulin dep. Diabetes  Stroke/TIA  Memory Loss
- Osteoporosis  Parkinson's  Alzheimer's  Sleep Apnea

**Spouse/Partner Medical History last 10 yrs:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Prescriptions / Dosage / Freq. / Onset:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any RX Changes in Last 12 Months? Yes  No

**Traditional Long-Term Care Insurance:**  Allianz  Genworth  Great American  John Hancock  
 MetLife  Med America  Mutual of Omaha  Prudential

**Proposal Benefits:**

Tax Qualified or Non-Qualified \_\_\_\_\_

Daily Nursing Home Benefit \_\_\_\_\_

Elimination Period \_\_\_\_\_  Calendar days  
 Service Days

Benefit Period \_\_\_\_\_

**Limited**

Pay Options:  Single Pay  5-Pay  10-Ppay  20-Pay  Paid at 65  Reduced at 65  Other

Daily Home Health Care Benefit \_\_\_\_\_

Inflation Protection \_\_\_\_\_

Couples Shared Benefits \_\_\_\_\_

Return of Premium \_\_\_\_\_

Nonforfeiture \_\_\_\_\_

**Method of Delivery:**

- E-Mail  Fax  Mail

E-mail Address: \_\_\_\_\_

Notes:

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_