

Long Term Care Quote Request Sheet

Agent _____ State of Sale _____
Email or fax _____

Please complete and return to our office

Client Profile:

Client name _____ DOB _____

Single _____ Partner/Spouse applying _____ Partner/Spouse NOT applying _____

Smoker any cigarettes in the last 12 months? _____ Other tobacco use? _____
Receiving disability benefits of any kind? _____ Current height/weight: _____
Previously declined for LCT coverage? _____ If so when/what for: _____

_____ If High blood pressure or diabetes, average reading (blood sugar for diabetes)? _____

All Prescription medicines taken in the last 12 months, and what taken for: _____

Health condition diagnosed or treated for during your lifetime? How long have they had these conditions?

_____ Still under treatment for any health conditions? _____ Please list: _____

_____ 2nd Insured Name _____ DOB _____

Smoker any cigarettes in the last 12 months? _____ Other tobacco use? _____
Receiving disability benefits of any kind? _____ Current height/weight: _____
Previously declined for LCT coverage? _____ If so when/what for: _____

_____ If High blood pressure or diabetes, average reading (blood sugar for diabetes)? _____

All Prescription medicines taken in the last 12 months, and what taken for: _____

Health condition diagnosed or treated for during your lifetime? How long have they had these conditions?

_____ Still under treatment for any health conditions? _____ Please list: _____

Benefits to be Quoted:

Daily Facility benefit: _____ Daily home care benefit/percentage: _____

Benefit period: _____ Elimination period: _____

Inflation rider-type: _____ Other riders: _____

Paid up option: _____ Endorsed group discount: _____

Pay mode: Annual _____ Semi-Annual _____ Quarterly _____ Monthly _____

Client signature: _____

2nd Insured signature: _____

