

Long Term Care Quote Request Form

Agent Information		
Name		
Phone		
Email		
Client Information	Proposed Insured	Secondary Insured
State of Residence		
DOB/Age		
Married Y or N Height/Weight		
Tobacco Usage Y or N		
Health Issues (Surgeries/hospitalizations/chronic conditions...)		
Daily Meds (Prescriptions/dosages/diagnosis)		
Per Day/Month Amount		
Benefit Duration		
Home Health Care %		
Elimination Period		
Inflation Protection None, Simple, Compound		
Preferred Carriers		
Other Options (Lifepay/10 pay/Return of premium/ Shared Care/Restoration of Benefits/Indemnity...)		

Disclaimer:

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