LONG TERM CARE INSURANCE PROPOSAL REQUEST

DATE:______________________________ ADVISOR NAME: ____

PHONE:_______________________________ FAX:________________________________ EMAIL:_________________________________

ADDRESS:____ CITY:_________________________________ STATE:_____ ZIP:___________

RETURN PROPOSAL BY: ☐ EMAIL ☐ FAX ☐ MAIL ☐ AGENT PICK UP NEEDED BY:____/____/____

INCLUDE SALES MATERIAL (IF AVAILABLE) ☐ YES ☐ NO

RESET FORM

CLIENT INFORMATION:

CLIENT 1

NAME:____

TOBACCO STATUS:_____________________________________

DATE OF BIRTH:_____/_____/_____

HEALTH CONDITIONS:________________________________

____

____

PRESCRIPTION DRUGS:_______________________________

____

____

CLIENT 2 (SPOUSE, DOMESTIC PARTNER)

NAME: ____

TOBACCO STATUS:_____________________________________

DATE OF BIRTH:_____/_____/_____

HEALTH CONDITIONS:________________________________

____

____

PRESCRIPTION DRUGS:_______________________________

____

____

STATE OF SALE:____________________________________

☐ MARRIED ☐ DOMESTIC PARTNER ☐ SINGLE

IS OTHER APPLYING? ☐ YES ☐ NO WHY NOT?____

POLICY INFORMATION:

BENEFIT: $__________/DA Y OR $__________/MONTH HOME HEALTH CARE: ☐ 100% OR ____________%

BENEFIT PERIOD (YEARS): ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ OTHER:_______ OR ☐ MAX

ELIMINATION PERIOD (DAYS): ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365

INFLATION PROTECTION:

☐ NONE ☐ 5% SIMPLE ☐ 3% COMPOUND ☐ 5% COMPOUND ☐ OTHER:__________________________

OPTIONAL RIDERS:

☐ WAIVER OF HHC E.P. ☐ SHARED CARE ☐ RESTORATION OF BENEFITS ☐ NON-FORFEITURE

☐ RETURN OF PREMIUM

OPTIONAL: CARRIER(S) DESIRED:

☐ GENWORTH ☐ MUTUAL OF OMAHA ☐ TRANSAMERICA ☐ JOHN HANCOCK

COMMENTS/ADDITIONAL MEDICAL INFO:____

____

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