Long-Term Care Proposal Request Form

Agent Name: ______________________

Email Address: ______________________ Phone Number: ______________________

Client Name: ______________________ Gender: ____ DOB: ________ Married __ Single __

Issue State: ________ Rate Class: ☐ Preferred ☐ Standard ☐ Substandard Daily Monthly/Benefit Amount: ________

Home Health Care: ☐ 50% ☐ 75% ☐ 100%

Benefit Period: ☐ 2 Yr ☐ 3 Yr ☐ 4 Yr ☐ 5 Yr ☐ 6 Yr

Elimination Period: ☐ 0 days ☐ 30 days ☐ 90 days ☐ Other

Inflation: ☐ 3% Compound ☐ 5% Compound ☐ GPO/None

Spouse Name: ______________________ Gender: ____ DOB: ________

Issue State: ________ Rate Class: ☐ Preferred ☐ Standard ☐ Substandard

Duplicate benefits from applicant? ☐ Yes ☐ No Shared Care Benefit: ☐ Yes ☐ No

Home Health Care: ☐ 50% ☐ 75% ☐ 100%

Benefit Period: ☐ 2 Yr ☐ 3 Yr ☐ 4 Yr ☐ 5 Yr ☐ 6 Yr

Elimination Period: ☐ 0 days ☐ 30 days ☐ 90 days ☐ Other

Inflation: ☐ 3% Compound ☐ 5% Compound ☐ GPO/None

Additional Medical Information: significant health conditions, associated medications and/or hospitalizations in the past 5 years. ______________________

Additional Comments: ______________________

Fax this request to 781.449.7694
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