Long-Term Care Proposal Request Form

Agent's Name: ____________________________________ Phone Number: ______________________________

Email Address: ____________________________________ Fax Number: ________________________________

Client's Name: _______________________________ ☐ M ☐ F DOB: __________ Marital Status: _________

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

Home Health Care: ☐ 50% ☐ 75% ☐ 100%

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

Elimination Period: ☐ 0 Days ☐ 30 Days ☐ 90 Days ☐ Other ___________________________

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

Spouse's Name: _______________________________ ☐ M ☐ F 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 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years ☐ 6 Years

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: ____

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Additional Comments: ____

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Please fax to 781.449.7694 Attn: Long-Term Care Specialist

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