# LTC Quote Request Form

Not an application for insurance. This form is used exclusively to gather specific information on
a proposed insured's medical history and other factors that may impact underwriting and rating classifications.

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Advisor Name: ____________________

Phone: (____) ____________________ Fax: (____) ____________________

Email: ____________________

Proposed Insured's Name: ____________________

Date of Birth or Age: __________ ❑ Male ❑ Female Tobacco? ❑ Yes ❑ No State: __________

Known health conditions: ____________________

**Please remember to include an LTC Prescreening Questionnaire.**

Married? ❑ Yes ❑ No

Spouse Insured's Name: ____________________

Date of Birth or Age: __________ ❑ Male ❑ Female Tobacco? ❑ Yes ❑ No State: __________

Known health conditions: ____________________

**Please remember to include an LTC Prescreening Questionnaire.**

Premium Tolerance: __________/year Investable Assets: __________

Please check: ❑ Daily ($50–$400) / ❑ Monthly ($1,500–$12,000): $__________

Benefit Period (2, 3, 4, 5 or 6 years): ____________________

Benefit Increase Rider: ❑ Yes ❑ No If yes, ❑ compound ❑ 3% ❑ 5%

Elimination Period: ❑ 20 days ❑ 30 days ❑ 90 days ❑ 100 days ❑ 180 days ❑ 365 days

Riders: Please check if you would like this rider included at an additional cost.

❑ Nonforfeiture ❑ Waiver of Home Care Elimination Period ❑ Survivorship

❑ Shared Care ❑ Return of Premium (*Riders vary with each carrier)

❑ Other Information: ____________________

*Not all are available with each product we offer. We will quote as close to the option you select based on the availability of the product.*

# LTC Prescreening Questionnaire

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Client/Applicant A: ______________________________

DOB: ______________ Height: _____ft. _____in. Weight: _______lbs Smoker? ❑ Yes ❑ No

Client/Applicant B: ______________________________

DOB: ______________ Height: _____ft. _____in. Weight: _______lbs Smoker? ❑ Yes ❑ No

Is there is a history of any of the following conditions for either of the persons named above:

| Client A YES | Client A NO | Client B YES | Client B NO | Question |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | ❑ | 1. Abnormal Blood Pressure |
| ❑ | ❑ | ❑ | ❑ | 2. AIDS/ARC |
| ❑ | ❑ | ❑ | ❑ | 3. Alcohol Abuse |
| ❑ | ❑ | ❑ | ❑ | 4. ALS |
| ❑ | ❑ | ❑ | ❑ | 5. Alzheimer's Disease |
| ❑ | ❑ | ❑ | ❑ | 6. Amputation |
| ❑ | ❑ | ❑ | ❑ | 7. Anemia |
| ❑ | ❑ | ❑ | ❑ | 8. Aneurysm |
| ❑ | ❑ | ❑ | ❑ | 9. Arthritis |
| ❑ | ❑ | ❑ | ❑ | 10. Asthma |
| ❑ | ❑ | ❑ | ❑ | 11. Atrial Fibrillation |
| ❑ | ❑ | ❑ | ❑ | 12. Bipolar/Manic Depression |
| ❑ | ❑ | ❑ | ❑ | 13. Cancer* (see below) |
| ❑ | ❑ | ❑ | ❑ | 14. Cardiomyopathy |
| ❑ | ❑ | ❑ | ❑ | 15. Carotid Artery Disease |
| ❑ | ❑ | ❑ | ❑ | 16. Cerebral Vascular Disease |
| ❑ | ❑ | ❑ | ❑ | 17. Congestive Heart Failure |
| ❑ | ❑ | ❑ | ❑ | 18. COPD / Emphysema |
| ❑ | ❑ | ❑ | ❑ | 19. Coronary Artery Disease |
| ❑ | ❑ | ❑ | ❑ | 20. Crohns Disease |
| ❑ | ❑ | ❑ | ❑ | 21. Dementia |
| ❑ | ❑ | ❑ | ❑ | 22. Depression/Anxiety |
| ❑ | ❑ | ❑ | ❑ | 23. Diabetes |
| ❑ | ❑ | ❑ | ❑ | 24. Dizziness/Vertigo |
| ❑ | ❑ | ❑ | ❑ | 25. Drug Abuse |
| ❑ | ❑ | ❑ | ❑ | 26. Eye Disease |
| ❑ | ❑ | ❑ | ❑ | 27. Heart Attack |
| ❑ | ❑ | ❑ | ❑ | 28. Hepatitis |
| ❑ | ❑ | ❑ | ❑ | 29. Hodgkins Disease |
| ❑ | ❑ | ❑ | ❑ | 30. Joint Replacement |
| ❑ | ❑ | ❑ | ❑ | 31. Kidney Failure |
| ❑ | ❑ | ❑ | ❑ | 32. Leukemia |
| ❑ | ❑ | ❑ | ❑ | 33. Lupus |
| ❑ | ❑ | ❑ | ❑ | 34. Lymphoma |
| ❑ | ❑ | ❑ | ❑ | 35. Memory Loss |
| ❑ | ❑ | ❑ | ❑ | 36. Multiple Sclerosis |
| ❑ | ❑ | ❑ | ❑ | 37. Muscular Dystrophy |
| ❑ | ❑ | ❑ | ❑ | 38. Myasthenia Gravis |
| ❑ | ❑ | ❑ | ❑ | 39. Neurogenic Bladder |
| ❑ | ❑ | ❑ | ❑ | 40. Neuropathy |
| ❑ | ❑ | ❑ | ❑ | 41. Organ Transplant |
| ❑ | ❑ | ❑ | ❑ | 42. Organic Brain Syndrome |
| ❑ | ❑ | ❑ | ❑ | 43. Osteoporosis |
| ❑ | ❑ | ❑ | ❑ | 44. Paralysis |
| ❑ | ❑ | ❑ | ❑ | 45. Parkinson's Disease |
| ❑ | ❑ | ❑ | ❑ | 46. Peripheral Vascular Disease |
| ❑ | ❑ | ❑ | ❑ | 47. Rheumatoid Arthritis |
| ❑ | ❑ | ❑ | ❑ | 48. Scleroderma |
| ❑ | ❑ | ❑ | ❑ | 49. Seizures |
| ❑ | ❑ | ❑ | ❑ | 50. Stroke or TIA |
| ❑ | ❑ | ❑ | ❑ | 51. Tremor |

**Provide name and dosage of ALL medications being taken and the condition being treated** *(refence question number if applicable)*

**Details for Applicant A**
Question #

| Question # | Details |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Details for Applicant B**
Question #

| Question # | Details |
|---|---|
| | |
| | |
| | |
| | |
| | |

Any others? If so, please describe: ______________________________

Are you currently using oxygen, a wheelchair, crutches or a cane? ______________________________

Are you currently on disability? ______________________________

Have you been declined for LTC insurance in the past 12 months? If so, reason? ______________________________

Do you have a surgery scheduled in the next six (6) months? ______________________________

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Advisor Name: ______________________________

Phone: (_______) ______________________ E-mail: ______________________

*Be sure to include this form with an LTC Quote request.*

*For cancer, please include type, stage/grade, any recurrence or lymphnode involvement, date of last treatment.