

LONG TERM CARE PROPOSAL REQUEST

Agent Name:		Date:
Company:		Email:
Address:		Phone:
City/State:	Zip:	Fax:

PROPOSED INSURED INFORMATION

Client Name:	DOB: _____	Non-Smoker: How Long: _____
	M / F	Smoker: Cigarettes / Cigar / Pipe / Chew Preferred + / Pref / Std / Substd
Client Name:	DOB: _____	Non-Smoker: How Long: _____
	M / F	Smoker: Cigarettes / Cigar / Pipe / Chew Preferred + / Pref / Std / Substd

INDIVIDUAL PLAN OPTIONS

Plan Name:	TQ / NTQ	Spousal Discount:	Y / N	Group Discount:	Y / N	Partnership:	Y / N
Health Concerns:							
Elimination Period(s): 0 20 30 45 (ML) 60 90 100 (ML) 180 365							
Benefit Period(s): 1 yr 2yrs 3yrs 4yrs 5yrs 6yrs 7yrs (ML) 10yrs Lifetime							
Daily Benefit Amount(s): \$ _____ \$ _____ \$ _____							
Home Health Care: 50% 70% 75% 100% 150% None							
Inflation Rider: Simple Compound None							
Survivorship Benefit: Y / N		Shared Benefit Rider: Y / N		Shared Wavier of Premium Benefit: Y / N			
Restoration Benefit: Y / N		Nonforfeiture Benefit: Y / N		Indemnity Rider: Y / N			