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LTCI Request Form

Broker Name: _____ Broker Phone: _____

Broker Address: _____

Client: _____ Date of Birth: _____ Smoker? Y N

Preferred () or Standard ()

Married? Y N Both Applying? Y N

Spouse: _____ Date of Birth: _____ Smoker? Y N

Preferred or Standard

Nursing Facility Benefit: _____ Home & Community Benefit: _____

Elimination Period (Days): 30 60 90 180 365 730

0 Day Home Care EP Calendar Day EP

Benefit Duration (Years): 1 2 3 4 5 6 7 Shared Lifetime

OPTIONS: (Circle)

Structure: Partnership Reimbursement Indemnity Cash Benefit

Inflation Protection: Compound Inflation () Simple Inflation () Future Purchase ()

Non-Forfeiture: Shortened BP () Return of Premium ()

Premiums: 10 Pay Reduced pay at 65 Age 65 pay Double Pay Discount

Other: Restoration of Benefits Survivorship Shared Care Monthly Benefit

Carrier Preferences: _____

Specific Medical Conditions and Medication Prescribed:

