Financial Solutions Group, Inc.
1311 S. Main Street, Suite 208, Mt. Airy, MD 21771
Email Request To: matthew@fsgbrokerage.com

Long-Term Care Illustration Request Form

Producer Information

Name_____ **E-Mail**_____**Fax**_____

Date: _____ Need by: _____ State: _____ **Send via: ☐ E-mail ☐ Fax ☐ Mail**

Insured Information

Name _____**DOB**_____**State**_____ **Sex ☐ Male ☐ Female**

Height _____ **Weight** _____ **☐ Married ☐ Living with Partner ☐ Single Living Alone**

Tobacco Use ☐ Current – Type _____ **☐ Former – Type & Date Quit** _____ **Never ☐**

Name of Spouse/Partner _____**DOB**_____**State**_____ **Sex ☐ Male ☐ Female**

Height _____ **Weight** _____

Tobacco Use ☐ Current – Type _____ **☐ Former – Type & Date Quit** _____ **Never ☐**

Medications – List Name & Dosage of Medications and *Condition Being Treated with the Medication*:

Medical Conditions or Hospitalizations in Last 10 Years

Policy Quote Information

Daily/Monthly Benefit Amount: _____

Benefit Period: ☐ 2 Yr ☐ 3 Yr ☐ 4 Yr ☐ 5 Yr ☐ 6 Yr ☐ 7 Yr ☐ 10 Yr

Elimination Period: ☐ 30 Day ☐ 60 Day ☐ 90 Day ☐ 180 Day ☐ 365 Day

Riders: ☐ Compound Inflation ☐ Simple Inflation ☐ Shared Care ☐ Waiver of HHC Elimination Period
☐ Restoration of Benefits ☐ Additional Cash Benefit ☐ Other

Existing Coverage Information

Coverage: ☐ NONE ☐ Group LTC ☐ Individual Elimination Period: _____ Monthly/Daily Benefit: _____
Benefit Period: _____ Company _____ Replacing Coverage? Y/N _____