

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 _____