Long Term Care Quote Request Form

Must be LTC certified to submit business.

Producer Name:	
Email:	
Phone Number:	

Date:

State Soliciting:	

Applicant A:		Applicant B:	
D.O.B.		D.O.B.	
Female/Male		Female/Male	
Height		Height	
Weight		Weight	
Tobacco User?		Tobacco User?	

Basic Benefits: Daily Benefit Amount:	$			
Elimination Period (days):	0	30	60	90
Benefit Period Year:	2	3	4	5
Expected Premium Range:	$			
Compound Increase:	3%	OR	5%	
Traditional LTC	UL with Chronic Illness Rider		LTC/Life Hybrid	
Other:				

Medical History Screening: Check all that apply	Applicant A:	Applicant B:
Do you use a cane or walker?		
Do you use oxygen or a respirator?		
Do you require assistance in performing the following: Moving in and out of bed or a chair, bathing, dressing, eating, toileting, bladder/bowel control?		
History of Cancer, Heart Disease, Diabetes?		
History of Asthma, COPD, Emphysema?		
History of Memory Loss, Stroke, TIA, Dementia, Parkinson's Disease?		
History of Liver or Kidney Disorder?		

If you answered "YES" to the above, specify which Applicant, Dates, and Details:	

Name of Medication	Date of when first started	Dosage	Frequency

Email To : newbusiness@lovettfinancial.net