

LTC QUOTE

AGENT: _____ Email/Phone: _____

INDIVIDUAL: _____ SHARED: _____

CLIENT NAME: _____

DOB/AGE: / / GENDER: M F

CLIENT NAME (SECOND INSURED) _____

DOB/AGE: / / GENDER: M F

SMOKER: ___ NON-SMOKER: ___

STATE: _____ PARTNERSHIP: _____

BENEFIT OPTION: MONTHLY: ___ DAILY: ___

ELIMINATION PERIOD: _____

BENEFIT PERIOD: _____

RATING (circle one): PREFERRED SELECT I II

PARTNER DISCOUNT: _____

INFLATION PROTECTION: _____% _____%

HEALTH DETAILS (i.e. medications, ailments, overall history of health and confinements): _____

Fax To: The Producers Firm 860-584-8462