

LONG TERM QUOTE WORKSHEET

Date: _____

Client Name: _____ Date of Birth: _____

State: _____ Spouse/Partner also applying? No Yes

Daily/Monthly Benefit Amt: _____ Benefit Period: _____

Elimination Period: _____

Inflation Protection: No Yes (if yes): Compound Simple

FIELD UNDERWRITING QUESTIONS

Are you currently, or have you ever used tobacco or nicotine products? No Yes (if yes, please explain)
Last date used & what form or products (cigarettes, cigars, pipe, chewing tobacco or nicorette gum)

Have you been hospitalized in the last 10 years? No Yes (if yes, please explain)

Do you have any medical conditions? No Yes (if yes, please explain)

What current prescriptions are you taking? Please indicate the name, dosage & times taken daily:

Do you use any medical devices (wheelchair, walker, oxygen or dialysis)? No Yes (if yes, please explain)

Do you require any kind of assistance when eating, dressing, walking or bathing? No Yes (if yes, please explain)

Do you have a monthly budget for LTC Insurance? No Yes (if yes, what amount)
