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Long Term Care Quote Request Form

Date: _____

Client/Name: _____ M-F Spouse: _____ M-F

DOB: _____ DOB: _____

Ht. _____ Wt. _____ Ht. _____ Wt. _____

Smoker: Y-N Chewing Tobacco: Y-N

Medications: _____

Medical Conditions: _____

Notes:

Facility Amount: \$ _____ Home Health Care: _____ 100% _____ 75% _____ 50%

Benefit Period: _____ 3yrs _____ 5yrs _____ 10yrs _____ Lifetime _____ Other

Elimination Period: _____ 0 _____ 30 _____ 60 _____ 90 _____ Other

Method of Payment: _____ Annual _____ Semi-Annual _____ Quarterly _____ Monthly

Premium Options: _____ 10yr-Pay _____ 20yr-Pay _____ Lifetime _____ +To Age 65

Benefit Increase: _____ None _____ 5% Simple _____ 5% Compound _____ Other

Return of Premium: _____ None _____ Shortened _____ Full

Other Riders: _____ Indemnity _____ Monthly Benefit _____ Daily Benefit

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