

Company Name Long-Term Care Insurance Quote Form

You may complete this form and send it to us using our secure server by clicking on the "Submit" button below or you may fill in the information, print the form from your browser window by clicking "Print Page" button above and mail or fax the form to:



Company Name
Company Address
City, State, Zip
Tel. (555) 555-5555
Fax (555) 555-5555
www.domain.com

* Denotes Required Field

General Information

*Name:

Social Security #:

Ex: 111-11-1111

*Address:

*City:

*State:

*Zip Code:

*Day Phone:

*Evening Phone:

Ex: 920-111-2222

Best Time to Call:

*E-Mail Address:

*Confirm E-Mail Address:

Personal Information

*Date of Birth:

Ex. 01/12/2007

Height:

ft.

in.

Weight:

lbs.

Marital Status:

If married, will spouse also be applying for coverage?

If "Yes," your spouse will need to complete a separate form

Have you been confined to a hospital in the last 24 months?

Current/Previous Insurance Information

Do you currently have another long-term care insurance policy, rider, or certificate? (Including health care services contract or health maintenance organization contract)

Did you previously have another long-term care insurance policy, rider, or certificate in force during the last 12 months

If so when did it lapse?

Ex. 01/12/2007

Are you covered by a state assistance program, such as Medicaid?

Do you intend to replace any of your medical or health insurance coverage with this policy, rider, or certificate?

Are you now receiving long-term care or disability benefits?

Have you ever been denied coverage for medical insurance, disability insurance, long-term care insurance, nursing home insurance, or life insurance?

If you answered "Yes" to any question in this section, please explain your answer(s) below:

Activities Information

Have you been confined to a hospital in the past 12 months?

Has a physician recommended in the past 24 months that you be hospitalized or confined to a nursing facility or have you had a surgical procedure?

Have you consulted with a physician in the last 12 months for loss of appetite, falling, unstable gait, bladder or bowel control, dizziness or vision problems, or weight loss of 10 pounds or more?

Do you need the help or supervision of another individual to perform your daily living activities; such as walking, dressing, eating, taking medication, or tending to personal hygiene?

Do you need the help or supervision of another individual to perform the independent activities of daily living; such as handling your finances, doing laundry, shopping, or using the telephone?

Do you use any assistive devices such as a walker, wheelchair, crutches, cane, grab bars, or any prescribed medical device or appliance?

If you answered "Yes" to any question in this section, please explain your answer(s) below:

Medical Information

In the past 5 years, have you ever had, been told by a physician you had, or been treated for:

Osteoarthritis, osteoporosis, amputation, bone or joint disease, rheumatoid arthritis, or spinal stenosis?

Internal cancer, tumor, leukemia, lymphoma, or Hodgkin's disease?

Disease of the kidney, stomach, liver, pancreas, or small or large intestine, or cirrhosis?

Diabetes or thyroid disease?

Disease of the lungs or respiratory system, emphysema, asthma, or shortness of breath?

Disease of the heart or circulatory system, heart attack, high blood pressure, or angina?

Psychological, psychiatric or mental disorder, anxiety, or depression?

Neurological disorder, including Parkinson's disease, multiple sclerosis, Alzheimer's disease, Stroke/TIA, paralysis, convulsions, epilepsy, seizures, or muscular dystrophy?

Have you been treated or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), or have you tested positive for the HIV virus (As indicated by the results of the ELISA-ELISA Western blot test series)?

Have you received medical advice, treatment, or counseling related to alcohol and/or drug abuse?

If you answered "Yes" to any question in this section, please explain your answer(s) below:

Medication Information

Please list below any prescription medications that you are currently taking:

Additional Information

Do you have a valid driver's license and drive at least twice per week?

Are you employed outside the home, or do you participate in any volunteer activities or organizations at least 8 hour per week?

Have you used tobacco products within the past 12 months?

Additional Comments

Please provide any additional comments that you feel would be appropriate for this quotation. If you have additional information to provide, where there were not enough fields above; please enter it here:

*Acknowledgement and Consent

I hereby certify that the above information is complete and accurate to the best of my knowledge. The agency receiving this application will retain the application whether or not a policy is issued. The agency may rely on this application when determining the quotation and when deciding whether to issue a policy. False statements may subject me to criminal penalties.

If a policy is issued, I authorize the agency to give information about me to its affiliates.

Yes No

***Enter Your Initials Here:**

***Today's Date:**

Ex: 01/12/2007

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