



# Long Term Care Insurance Quote Request Form

Please print legibly, failure to do so may result in incorrect or delayed quote delivery.

Date: \_\_\_\_\_

## AGENT INFORMATION

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Ext.: \_\_\_\_\_

Agent License Number (mandatory for FL and CA producers): \_\_\_\_\_

Company Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_

Email: \_\_\_\_\_

## CLIENT INFORMATION

Name: \_\_\_\_\_  Male  Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Smoker:  Yes  No

Marital Status: \_\_\_\_\_ Is Client's Spouse Applying?  Yes  No  
*Discounts may apply even if spouse is not applying.*

*If spouse is applying, please provide the following information:*

Spouse's Name: \_\_\_\_\_  Male  Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Smoker:  Yes  No

Client's Resident State: \_\_\_\_\_ State where application will be signed: \_\_\_\_\_  
*If an application is signed in a state other than the client's resident state, a valid reason must be provided.*

## POLICY OPTIONS

Carriers You Would Like Quoted: \_\_\_\_\_

Target Premium/Desired Premium Range: \_\_\_\_\_

Nursing Home Monthly Benefit: \$ \_\_\_\_\_ Nursing Home Benefit Duration: \_\_\_\_\_ Yrs. (1,2,3,4,5,6, lifetime)

Home Health Care Coverage:  50%  75 - 80%  100%

Elimination Period: \_\_\_\_\_ Days

Inflation Protection Option:  Compound \_\_\_\_\_ %  None

Riders:  Shared Care  Waiver of Elimination Period for Home Care  Survivorship

Joint Waiver of Premium  Nonforfeiture

I would like Lakeview Financial to call me to discuss available long term care insurance options.

Special Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Please note: Lakeview Financial will only quote a standard rate unless a completed Medical History Form is provided along with this Quote Request Form.*

**Contact Lakeview Financial for more information at 800.841.2855.**

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