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Today's Date: ___ / ___ / ___

LTCi Quote Request

Return this completed request form to our office via fax or email and we will provide you with a prompt and educated response!

CLIENT(S) INFORMATION

Name: _____ DOB: _____ Sex: Male Female State: _____
 Height: _____ Weight: _____
 Medications: _____

Brief Medical History for last 5 years: _____

Self-Employed: Yes No Corporation Type: C-Corp S-Corp LLC

Spouse or Partner Name: _____ DOB: _____ Sex: Male Female
 Spouse Height: _____ Spouse Weight: _____
 Medications: _____

Brief Medical History for last 5 years: _____

POLICY BENEFIT SELECTION

Benefit: \$ _____ (Daily/Monthly) Home-Community: _____ %
 Elimination Period: _____ Days Benefit Period: _____ Years (2-10, Unlimited)

Inflation Protection: 5% Simple 5% Compound 2x 3% Compound No Max
 5% Compound None

Additional Riders: Shared Care Shared Waiver Restoration of Benefits
 Survivorship 10 yr Payment To Age 65 Premium
 Cash Benefit Return of Premium Other: _____

Desired Rate Class: Standard Preferred

Quote Specific Company: MedAmerica (CASH) Prudential (CASH) MetLife
 Great American (CASH) Genworth Allianz
 Other: _____

Miscellaneous: _____

LICENSED AGENT INFORMATION

Licensed Agent: _____ Phone: _____
 Fax: _____ Email: (preferred) _____

Client Name:	Age:	State:
Telephone Number:	Height:	Weight:

CLIENT HEALTH INFORMATION

Medications - Dosages - Number of Years/Months Taking Medication - What Condition Medication is Treating

Medication	Condition Treating	Medication	Condition Treating
1.		4.	
2.		5.	
3.		6.	

1. In the last 5 years, what conditions, special tests or other treatments, or hospitalizations/surgery have you had? ____	
When diagnosed?	How Treated?
Current Status?	Any ADL/IADL Limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Date last time seen by primary doctor: mm/yyyy?	
3. Most recent blood pressure reading?	
4. Do you see any specialists? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. What is your occupation?	
6. How many hours a week do you work?	
7. Hobbies/Activities?	
8. Any limitations or symptoms we have not discussed? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list:	
Medical Conditions-please mark all that apply: <input type="checkbox"/> 3 or more cardiac medications <input type="checkbox"/> Emphysema/COPD	
<input type="checkbox"/> 3 or more treated medical conditions <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Conditions treated with steroids <input type="checkbox"/> Compression Fractures	
<input type="checkbox"/> Dizziness/Fainting/Head Trauma <input type="checkbox"/> History of stroke/TIA within last 5 years <input type="checkbox"/> Diabetes	
<input type="checkbox"/> Depression with Psychotherapy	

ADDITIONAL QUESTIONS IF THE FOLLOWING CONDITIONS EXIST

❖ **BONE, JOINT, OR MUSCULAR PROBLEM ADDITIONAL QUESTIONS?**

1. Surgery/joint replacements in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. Any history of joint injections in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Any "flares" of symptoms in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Do you have any joint deformities? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you currently in physical therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Do you use a cane, walker, braces, crutches, wheelchair, stair lift, scooter? <input type="checkbox"/> Yes <input type="checkbox"/> No

❖ **DIABETES ADDITIONAL QUESTIONS?**

1. Do you check your own blood sugars? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. How often does your doctor check your bloodwork?
3. What are your fasting blood sugars usually?	4. Do you know your glycosolated hemoglobin (A1C)? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you have any neuropathy - tingling, numbness, pain in arms or legs? Describe symptoms: How long? Any change to lifestyle? Any increase?	6. In addition to Diabetes, do you have any condition requiring Steroid or Immunosuppressant Therapy? (IF YES: Not Insurable) <input type="checkbox"/> Yes <input type="checkbox"/> No

❖ **CANCER ADDITIONAL QUESTIONS?**

1. Do you know what stage your cancer was?	2. Do you have any positive lymph nodes? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. How was your cancer treated?	4. When did treatment end? Chemotherapy? Radiation? Surgery? Seed Implants?