

"I NEED A QUOTE"

FAX COMPLETED FORM TO 651.636.6886
FOR ASSISTANCE, CALL 651.636.6333

Rush / Prepare Immediately **Normal** / In 24 hours Please call me to discuss my case

NAME _____

PHONE _____ EMAIL _____ FAX _____

TELL US ABOUT YOUR CLIENT(S)

Recent Decline Yes No

Name _____ Date of Birth _____ State _____

Married Yes No Spouse/ Partner Applying: Name _____ Date of Birth _____

Carrier Preference _____ Most Competitive Carrier

Notable Health Concerns _____

Medications (Include dosage and length of treatment) _____

CHOICE OF BENEFITS

Maximum Daily Benefit (NH) _____ Plan Duration (Years) 3 4 5 6 8 10 Unl 5+1M

Elimination Period (Days) 0 30 60 90 180 | Waive Elimination Period for HHC

Assisted Living (% of NH) 50% 60% 70% 80% 100%

Professional HHC (% of NH) 100% 200% 300% (Basic paid at 1/2 of Prof)

CHOICE OF OPTIONS

Monthly HHC Option – Benefits paid on monthly (instead of daily) basis

Benefit Increase Options: Compound Lifetime: 4% 4.5% 5% Consumer Price Index

5% Compounded – 10 Years 5% Compounded – 20 Years 5% Compounded – Double Max

5% Simple Future Purchase Option

Spouse Related Options: Shared Care Survivorship/Waiver of Premium Spouse Security

Return of Premium: Full Less Claims

Pay Period: Lifetime 10 Pay 20 Pay Pay to Age 65 Single Pay

BENEFIT PAYMENTS

Reimbursement of Incurred Charges Cash regardless of Incurred Charges

Reimbursement w/some cash

IS THERE COMPETITION?

Company _____

New Insured (Include proposed Schedule of Benefits)

Replacement (Include current Schedule of Benefits or Information you have.)

