

# 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 included.* \_\_\_\_\_

## 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 LWT to call me to discuss available long term care insurance options.

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

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



Please send this completed Quote Request Form in an encrypted email to [ltcsales@lwtsolutioncenter.com](mailto:ltcsales@lwtsolutioncenter.com). If you have additional questions, please contact LWT LTC Solution Center Sales Desk at 800.998.3382, option 2, option 3



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